Serving Citizens Through the 202A Process

Kentucky Judicial Commission on
MENTAL HEALTH

Findings and Recommendations from the 2025 KJCMH Virtual Forums

Executive Summary

The Kentucky Judicial Commission on Mental Health (KJCMH), in partnership with the Kentucky Supreme Court and the Cabinet for Health and Family Services' Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID), convened fourteen regional KJCMH Virtual Forums: Serving Citizens through the 202A Process in the summer of 2025. These forums created a rare opportunity for judges, clerks, attorneys, sheriffs, jailers, behavioral health providers, hospitals, and community leaders to engage in frank dialogue about Kentucky's involuntary commitment process under KRS Chapter 202A.

The forums revealed recurring barriers to effective acute behavioral health crisis response, particularly in transportation, evaluator availability, medical clearance, and communication across systems, but also highlighted pockets of innovation and strong cross-system partnerships. The discussions made clear that while the challenges are complex, solutions are emerging at both the local and statewide levels.

This report provides an overall summary of the statewide forums, analyzes statewide challenges, documents promising practices, and sets forth recommendations for policy reform, training, and continued collaboration. The findings underscore that Kentucky's response to behavioral health crisis requires not only system improvements but also shared collaboration across disciplines to uphold dignity, safety, and access to care.

Introduction and Background

Kentucky's 202A process governs involuntary hospitalization and evaluation of individuals experiencing acute behavioral health crisis. These cases place courts in the difficult position of balancing constitutional rights, public safety, medical needs, and community expectations.

The Kentucky Supreme Court, recognizing systemic concerns with this process, charged the KJCMH with convening partners to study the issue. From June to September 2025, fourteen forums were conducted, one in each Community Mental Health Center (CMHC) catchment area.

The forums were not public hearings but solution-focused conversations. Participants were candid, describing real challenges while also highlighting innovations that could serve as statewide models.

Purpose of the Forums

The 202A Virtual Forums were convened to achieve several overarching goals:

1. **Review the 202A process.** Provide an overview of the involuntary commitment system, including terminology, pathways, and clinical/legal considerations.
2. **Identify barriers.** Gather insights from partners about obstacles that hinder timely, effective, and humane responses to individuals in crisis.
3. **Share best practices.** Highlight successful local strategies already in use and assess their adaptability across regions.
4. **Develop localized solutions.** Encourage collaboration among community partners to design action steps suited to the unique resources and challenges of each region.
5. **Strengthen statewide policy.** Ensure that insights from local conversations inform recommendations to the Kentucky Supreme Court, the General Assembly, and partner agencies.

These forums acknowledged the profound impact of involuntary hospitalization on individuals, families, and communities. Participants were reminded that the stakes include public safety, constitutional rights, and the dignity of individuals with mental illness, all of which demand a coordinated and compassionate system response.

Key Partners and Their Roles in the 202A Process

Forum participation included partners from all sectors involved in the 202A process, each offering insight into their role and the challenges they encounter.

- **Circuit Court Clerks:** process petitions, certify and transmit court orders, and maintain required documentation that moves each stage of the 202A process forward.
- **Community Mental Health Center Representatives (CMHCs):** serve as qualified mental health professionals who conduct evaluations and certifications referenced in KRS 202A and provide recommendations regarding appropriate levels of care.
- **Community Partners (e.g., hospitals, private providers):** regularly interact with individuals during the crisis phase of the 202A process, provide clinical services, initiate referrals, coordinate care, and assist with discharge planning. Their involvement offers critical context on service availability, operational challenges, and opportunities for stronger front-end intervention.
- **County Attorneys:** advise petitioners, represent the Commonwealth at hearings, and ensure compliance with legal standards set forth in KRS 202A.
- **County Judge/Executives:** play an administrative and fiscal role, including oversight of local resources and county-level supports that influence timely transport, coordination, and system capacity.

- **Department of Public Advocacy (DPA):** provides representation to respondents, ensuring statutory due process, protection of rights, and legal advocacy throughout the proceedings.
- **District Court Judges:** make statutory determinations on petitions, issue orders for examination and hospitalization, and ensure due process is followed under KRS 202A.
- **Jailers:** often encounter individuals during crisis, manage custody and sometimes assist with transport when individuals are held pending evaluation, and coordinate with courts and evaluators under statutory timelines.
- **Sheriff's Departments:** carry out service of process and statutory responsibilities related to transport, including moving individuals for examination, evaluation, or hospitalization.
- **State Psychiatric Hospital:** conducts mandated evaluations, provides certification and clinical documentation required by the court, and delivers hospitalization and treatment as outlined in statute.

KRS 202A Involuntary Hospitalization Process

Kentucky's involuntary hospitalization process, outlined in KRS Chapter 202A, establishes the legal framework for responding to individuals experiencing acute behavioral health crises when voluntary treatment is not possible. The statute defines the thresholds for intervention, the responsibilities of courts and clinical providers, and the procedural steps required to ensure constitutional protections while addressing immediate safety concerns. This section provides a basic explanation of the statutory pathways, from petition to evaluation, court review, and potential hospitalization, to support a shared understanding of how the process operates across systems involved in emergency behavioral health response.

Involuntary hospitalization is typically initiated by either:

1. **BY WARRANTLESS ARREST** (per KRS 202A.041)**:**
    - **a.** Peace officer has reasonable grounds to believe that an individual is mentally ill and presents danger or threat of danger to self, family, or others
    - **b.** Peace officer may transport the individual to a hospital or behavioral health facility designated by the cabinet to be evaluated by a contract mental health evaluator
    - **c.** Peace officer shall provide written documentation that describes the behavior of the person that caused the peace officer to take the person into custody
    - **d.** Person is evaluated, and:
        - **i.** If after evaluation, the mental health evaluator finds the person **does meet criteria** for involuntary hospitalization, 202A proceedings must be initiated **or**
        - **ii.** If after evaluation, the mental health evaluator finds the person **does not meet criteria** for involuntary hospitalization, the person must be released immediately and transported back to their home county (transportation as provided in KRS 202A.010) **or**
        - iii. If after evaluation, the mental health evaluator finds the **person does not meet criteria** for involuntary hospitalization and the peace officer has probable cause to believe the person has committed a criminal offense, the peace officer may issue a warrant and take the person before a judge

Person may be held up to 18 hours to accomplish certification of initial evaluation and initiation of proceedings under KRS 202A

2. **HOSPITALIZATION BY COURT ORDER (per KRS 202A.028):**
    - **a.** Person is examined by a qualified mental health professional [1] and the qualified mental health professional certifies that the person meets criteria for involuntary hospitalization
    - **b.** Judge may order the person to be involuntarily hospitalized, **but for no more than 72 hours** *(not including weekends or holidays)*
    - **c.** After the person is ordered to be admitted, they must be transported from the person's home county by the sheriff or other peace officer as ordered by the court – the sheriff or other peace officer may, upon agreement, authorize another party to do the transfer (the cabinet, a private agency that has a contract with the Cabinet, or an ambulance service that the Cabinet designates)[2]
    - **d.** After the 72 hours is completed, there are three options:
        i. Patient needs further inpatient treatment and agrees to sign a voluntary admission
        ii. Patient does not require further inpatient treatment and is released
        iii. Patient needs further treatment and will not agree to voluntary admission, so hospital files 60-day (or 360-day) petition for longer period of involuntary hospitalization
    - **e.** Anyone released under this 72-hour court order must be transported back to their county by a sheriff or other peace officer, by ambulance services designated by the Cabinet, or by other appropriate means of transportation consistent with the treatment plan of the person.

No one held under this 72-hour court order shall be held in jail pending evaluation and transportation to the hospital

3. **72- HOUR EMERGENCY ADMISSION** (per KRS 202A.031):
    - **a.** An authorized staff physician may order the admission of any person who is present at a hospital[3]
    - **b.** The authorized staff physician may order the person to be involuntarily hospitalized
    - **c.** Within 24 hours [*this does not include weekends or holidays]* of admission, the staff physician must certify in the record why he believes the person should be involuntary hospitalized
    - **d.** After the 72 hours is completed, there are three options:
        i. Patient needs further inpatient treatment and agrees to sign a voluntary admission
        ii. Patient does not require further inpatient treatment and is discharged
        iii. Patient needs further treatment and will not agree to voluntary admission, so hospital files 60-day (or 360-day) petition for longer period of involuntary hospitalization

[1] See KRS 202A.028(1)(a)–(c) ("a staff member of a regional community program for mental health or individuals with an intellectual disability; an individual qualified and licensed to perform the examination through the use of telehealth services; or the psychiatrist ordered, subject to the court's discretion, to perform the required examination").
[2] *See* KRS 202A.028(3) (providing that transportation costs shall be paid by the Cabinet).
[3] *See* KRS 202A.031 (defining "hospital" to include any acute care hospital licensed by the Commonwealth).

4. **BY A PETITION FROM AN INTERESTED PARTY** (per KRS 202A.051)

Proceedings for 60 and 360 Day Involuntary Hospitalizations (per KRS 202A.051)

Who can file:

a. The petition shall be filed by a qualified mental health professional, peace officer, county attorney, Commonwealth's attorney, spouse, relative, friend, or guardian of the individual concerning whom the petition is filed, **or any other interested person**.
b. Interested party includes a qualified mental health professional, peace officer, county attorney, Commonwealth's attorney, spouse, relative, friend, or guardian of the individual, or any other interested person who believes that an individual is mentally ill and presents an immediate danger or threat of danger to self, family or others.
c. Once the court receives the petition, the court must examine the petitioner under oath (*Exception: if the petitioner is a qualified mental health professional, the court may dispense with the examination*).

Before the preliminary hearing:

a. If the court finds there is **no probable cause to believe** the individual should be involuntarily hospitalized, the petition is dismissed.
b. If the court finds **there is probable cause to believe** the individual should be involuntarily hospitalized, there are two options that can happen, depending on what the judge finds and the individual's current status:

Option 1 – If the court (and parties) do not object, the court must implement the procedures of KRS 202A.028 and order the individual to be examined without delay by a qualified mental health professional.
Option 2 – If the court or any party object to using the 202A.028 procedure, or if the individual is already being held under the provisions of 202A, the court shall set a date for a preliminary hearing.

Preliminary hearing:

a. The preliminary hearing shall be set within 6 days *(excluding holidays and weekends)* from the respondent's holding, or if not held, from the time of examination.
b. The court shall notify the respondent, the legal guardian, if any, and if known, and the spouse, parents, or nearest relative or friend of the respondent concerning the allegations and contents of the petition and the date and purpose of the preliminary hearing; and the name, address, and telephone number of the attorney appointed to represent the respondent.
c. The court shall cause the respondent to be examined without unnecessary delay by two (2) qualified mental health professionals, at least one (1) of whom is a physician. The qualified mental health professionals shall certify within twenty-four (24) hours (excluding weekends and holidays) their findings.

After the preliminary hearing:

a. Venue shall be transferred to the county where the individual is hospitalized or the court can, upon its own motion or motion of a party, retain venue (see KRS 202A.053)
b. **If the court does not find probable cause after preliminary hearing**, the proceedings against the individual shall be dismissed, and the individual shall be released from any holding (see KRS 202A.051(10))
c. **If the court finds there is probable cause to believe the individual should be involuntarily hospitalized**, the court shall order a final hearing within 21 days from the date of holding (or if the person is not held, then the date of the examination) to determine if the individual should be involuntarily hospitalized.

Final hearing

a. At the final hearing, if the court finds the individual **meets criteria for involuntary hospitalization,** then the court shall order hospitalization for up to 60 consecutive days (if requested) or up to 360 consecutive days (if criteria and petition requirements are met).
b. At the final hearing, if the court finds the individual **does not meet criteria**, the proceedings against the individual shall be dismissed, and the individual shall be released from any holding.

Implementation Plan Overview

The forums followed a consistent structure:

- Opening remarks from the Kentucky Supreme Court and DBHDID leadership.
- An overview of KRS 202A and current challenges, presented by DBHDID, as seen in Appendix A.
- Process-based discussions with judiciary, providers, and law enforcement.
- Solution planning and identification of next steps.
- Closing remarks emphasizing continued collaboration and post-forum survey follow-up.

This intentional design created a safe, solution-focused space. Participants were encouraged to be candid, while understanding that conflicting viewpoints were expected and respected. The forums were not meant to resolve every issue but to document barriers, brainstorm solutions, and chart a collective path forward.

Schedule of Forums by Region

The following forums were conducted, each tailored to the counties served by the designated Community Mental Health Center:

1. **June 25 – NorthKey Community Care (Eastern State Hospital region)**
   Counties: Boone, Campbell, Carroll, Gallatin, Grant, Kenton, Owen, Pendleton
2. **July 7 – Pathways, Inc. (Eastern State Hospital region)**
   Counties: Bath, Boyd, Carter, Elliott, Greenup, Lawrence, Menifee, Montgomery, Morgan, Rowan
3. **July 8 – Kentucky River Community Care (Appalachian Regional Healthcare region)**
   Counties: Breathitt, Knott, Lee, Leslie, Letcher, Owsley, Perry, Wolfe
4. **July 14 – LifeSkills, Inc. (Western State Hospital region)**
   Counties: Allen, Barren, Butler, Edmonson, Hart, Logan, Metcalfe, Monroe, Simpson, Warren
5. **July 15 – Communicare, Inc. (Central State Hospital region)**
   Counties: Breckinridge, Grayson, Hardin, Larue, Marion, Meade, Nelson, Washington
6. **July 16 – Comprehend, Inc. (Eastern State Hospital region)**
   Counties: Bracken, Fleming, Lewis, Mason, Robertson
7. **July 23 – Cumberland River Behavioral Health (Appalachian Regional Healthcare region)**
   Counties: Bell, Clay, Harlan, Jackson, Knox, Laurel, Rockcastle, Whitley
8. **August 18 – Mountain Comprehensive Care Center (Appalachian Regional Healthcare region)**
   Counties: Floyd, Johnson, Magoffin, Martin, Pike
9. **August 20 – New Vista (Eastern State Hospital region)**
   Counties: Anderson, Bourbon, Boyle, Clark, Estill, Fayette, Franklin, Garrard, Harrison, Jessamine, Lincoln, Madison, Mercer, Nicholas, Powell, Scott, Woodford
10. **August 25 – Four Rivers Behavioral Health (Western State Hospital region)**
    Counties: Ballard, Calloway, Carlisle, Fulton, Graves, Hickman, Livingston, McCracken, Marshall
11. **August 26 – River Valley Behavioral Health (Western State Hospital region)**
    Counties: Daviess, Hancock, Henderson, McLean, Ohio, Union, Webster
12. **August 27 – Adanta (Eastern State Hospital region)**
    Counties: Adair, Casey, Clinton, Cumberland, Green, McCreary, Pulaski, Russell, Taylor, Wayne

13. **September 2 – Pennyroyal Center (Western State Hospital region)**
    Counties: Caldwell, Christian, Crittenden, Hopkins, Lyon, Muhlenberg, Todd, Trigg
14. **September 3 – Seven Counties Services (Central State Hospital region)**
    Counties: Bullitt, Henry, Jefferson, Oldham, Shelby, Spencer, Trimble

Regional Forum Overview

Across the forums, participants engaged in open discussion about how the involuntary commitment process operates in their communities, offering a wide range of experiences that highlighted the varied realities across the state. While many themes were shared across regions, each community also described distinct pressures shaped by geography, staffing, local infrastructure, and available behavioral health resources. Partners discussed how small or rural jurisdictions often face challenges that differ significantly from more populated areas, including longer travel distances, limited after-hours availability, and fewer specialized services. Others noted that more urban environments may experience high volumes of petitions, strained emergency departments, or complex coordination challenges across multiple service systems. These differences underscored the importance of tailoring statewide reforms to accommodate diverse local contexts.

Forum participants described a number of situational factors that complicate the 202A process beyond the broader trends summarized later in this report. Some communities shared that the physical distance between hospitals, courts, and behavioral health providers created additional stress for both individuals in crisis and the agencies responsible for responding. In several areas, long wait times in crowded emergency departments left individuals in heightened distress, and participants reported families' struggles navigating the system. Participants described how individuals with complex medical needs or co-occurring conditions sometimes moved between facilities repeatedly because appropriate placements were limited.

Communication across systems emerged as a layered concern. Partners described circumstances where information did not flow consistently between hospitals, law enforcement, behavioral health providers, and courts, leading to confusion about next steps, timelines, or the responsibilities of each agency. Several communities discussed the challenge of coordinating care when multiple jurisdictions or service areas were involved, noting that differences in policies, capacity, and communication practices could lead to delays or misalignment. In some places, partners described that individuals were transported or placed based on availability rather than local relationships, which created disconnects in follow-up care or continuity.

Forum participants also described how population-specific needs influenced their local processes. Communities frequently mentioned that older adults, individuals with dementia, individuals with intellectual or developmental disabilities, and those with significant medical needs often required solutions that did not exist within their region. In some cases, individuals who were willing to seek help voluntarily still entered the involuntary pathway due to gaps in placement or guardianship availability. Several partners expressed worry about individuals returning quickly to crisis settings without adequate follow-up supports, especially when housing, long-term treatment options, or case management resources were limited.

Despite these challenges, the forums surface meaningful examples of innovation and local problem-solving. Communities shared how they created written protocols, collaborative workgroups, and streamlined processes to reduce confusion and improve efficiency. Some developed alternative response models or crisis stabilization approaches that diverted individuals away from more restrictive levels of care when appropriate. Others reported that reallocating resources or developing new partnerships significantly improved how quickly individuals received help. Several communities adopted new communication practices that strengthened coordination, while others piloted voluntary evaluation or

observation programs that led to better outcomes for individuals and reduced strain on law enforcement and hospitals.

While the specific circumstances varied across regions, all partners demonstrated a shared commitment to improving safety, timeliness, and outcomes for individuals experiencing a mental health crisis. Following the completion of all fourteen forums, the recordings were reviewed, and participant comments were transcribed and coded for common themes. These qualitative insights were then combined with the quantitative data gathered from the post-forum surveys, which captured input from additional partners who were unable to attend or wished to provide further feedback. Every comment was categorized and added to the survey data to yield the emerging trends presented in this report.

Survey Results and By the Numbers

Following each of the fourteen 202A Regional Forums, the Commission invited participants to complete a brief follow-up survey to share additional insights about their experiences with Kentucky's involuntary commitment process. The survey link was provided to all attendees, along with those unable to participate in the forums, ensuring broad representation of perspectives across systems and regions. These responses reflect the experiences of court personnel, law enforcement, hospitals, community mental health centers, mobile crisis teams, and other partners who play a role in the 202A process.

The primary purpose of collecting this information was to better understand how the process functions locally, identify shared challenges, and highlight opportunities for strengthening coordination, communication, and practice consistency statewide. The feedback summarized in the following sections provides an important foundation for shaping future recommendations, training efforts, and system-level improvements.

202A Virtual Forum Survey Results

A total of 139 individuals completed the 202A Virtual Forum Follow Up Survey, representing a broad cross section of Kentucky's behavioral health, legal, law enforcement, medical, and court systems. The survey drew participation from every region of the state, including both rural and urban counties, which provides an accurate picture of the statewide experience with the 202A process.

Participants were asked to identify the Community Mental Health Center region they serve or support, and responses showed representation across all fourteen regional centers. Communicare had the highest number of selections with 18 respondents indicating that they serve this region. Cumberland River Behavioral Health and Adanta each received 17 selections. NorthKey received 15 selections, while Pathways and RiverValley each received 11. Seven Counties Services received 10 selections, and both Comprehend and Pennyroyal received 9. Mountain Comprehensive Care and Four Rivers received 7 each, and both LifeSkills and Kentucky River Community Care received 6. Four respondents reported serving in a statewide capacity. Because this was a multi select question, these numbers reflect total selections rather than the number of respondents in each region.

With regard to the role of participants in the system, the largest participation came from district court judges, jailers, and circuit clerks. These three roles made up over one-third of the total responses. Other commonly represented roles include county attorneys, community mental health center representatives, and sheriffs.

Participants were also asked whether they attended their regional 202A virtual forum. Most respondents reported that they participated in a forum (83%) and the overall engagement suggests a strong interest from local professionals in improving the involuntary hospitalization process. Even among those who did

not attend, many still provided detailed feedback, which reinforces the level of concern and investment across counties.

Respondents identified a wide range of challenges within the current 202A process. Although these responses were captured through multi select options, the general themes reflect systemic issues that impact nearly every region of the state. Participants frequently described delays in psychiatric evaluations, long wait times in emergency departments, and restricted mental health bed capacity in certain designated psychiatric catchment areas. A desire for more psychiatric services in each region was expressed. Several reported that law enforcement is often left waiting for extended periods in emergency departments or transporting individuals across long distances due to a lack of local resources. Communication gaps between hospitals, community mental health centers, courts, and law enforcement were also repeatedly mentioned as major barriers. These challenges prevent individuals in crisis from receiving timely and appropriate care and create heavy burdens on county level systems.

When asked what improvements they would most support, respondents identified a need for clearer guidance, better interagency collaboration between court staff and behavioral health providers, and expanded access to crisis services less restrictive than hospitalization. Statewide cross training was frequently recommended as a way to improve consistency in how 202A cases are processed. The need for standardized tools, such as flowcharts, timelines, and local response templates, also appeared repeatedly in open responses. In addition to these operational changes, many respondents emphasized the need for increased funding to support the behavioral health infrastructure that the 202A process relies on. Several noted that jails, hospitals, and crisis providers cannot meet statutory expectations without additional resources. Participants described long wait times for psychiatric beds, limited detox options, and a lack of local crisis stabilization units. Respondents explained that meaningful improvement to the 202A process will require investments in treatment facilities, staffing, transportation, and community-based services that can safely divert individuals from unnecessary hospitalization or incarceration. As a result, increased funding for both facilities and services was identified as one of the most significant needs across regions.

Participants were asked to identify collaboration gaps within the 202A process. The most common gap, reported by nearly one in four participants, was between law enforcement and behavioral health. Other gaps identified included those between medical and legal professionals, community mental health centers and emergency departments, and courts and hospitals, each cited by approximately 12–14% of respondents.

Participants were asked to identify the types of resources that would assist them in their roles. The most requested resource was a contact list for local 202A partners, cited by roughly 18% of respondents. An additional 15% requested access to training on 202A law and procedure, while 14% identified a need for greater clarification around roles and responsibilities within the 202A process. Respondents further noted that outcome data and regional implementation guides would be helpful resources.

Participants were asked which topics they would like addressed in future forums or trainings. Legal roles and responsibilities and examples from successful counties each received 51 selections. Criteria for involuntary hospitalization received 47 selections, and courtroom best practices received 27. Ten respondents indicated that none of the listed topics were needed. Several respondents provided additional suggestions, including further training on 202B, expanded inpatient commitment options, and improved understanding of discharge planning for individuals receiving inpatient behavioral health services.

Respondents were asked whether they would like assistance with developing a local 202A response plan. Seventy respondents selected “maybe” and indicated they would like more information before deciding, while twenty-two selected “yes” and requested direct assistance. Forty-seven respondents stated that their county does not need a response plan at this time. These results indicate that more than two thirds of

respondents are at least open to developing a structured local plan to improve coordination across agencies. The most commonly requested types of assistance were a 202A implementation toolkit and support identifying existing resources.

Finally, survey participants were asked whether they would like to receive follow up information or updates about future forums, resources, or trainings. One hundred thirty respondents selected yes and only nine selected no. This result demonstrates a very high level of interest in ongoing communication, training, and statewide support related to the 202A process.

Overall, the survey results reflect a strong desire for improved consistency, communication, and access to services across the entire state. Respondents clearly recognize the strain that the current system places on individuals in crisis, their families, law enforcement, hospitals, and courts. The numbers show that Kentucky professionals want clarity, structure, collaboration, and statewide support to create a more effective and humane 202A process.

*Please see Appendix B for a full list of survey questions and the corresponding data.

Statewide Trends, Recommendations, and Next Steps

Introduction to Statewide Findings

While each of the fourteen regional forums reflected the unique geography, resources, and culture of its counties, common threads emerged across all conversations. These recurring themes illustrate not only the shared burdens but also the collective opportunities for reform. The 202A process, as currently implemented, places significant strain on law enforcement, hospitals, courts, and families alike. Yet within these challenges, court partners identified creative solutions, collaborative partnerships, and promising models that point the way forward.

The following analysis synthesizes statewide findings into seven major trends, illustrated with examples drawn from across the forums and post forum survey. Each trend is paired with recommendations that emerged from the discussions, alongside forward-looking strategies for the Kentucky Judicial Commission on Mental Health to pursue in partnership with the courts, the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID), and the legislature.

Trend 1: Transportation and Access as the Most Urgent and Universal Barrier

No issue generated more passionate discussion than transportation. In every forum, sheriffs and deputies described transports as overwhelming, time-consuming, and unsafe. In rural counties, deputies regularly spent 6–8 hours transporting an individual to a hospital several counties away. During that time, entire communities were left uncovered.

Some deputies described leaving their jurisdiction unprotected for nearly a full day to complete a single 202A transport. Other deputies admitted to refusing transports when resources were too thin, forcing petitions to expire and restarting the entire process.

The burden was not limited to law enforcement. Families were often left waiting anxiously while officers tried to secure a bed and coordinate transport. Judges acknowledged feeling conflicted when signing orders that required deputies to drive hours away, knowing it created local safety risks.

Recommendation: Kentucky must reform its transportation protocols. Solutions raised across forums included:

- Clarifying statutory responsibility for transport.
- Funding alternatives, including EMS and contract transport services.
- Providing reimbursement through Medicaid or opioid settlement funds.
- Encouraging regional transport collaboratives to share burdens.

The Commission should prioritize a statewide study of transport times and costs to inform legislative advocacy. Without relief in this area, every other system reform will remain limited in impact.

Trend 2: Variations in Medical Clearance Processes Can Create Assessment Delays

Inconsistent application of medical and clinical clearance practices emerged as another significant barrier in the 202A process. While some state-operated psychiatric hospitals may not require formal medical clearance prior to admission, hospital emergency departments require medical clearance prior to transfer or discharge to comply with regulatory expectations for emergency care. However, differences in medical staff resources among hospitals can contribute to variations in how and when patient-centered decisions are made in the emergency department setting. The result can be extended delays, confusion, and frustration for families, law enforcement, and court personnel. Participants described situations in which individuals remained in emergency departments for hours awaiting clearance that ultimately could not be completed, delaying access to appropriate psychiatric care.

Judges and attorneys expressed concern that prolonged clearance processes strain limited resources and may conflict with statutory timelines designed to protect individual rights. At the same time, partners acknowledged that medical clearance must remain patient-centered and responsive to individual medical needs, as well as compliant. Moreover, partners recognized clearance requirements will vary across facilities due to differing operational models, medical staff bylaws, and admitting authority.

Recommendation: Kentucky should pursue a coordinated, statewide framework for medical and clinical clearance that is developed collaboratively by the Department for Behavioral Health, Developmental and Intellectual Disabilities, the Kentucky Hospital Association, and the courts. Rather than imposing a rigid, one-size-fits-all standard, this framework should establish shared guiding principles, clarify when medical clearance is clinically necessary, promote consistent communication expectations, and support facility-appropriate protocols. The goal should be to reduce unnecessary delays while ensuring patients are medically stable for transfer and receive timely access to the appropriate level of behavioral health care.

Trend 3: Evaluator Capacity and Consistency

Nearly every forum highlighted evaluator shortages. Mobile crisis teams and telehealth were praised when available during daytime hours, but after-hours availability was perceived to rarely functioned consistently. As a result, individuals in crisis sometimes waited overnight in jail cells or hospital ERs until an evaluator could be reached.

Some judges described struggling to schedule hearings when no evaluators were available. For example, one evaluator covered multiple counties overnight, creating inevitable delays.

Recommendation: Expand evaluator capacity through a combination of strategies:

- Fund additional evaluator positions with priority for rural areas.
- Expand after-hours telehealth access statewide.
- Develop regional hubs with evaluators on-call 24/7.
- Create funding incentives for CMHCs to maintain reliable after-hours coverage.

Trend 4: Judicial Access, Processes and Statutory Clarity

Judicial access afterhours varied significantly across counties. Many jurisdictions reported having judges available through 24-hour on-call rotations, while others relied on pre-signed orders or standing authorizations with unclear expiration periods. These practices contributed to confusion and inconsistent application of the law for law enforcement, hospitals, and court staff. Participants also identified wide variation in judicial procedures related to the use of electronic forms and electronic signatures, with some courts fully utilizing available technology and others relying on paper-based or in-person processes.

Judges themselves acknowledged uncertainty regarding statutory thresholds, particularly the interpretation of what constitutes "danger to self or others." Judges, attorneys, and advocates expressed concern that inconsistent judicial access and decision-making standards across counties undermine procedural fairness, due process, and public confidence in the 202A process.

Recommendation: Judicial involvement in the 202A process should be timely, accessible, and consistent statewide. Judges should make themselves available during nights, weekends, and holidays to review and sign petitions and certifications, ensuring that decisions affecting an individual's liberty are made through real-time judicial review rather than reliance on pre-signed or standing orders. The Commission should develop judicial bench cards, model orders, and ongoing training to support consistent application of statutory criteria across jurisdictions.

In addition, the courts should work toward a standardized statewide process for judicial review of 202A certifications, including universal access to electronic forms, electronic signatures, and secure digital petition platforms to support after-hours review. Legislative clarification should also be considered to address statutory ambiguities, including the permissible use and expiration of pre-signed orders. Together, these steps would strengthen due process protections, promote uniformity, and enhance public trust in Kentucky's involuntary hospitalization framework.

Trend 5: Cross-System Communication and Coordination

Throughout the forums, participants described communication as fragmented and unreliable. Hospitals discharged patients without notifying CMHCs. Courts were unaware of delays in evaluations. Law enforcement struggled to coordinate with hospitals about bed availability.

In one region, CMHC staff were often not informed when patients were discharged, undermining continuity of care. In the Kentucky River region, judges said communication failures prolonged de novo hearings for days.

Recommendation: Establish regional communication protocols supported by the Commission. These could include:

- Shared contact lists of key 202A partners in each county.
- Secure electronic records accessible to courts, CMHCs, and hospitals.
- Regional task forces to monitor collaboration and problem-solve.

Trend 6: Housing, Guardianship, and System Navigation

A recurring theme was the lack of housing and guardianship resources for individuals with dementia, intellectual disabilities, and serious mental illness. Many were repeatedly admitted under 202A without meaningful solutions.

Judges described guardianship as "a revolving door we cannot close." Families begged for long-term placement options, but none were available.

Another troubling finding was the misuse of 202A in contexts such as domestic violence. One participant reported an abuser filing a petition against a victim as a form of control. Judges and attorneys called for safeguards to prevent such misuse while ensuring access to real help.

Recommendation:

- Expand housing options through Medicaid waivers, federal and state funding.
- Increase guardianship capacity, including pilot projects for supported decision-making.
- Provide judicial training on identifying potential misuse of 202A petitions, particularly in DV contexts.
- Educate families on the statute's criteria to prevent false expectations.

Trend 7: Processes and Consistency

Variability in how core procedures are carried out surfaced as a significant concern across regions. Forum participants noted considerable differences in documentation practices, expectations around timelines, and the application of statutory procedures. Many described challenges with tracking paperwork, determining responsibility for each step, and navigating inconsistent expectations when working with vested partners. These gaps often lead to delays, confusion, and inefficiencies that ultimately affect the individual in crisis. Across multiple areas, court partners emphasized that clearer, more standardized processes would significantly strengthen the overall functioning of the 202A pathway.

Recommendation:

- Establish regional or statewide learning collaboratives to support shared understanding, promote best practices, and strengthen ongoing professional development across systems.
- Expand access to consistent, cross-system training on statutory requirements, crisis procedures, and clinical and operational responsibilities to ensure all partners are aligned in practice.
- Develop clear, role-specific onboarding and reference materials to support new staff and reduce confusion during transitions or turnover.

Legal Questions and Clarifications

During the course of the fourteen 202A Regional Forums, several recurring legal questions were identified by judges, clerks, attorneys, and other court partners. These questions highlight areas of statutory ambiguity and practice inconsistency that create uncertainty for courts, law enforcement, hospitals, and families. While some of these matters have since received legal clarification, the issues outlined below remain central to understanding how 202A is interpreted and applied across regions and may continue to benefit from further guidance and discussion.

1. Court Security Officers (CSOs) to Transport under KRS 202A

- **Matter Requiring Clarification:** Participants across multiple forums questioned whether Court Security Officers have statutory authority to conduct transports under KRS 202A. In many counties, CSOs are asked to assist with or assume responsibility for psychiatric transports, particularly when sheriff's deputies are unavailable. However, their legal authority to do so remains unclear. This ambiguity raises liability concerns for both the individuals involved and the courts that may be authorizing or relying on CSOs for this function. Clarification is needed to

determine whether statutory changes or administrative guidance are required to authorize CSOs explicitly.

- **Legal Clarification:** The current statutory framework outlining the scope of CSOs appears to be unclear, resulting in varied practices statewide. Further exploration is needed to determine whether statutory recommendations or policy development is necessary to provide explicit authority, clarity, and consistency regarding CSO involvement in these transports.

2. Guardian Consent to Psychiatric Hospital Admission under KRS 202A

- **Matter Requiring Clarification:** Another area of uncertainty involves the role of guardians in psychiatric hospital admission. Court partners questioned whether a guardian may legally consent to admission under KRS 202A, effectively bypassing the need for a judicial order. Complications arise when guardians decline less-restrictive alternatives, such as placement in a personal care home, leading to prolonged hospital stays even when discharge appears clinically appropriate. Clear statutory interpretation is needed to balance the rights of the individual, the authority of the guardian, and the responsibilities of the treatment provider.
- **Legal Clarification:** The 14th Amendment provides guaranteed due process protections to individuals prior to being involuntarily committed to a psychiatric hospital, which are reflected in the special statutory proceedings adopted in KRS Chapter 202A. Per KRS 202A.026, before someone can be involuntarily hospitalized, they must be found to be a mentally ill person:
    - (1) who presents a danger or threat to self, family or others as a result of the mental illness;
    - (2) who can reasonably benefit from treatment; and
    - (3) for whom hospitalization is the least restrictive mode of treatment presently available. KRS 202A.051 specifically allows a legal guardian to file a petition for involuntary hospitalization.

3. Expiration of 202A Petitions

- **Matter Requiring Clarification:** Courts reported inconsistent practices regarding the shelf life of 202A petitions. In some jurisdictions, petitions remain active until adjudicated, regardless of when they were filed. In others, petitions are considered stale or invalid after a period of time. Forum participants noted cases in which orders were issued on petitions that were one or two months old, raising concerns about due process, changes in clinical risk over time, and the timeliness of emergency intervention. Clarification on whether petitions have an expiration period, and what that period should be, is needed to ensure fairness and consistency statewide.
- **Legal Clarification:** KRS 202A.051 lays out the statutory process for petitioning and ordering involuntary hospitalization, which is constrained by varying time limitations and evidentiary standards. It does not state anywhere in the statute that a petition filed pursuant to KRS Chapter 202A ever expires. Consideration could be given to adopting a statutory revision to specify how long a 202A petition remains valid.

Additional Recommendations

Involuntary Commitment Processes for Minors in Kentucky: Rationale and Context

In all fourteen forums, the focus was on adult involuntary commitment under KRS 202A. However, court partners did note a gap: Kentucky's statutory framework for addressing psychiatric crises in minors lacks the clarity, capacity, and procedural protections necessary to meet children's unique needs. Involuntary commitment of minors is regulated under a different statutory chapter KRS Chapter 645 (the Mental Health Act) rather than under the adult 202A process.

Because the crisis system is increasingly seeing minors in acute psychiatric distress (including suicidal ideation, psychosis, self-harm, or severe behavioral dysregulation), the need for robust, child-appropriate involuntary commitment processes becomes more pressing. In response, the recommendations here aim to ensure Kentucky develops a developmentally informed, legally sound, and practically usable involuntary commitment framework for minors that aligns with best practices and protects the rights of youth, families, and communities.

Casey's Law and Assisted Outpatient Treatment (AOT): Rationale and Context

In addition to the concerns raised about minors, community partners across regions identified two additional areas that require clarity, guidance, and statewide support. These include the application of Casey's Law and the expansion of Assisted Outpatient Treatment.

Clarification and Support for Casey's Law

Many counties reported confusion about the appropriate use of Casey's Law (involuntary substance use disorder treatment) and the relationship between Casey's Law petitions and 202A mental health petitions. Respondents noted that the lack of statewide guidance contributes to inconsistent practices across jurisdictions. Several court partners requested clear, accessible tools that explain when Casey's Law is appropriate, how it intersects with mental health petitions, and what responsibilities fall to courts, treatment agencies, and families.

Participants also asked for a statewide review of procedural steps, including timelines, the availability of qualified evaluators, and access to treatment facilities that can accept individuals under an active Casey's Law order. Community partners requested practical resources such as flowcharts, standardized forms, and summary sheets that could guide judges, attorneys, clerks, and petitioners through the process. A consistent theme across multiple forums was the need for more education on the statute and more uniform expectations for counties implementing it.

Expansion of Assisted Outpatient Treatment (AOT)

Participants also emphasized the need to continue efforts to expand Assisted Outpatient Treatment for individuals with serious mental illness who cycle through crisis, hospitalization, homelessness, and jail due to untreated symptoms. Court partners expressed interest in learning how AOT could help provide greater stability for individuals who do not meet the criteria for inpatient hospitalization but still require structured oversight and treatment engagement.

Many community partners explained that counties have limited treatment options for individuals who repeatedly enter the emergency system but do not remain engaged once discharged. They saw AOT as a potential tool to reduce repeated crisis encounters, improve continuity of care, and give courts clearer mechanisms to support treatment compliance without relying solely on hospital beds or incarceration. Respondents requested more information on what AOT looks like in practice, how programs operate in other states, and what resources would be needed to pilot AOT models in Kentucky.

Alignment with Broader Report Goals

These recommendations align with the larger goals of the 202A report, which include reducing delays, clarifying statutory responsibilities, improving communication across systems, and ensuring that individuals receive care in the least restrictive and most clinically appropriate setting. Expanding the focus beyond adult processes reflects the reality that Kentucky's crisis system serves people of all ages, and that each age group requires procedures and protections suited to their developmental and clinical needs.

By including a recommendation specific to minors, Kentucky affirms that youth experiencing psychiatric crises deserve pathways that are safe, appropriate, and supported by clear statutory direction. This recommendation will be shared with the Juvenile Justice Workgroup to carry forward the development of a child and adolescent focused framework for involuntary hospitalization.

In addition, community partners identified two additional areas that require immediate statewide attention. These include the need for clearer guidance and practical tools related to Casey's Law, and a call to prioritize current and ongoing efforts to expand Assisted Outpatient Treatment for individuals with serious mental illness who repeatedly cycle through crisis, hospitalization, and incarceration. Both of these recommendations support the broader objectives of improving treatment continuity, strengthening legal pathways that promote stability, and reducing unnecessary justice involvement for individuals with unmet behavioral health needs.

Because these recommendations directly involve court administered procedures and adult behavioral health responses, both the clarification of Casey's Law and the exploration of AOT expansion will be provided to the Court Responses Workgroup for further analysis and development.

Together, these recommendations advance the overarching goal of strengthening Kentucky's behavioral health crisis response system. They reflect a commitment to improved outcomes for adults, minors, and families, and they support a more coordinated and responsive statewide system.

Implications

The feedback gathered across all fourteen regions and post forum survey highlights several important implications for statewide planning, cross-system collaboration, and future workgroup priorities. Participation varied across roles, with some regions showing strong engagement from each group and others showing gaps in representation. In some regions, there was limited representation from several key groups, including law enforcement, judges, and others. Because law enforcement participates in nearly every stage of the 202A process, continued engagement from sheriffs, deputies, and municipal police agencies remains essential.

This pattern was true for several other invited partner groups. Because law enforcement plays a significant role in nearly every stage of the 202A process, continued engagement from sheriffs, deputies, and municipal police agencies remains essential.

The survey results show that law enforcement response and transportation were identified as some of the most significant barriers to timely care. This makes it especially important to ensure that front line law enforcement perspectives are consistently included in future planning. Increasing opportunities for listening sessions, targeted outreach, and collaborative discussions will support a more complete understanding of operational realities across counties. Strengthening these partnerships will help Kentucky design reforms that reflect the experiences and needs of all community partners involved in crisis response.

The data also reveal a crisis system strained by limited capacity, inconsistent processes, and resource shortages across nearly every region. Respondents repeatedly cited insufficient outpatient alternatives, shortages of inpatient psychiatric beds, lack of mobile crisis teams, inadequate discharge planning, and

emergency department overload as primary obstacles. These systemic issues delay care, create avoidable procedural bottlenecks, and increase the likelihood that individuals will cycle between hospitals, jails, and courtrooms without meaningful intervention. Notably, the most strongly supported improvement across all regions was increased funding for facilities and services, reflecting widespread recognition that statutory changes alone cannot address the current infrastructure gaps.

Another significant implication is the need for more consistent and reliable communication across partners. Respondents identified collaboration gaps between law enforcement and behavioral health, between courts and hospitals, and between medical and legal professionals. Forty percent of respondents indicated they need contact lists for local partners, and a substantial portion requested role clarity, regional implementation guides, and practical toolkits. These findings demonstrate that Kentucky partners value clear expectations, streamlined coordination, and structures that make it easier to know who to call during a crisis.

Taken together, the survey data and forum discussions reveal a clear direction for statewide improvement. Kentucky partners want a system that is timely, coordinated, consistent, and supported by adequate resources. They want clear roles, practical tools, and enhanced collaboration. Most importantly, the near unanimous request for continued communication and follow up underscores that community partners across all regions are willing and eager to work together to strengthen the crisis response system.

Next Steps for the Commission

The forums revealed that while Kentucky's 202A process is deeply strained, it is not broken beyond repair. The Commission is uniquely positioned to lead reform by:

1. Publishing this comprehensive report and sharing findings with the Supreme Court, legislature, and partner agencies.
2. Developing toolkits and judicial resources to standardize practice, where appropriate.
3. Advocating for legislative reforms that address themes identified here.
4. Building partnerships that expand crisis stabilization and alternative response models that serve all of Kentucky.
5. Establishing a timeline for follow-up information gathering to measure progress and accountability.

Conclusion

The 202A Virtual Forums gave voice to the frustrations, hopes, and solutions of those on the frontlines of Kentucky's mental health crisis. The message was clear: the system cannot continue as it is. Law enforcement cannot be the default transport system. Families cannot be left waiting. Judges cannot be left without guidance. And individuals in crisis cannot be left without care.

The Kentucky Judicial Commission on Mental Health now carries the responsibility of translating these findings into action. By addressing transportation, clearance, evaluator shortages, judicial access, communication, and housing, Kentucky can build a system that is not only more efficient but also more humane.

The work ahead is urgent, but the forums demonstrated that the will to change is strong. Kentucky has the opportunity to create a national model for involuntary commitment reform, one that honors both justice and compassion.

Appendices

Appendix A

Presentation Provided by the Department for Behavioral Health, Intellectual and Developmental Disabilities within the Cabinet for Health and Family Services

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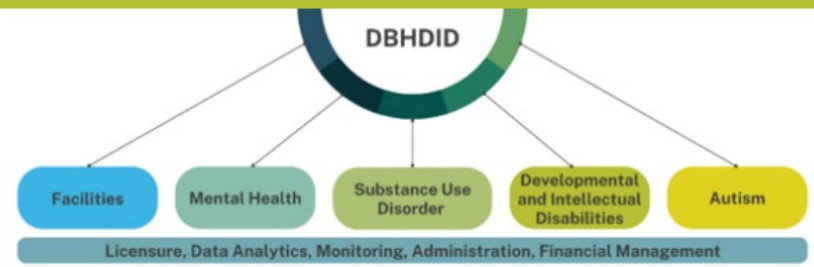
Department for Behavioral Health, Developmental and Intellectual Disabilities

Overview of KRS 202A

Kentucky Judicial Commission on Mental Health Virtual Forums 2025

Mission: Promote health, well-being, and resilience for all; facilitate recovery for people affected by mental illness and substance use; and support people with developmental and intellectual disabilities.



Key Priority 1	Key Priority 2	Key Priority 3
Increase **access** to behavioral health and intellectual disability services and supports.	Improve **quality** of care in the behavioral health and intellectual disabilities service delivery system.	Reinforce a resilient, inclusive, and equitable organizational **workforce** culture.

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KY Designated Psychiatric Hospitals (202A)

- **Eastern State Hospital**, Lexington, Fayette County; managed by UK HealthCare
  - Adair, Anderson, Bath, Boone, Bourbon, Boyd, Boyle, Bracken, Campbell, Carroll, Carter, Casey, Clark, Clinton, Cumberland, Elliott, Estill, Fayette, Fleming, Franklin, Gallatin, Garrard, Grant, Green, Greenup, Harrison, Jessamine, Kenton, Lawrence, Lewis, Lincoln, McCreary, Madison, Mason, Menifee, Mercer, Montgomery, Morgan, Nicholas, Owen, Pendleton, Powell, Pulaski, Robertson, Rowan, Russell, Scott, Taylor, Wayne, Woodford
- **Central State Hospital**, Louisville, Jefferson County
  - Bullitt, Breckinridge, Grayson, Hardin, Henry, Jefferson, Larue, Marion, Meade, Nelson, Oldham, Shelby, Spencer, Trimble, Washington
- **Western State Hospital**, Hopkinsville, Christian County
  - Allen, Ballard, Barren, Butler, Caldwell, Calloway, Carlisle, Christian, Crittenden, Daviess, Edmonson, Fulton, Graves, Hancock, Hart, Henderson, Hickman, Hopkins, Livingston, Logan, Lyon, McCracken, McLean, Marshall, Metcalfe, Monroe, Muhlenberg, Ohio, Simpson, Todd, Trigg, Union, Warren, Webster
- **Appalachian Regional Healthcare (ARH),** Hazard (Perry Co.), Harlan (Harlan Co.), Prestonsburg (Floyd Co.); Contracted
  - Bell, Breathitt, Clay, Floyd, Harlan, Jackson, Johnson, Knott, Knox, Laurel, Lee, Leslie, Letcher, Magoffin, Martin, Owsley, Perry, Pike, Rockcastle, Whitley, Wolfe

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Community Mental Health Centers (CMHCs)

- There are 14 CMHCs in Kentucky serving counties by designated regions.
- Centers contract with DBHDID to provide community-based safety net services for individuals affected by behavioral health needs including mental illness, substance use, and developmental and intellectual disabilities.
- Crisis services for adults and children
- Prevention services (988, hotlines, warmlines, substance use and suicide prevention)
- Treatment, therapy, medication, peer support
- Response to community disasters

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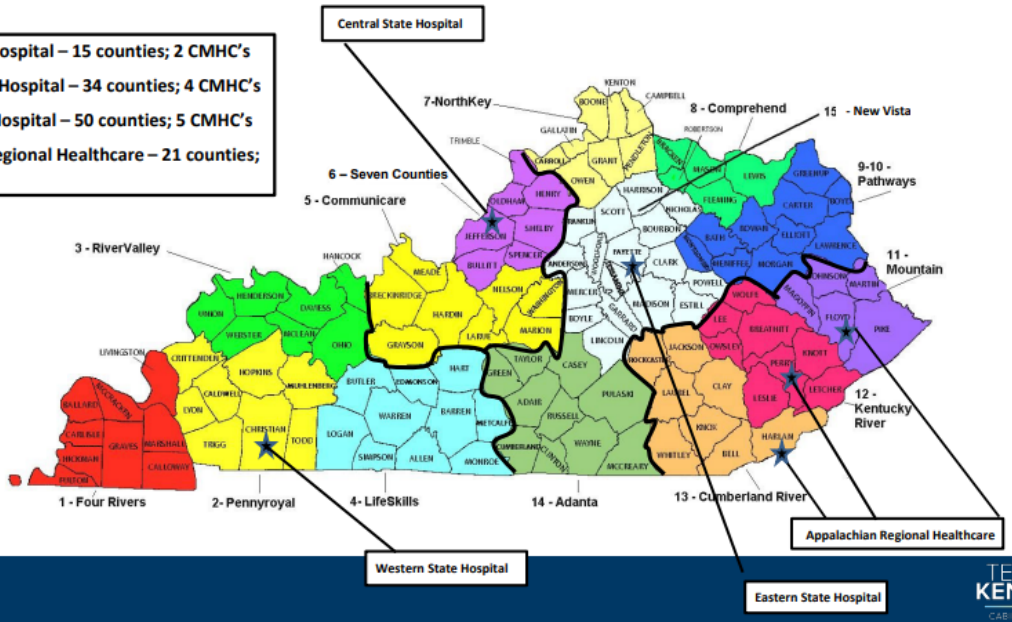
State Psychiatric Hospitals & CMHC's

- Central State Hospital – 15 counties; 2 CMHC's
- Western State Hospital – 34 counties; 4 CMHC's
- Eastern State Hospital – 50 counties; 5 CMHC's
- Appalachian Regional Healthcare – 21 counties; 3 CMHC's



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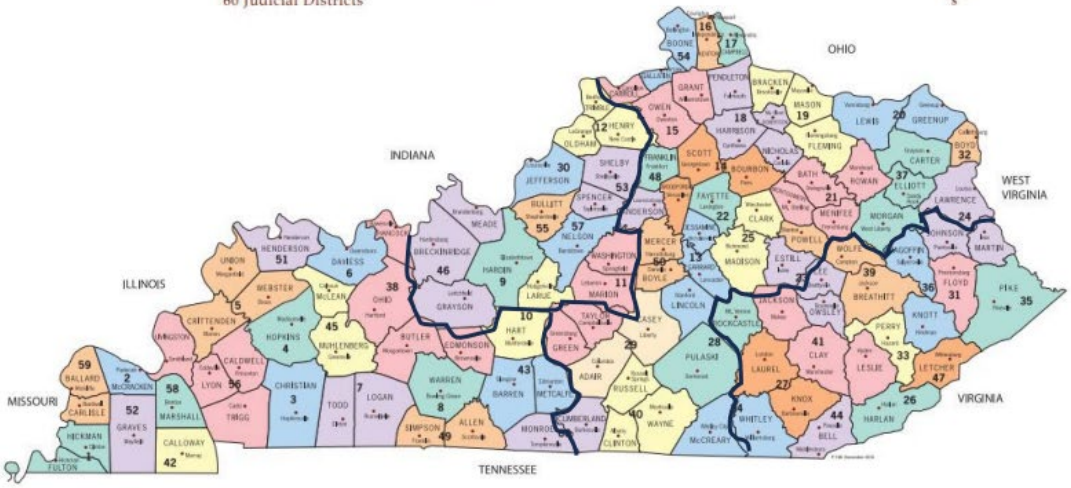
KENTUCKY COURT OF JUSTICE

JUDICIAL DISTRICTS

60 Judicial Districts



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Hospitals & Judicial Districts

- Eastern State Hospital (ESH) – 25 judicial districts
- Central State Hospital (CSH) – 9 judicial districts
- Western State Hospital (WSH) – 20 judicial districts
- Appalachian Regional Healthcare (ARH) – 14 judicial districts
- 9 districts are split between 2 hospitals:
  - WSH/CSH – 1
  - ESH/CSH – 2
  - ESH/ARH – 5
  - ESH/WSH – 1

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KRS 202A

"The Kentucky Mental Health Hospitalization Act"
- enacted in 1982

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KRS 202A Statistics – State Fiscal Year 2024

- **10,776** 202A evaluations were conducted by KY Community Mental Health Centers
- State Hospital Admissions:
  - Appalachian Regional Healthcare (ARH): 2,430
  - Central State Hospital (CSH): 670
  - Eastern State Hospital (ESH): 3,278
  - Western State Hospital (WSH): 1,294

  TOTAL: **7,672**

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KRS 202A Process

- **Jurisdiction (202A.014)**
  - Initiated in the **District Court** of county where Respondent resides or may be at the time of filing the petition
- **County Attorney (KRS 202A.016)**
  - Duty of the **county attorney** to assist the petitioner and represent interest of Commonwealth and to assist court in its inquiry by the presentation of evidence
- **Right to Counsel (KRS 202A)**
  - The court shall **appoint an attorney** to represent Respondent unless the Respondent retains private counsel
  - Attorney shall be given access to the court records relating to the petition
- **Right to be Present (KRS 202A.131)**
  - Respondent **shall be present** at all hearings unless Respondent and their attorney intelligently waive that right or the court makes a specific finding that Respondent should be removed because of conduct so disruptive the proceeding cannot continue in a reason able manner
- **Disclosure of Communications (KRS 202A.096)**
  - **No privilege** between qualified mental health professional and patients. Authorized to disclose communications related to diagnosis and treatment of mental condition in proceedings under 202A

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KRS 202A Process

- **Mentally Ill Person -** A person with substantially impaired capacity to use self control, judgment, or discretion in the conduct of the person's affairs and social relations, associated with maladaptive behavior or recognized emotional symptoms where impaired capacity, maladaptive behavior, or emotional symptoms can be related to physiological, psychological or social factors. (KRS 202A.011)
- Applies only to persons **18 years of age or older** (KRS 202A.012; involuntary hospitalization of minors is in KRS 645)
- **No person** held under the provisions of this chapter **shall be detained in jail** unless criminal charges are also pending. (KRS 202A.251)
- All individuals transporting or holding persons…shall use the least restrictive level of restraint consistent with the person's needs. (KRS 202A.241)

Qualified Mental Health Professional (QMHP)

- Licensed **physicians**
- Licensed **psychiatrists**
- Licensed **psychologists** (doctoral and masters)
- Some **nurses***
- Licensed clinical **social workers** and some certified social workers*
- Some **marriage and family therapists***
- Some **professional counselors***
- Some **physician assistants***

**with specified education and/or experience*

KRS 202A.026 Criteria for Involuntary Hospitalization:

"Is a mentally ill person":

(1) Who presents a ***danger or threat of danger to self, family or others*** as a result of the mental illness

- substantial physical harm or threat of substantial physical harm upon self, family, or others, including actions which deprive self, family or others of the basic means of survival including provision for reasonable shelter, food, or clothing (KRS 202A.011)

(2) Who can ***reasonably benefit*** from treatment

(3) For whom hospitalization is the ***least restrictive alternative mode of treatment*** presently available

- treatment which will give a mentally ill individual a realistic opportunity to improve the individual's level of functioning, consistent with accepted professional practice in the least confining setting available. (KRS 202A.011)

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5 Pathways to Hospital Admission - KRS 202A

1) Voluntary Patients (202A.021)

Involuntary Options:

2) Warrantless Arrest (202A.041)

3) Hospitalization by Court Order (202A.028)

4) 72-Hour Emergency Admission (202A.031)

5) 60-day or 360-day Involuntary Hospitalization (202A.051)

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1) Voluntary Patients (202A.021)

- If person is willing to enter the hospital voluntarily, involuntary hospitalization process under KRS 202A does NOT apply
- Voluntary patients should NOT be put under an involuntary petition or court order solely to obtain transportation
- Voluntary patients must be discharged upon their written request unless further detained under other sections of KRS 202A

2) Warrantless Arrest (202A.041)

- Any peace officer who has reasonable grounds to believe an individual is mentally ill and presents a danger or threat of danger to self, family or others if not restrained may take the individual into custody and transport without unnecessary delay to a hospital or psychiatric facility designated by the cabinet for purpose of an evaluation to be conducted by a qualified mental health professional
- Peace officer shall provide written documentation describing behavior of individual which caused the peace officer to take the person into custody
- If criteria is not met, the individual shall be released and immediately transported back to home county
- If criteria are met, proceeding under KRS 202A shall be initiated.
- Person may be held for up to 18 hours to accomplish certification of initial evaluation and initiation of proceedings under KRS 202A

3) Hospitalization by court order (202A.028) "72 Hour Court Order"

- Following an examination* by a qualified mental health professional and a certification that the Respondent meets criteria, a judge may order the person hospitalized for a period not to exceed 72 hours, excluding holidays and weekends
- *at CMHC or other designated site; can be by telehealth
- "shall" be transported by sheriff, other peace officer, or other Cabinet-authorized entity

(AOC Forms: 711, 712, 713)

4) 72 Hour Emergency Admission (202A.031) "72 Hour Physician Hold"

- An authorized staff physician may order the admission of any person who is present at, or is presented at, a hospital
- For purposes of this subsection a hospital may include any acute care hospital that is licensed by the Commonwealth
- Within 24 hours (excluding weekends and holidays) of admission, the physician ordering the admission shall certify that in their opinion the individual should be involuntarily hospitalized
- Shall be released within 72 hours (excluding weekends and holidays) unless further detained under applicable provisions of this chapter

When 72 Hour Order or Hold Expires

- When patients are on a 72-hour court order or 72-hour emergency admission (physician hold) and the 72 hours is expiring, there are 3 options:

1) Patient needs further inpatient treatment and agrees to sign a **voluntary admission**
2) Patient does not require further inpatient treatment and is **discharged**
3) Patient needs further treatment and will not agree to voluntary admission, so hospital files **60-day (or 360-day) petition** for longer period of involuntary hospitalization

5) Proceedings for 60 and 360 Day Involuntary Hospitalizations (typically occur in the state hospitals)

- **Petition – Who can file? (KRS 202A.051(3))**
  - A qualified mental health professional, peace officer, county attorney, Commonwealth attorney, spouse, relative, friend, or guardian of Respondent, or any other interested person
- **Petition (KRS 202A.051(4)) – Includes:**
  - Petitioner's belief, including factual basis, that Respondent is mentally ill and presents a danger or threat to self, family, or others
  - *If seeking 360-day involuntary hospitalization – Respondent has been hospitalized in a psychiatric or forensic psychiatric facility for 30 days pursuant to 202A or KRS 504 within preceding 6 months*
- *Requires 2 certifications: one must be a physician; the second may be any QMHP*

Proceedings for 60 and 360-Day Involuntary Hospitalizations

- **Preliminary Hearing – KRS 202A.051(6)(a), KRS 202A.071(1), 202A.076(1)**
  - Shall be set within 6 days from Respondent's holding, or if not held, from time of examination
  - Can be informal – held in chambers, at a hospital, or other suitable place
  - Respondent afforded opportunity to testify, present, and cross examine witnesses
  - Respondent and their attorney may waive preliminary hearing
- After the preliminary hearing venue shall be transferred to the county where Respondent is hospitalized (KRS 202A.053)
  - A court may, upon its own motion or motion of a party retain venue
  - Often will take place in county Respondent transported to for hospitalization
- If the court does not find probable cause after the preliminary hearing then proceedings shall be dismissed and Respondent released from any holding (KRS 202A.051(10)

Proceedings for 60 and 360-Day Involuntary Hospitalizations

- **Final Hearing – KRS 202A.051(9), KRS 202A.071(2), KRS 202A.076(2)**
  - If upon completion of preliminary hearing the court finds probable cause the respondent should be involuntarily hospitalized the court shall set a final hearing within 21 days from the date of holding or if not held, the date of the examination
  - Can be informal consistent with orderly procedures and in a physical setting not likely to have a harmful effect on mental or physical health of Respondent. May be held in chambers, a hospital, or other suitable place
  - Respondent afforded opportunity to testify, present, and cross examine witnesses
  - Manner and rules of evidence shall be the same as those in any criminal proceeding
  - Burden of Proof – beyond a reasonable doubt
  - Heard by a judge unless a party requests a jury trial; cannot be waived
  - If criteria are met, judge may order hospitalization for up to 60 days (or up to 360 days, if applicable)

  (AOC Forms: 710, 715, 720, 725, 726, 730)

Hospital Review Committee

- Every hospital shall have a review committee of 3 QMHP's to review the appropriateness of a patient's individual treatment plan.
- Upon the refusal of an involuntary patient to participate in any or all aspects of his treatment plan, the review committee shall…examine…the plan…and…meet with the patient…to discuss its recommendations.
- The hospital may petition the District Court for a de novo determination of the appropriateness of the proposed treatment. A hearing is conducted, and the court shall enter an appropriate judgment (which may include an order for the patient to accept the recommended treatment).

(AOC Forms: 735, 736)

Discharge from Hospital

- "An authorized staff physician of a hospital shall discharge an involuntary patient when he no longer meets the criteria for involuntary hospitalization." (KRS 202A.171)
- This means that patients often may not stay in the hospital for the entire court-ordered period of involuntary hospitalization (60 or 360 days)

Two Pathways to Less Restrictive Court-Ordered Outpatient Treatment in KRS 202A

1) Community-based Outpatient Treatment ("Agreed Order") – 202A.081

NOT TO BE CONFUSED WITH

2) Assisted Outpatient Treatment (AOT or "Tim's Law") – 202A.0811 thru 202A.0831

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1) Community-Based Outpatient Treatment ("Agreed Order")

- KY law since 1994; is a form of "conditional release" from hospital treatment
- Initiated in the hospital, this allows for 60-day outpatient treatment order after preliminary hearing but prior to final hearing (60/360-day proceedings) if all parties are in agreement
- Patient is discharged and receives treatment in the community (CMHC)
- 60-day order can be extended one time for up to 60 additional days
- Person can be re-hospitalized and final hearing resumes if it is "to the best interest of the person or others"

(AOC Form 724)

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2) Assisted Outpatient Treatment (AOT; "Tim's Law")

AOT is the practice of providing **community-based** mental health treatment under a **civil court order**, as a less restrictive option than hospitalization, to:

1) Motivate an adult with serious mental illness who struggles with voluntary treatment participation to engage fully with their treatment plan

2) Interrupt the "revolving door" which can lead to repeated hospitalizations, arrests, incarceration, and homelessness

To be eligible for AOT (Tim's Law):

1) Diagnosed with a serious mental illness;

2) History of repeated nonadherence with mental health treatment which has:

- Been a significant factor in necessitating hospitalization or arrest at least twice within the last 48 months; or
- Resulted in an act, threat, or attempt at serious physical harm within the last 24 months;

To be eligible for AOT - continued

3) Unlikely to adequately adhere to outpatient treatment on a voluntary basis based on qualified mental health professional's

a) Clinical observation and

b) Identification of specific characteristics of the person's clinical condition that significantly impair the person's ability to make and maintain a rational and informed decision as to whether to engage in outpatient treatment voluntarily

4) Is in need of court-ordered AOT as the least restrictive alternative mode of treatment presently available and appropriate.

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How Does AOT Work?

- Any interested person (in a county with an AOT program) files AOT petition with District Court. Referrals can start in a hospital, jail, court or in the community.
- Judge determines probable cause and orders evaluation and outpatient treatment plan by QMHP
- After completed evaluation and hearing, judge may order AOT for up to 360 days
- Community Mental Health Center (CMHC) provides an array of services specified in treatment plan
- Regular follow-ups with the court to monitor participation
- Re-hospitalization does not nullify the AOT order

(AOC Forms: 737 – 737.6)

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AOT Expansion

AOT courts are active in 20 KY counties representing 47% of the state's population:

- Jefferson (Seven Counties); Hardin, Grayson, Nelson (Communicare); Fayette, Scott, Bourbon, Woodford, Jessamine, Garrard, Lincoln (New Vista); Kenton (NorthKey); Mason (Comprehend); Daviess (River Valley); Christian, Muhlenberg (Pennyroyal); McCracken (Four Rivers); Warren (Lifeskills); Harlan (Cumberland River); Perry (Kentucky River)
- Further expansion is rapidly progressing throughout the state
- Further education and training on AOT procedures is planned

Less Restrictive Alternatives to Involuntary Hospitalization Under KRS 202A

- Voluntary Inpatient Treatment
- Intensive Outpatient Treatment (IOP) Programs
- Assisted Outpatient Treatment (AOT; "Tim's Law")
- Crisis Stabilization Units
- Mobile Crisis Teams
- Assertive Community Treatment (ACT) Teams
- Utilization of 988 Suicide and Crisis Lifeline
- Standard Array of CMHC Outpatient Services
- Other Community Behavioral Health Services (public and private)

202A System – Opportunities for Improvement

- Improve communication among CMHC's, judges, judicial partners, law enforcement to improve response time when a 202A crisis involving danger to self, family or others is occurring
- Explore options for alternative transportation models for individuals undergoing 202A assessment
- Divert individuals to less restrictive treatment options as previously outlined
- Define and address local and region-specific obstacles through collaboration among all involved partners

Goals

- Improve 202A processes to ensure that involuntary hospitalization is quickly and easily accessible in every county as a 24-hour crisis response
- 202A is used only as a last resort to ensure the safety of the individual and the public when all less restrictive treatment options are no longer viable

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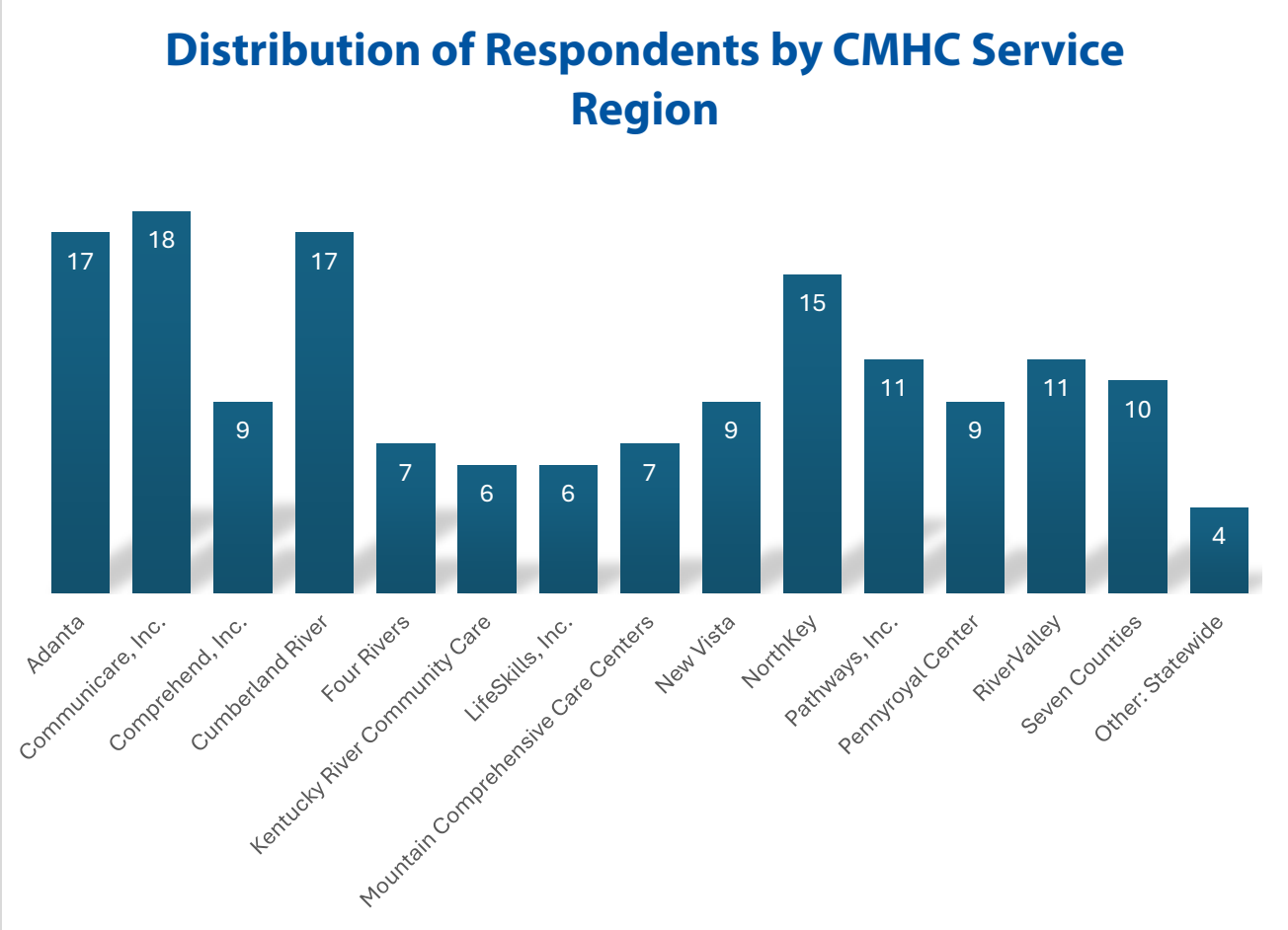
Appendix B

Survey Questions and Corresponding Data Collection

1. Which Community Mental Health Center (CMHC) region do you serve or support?

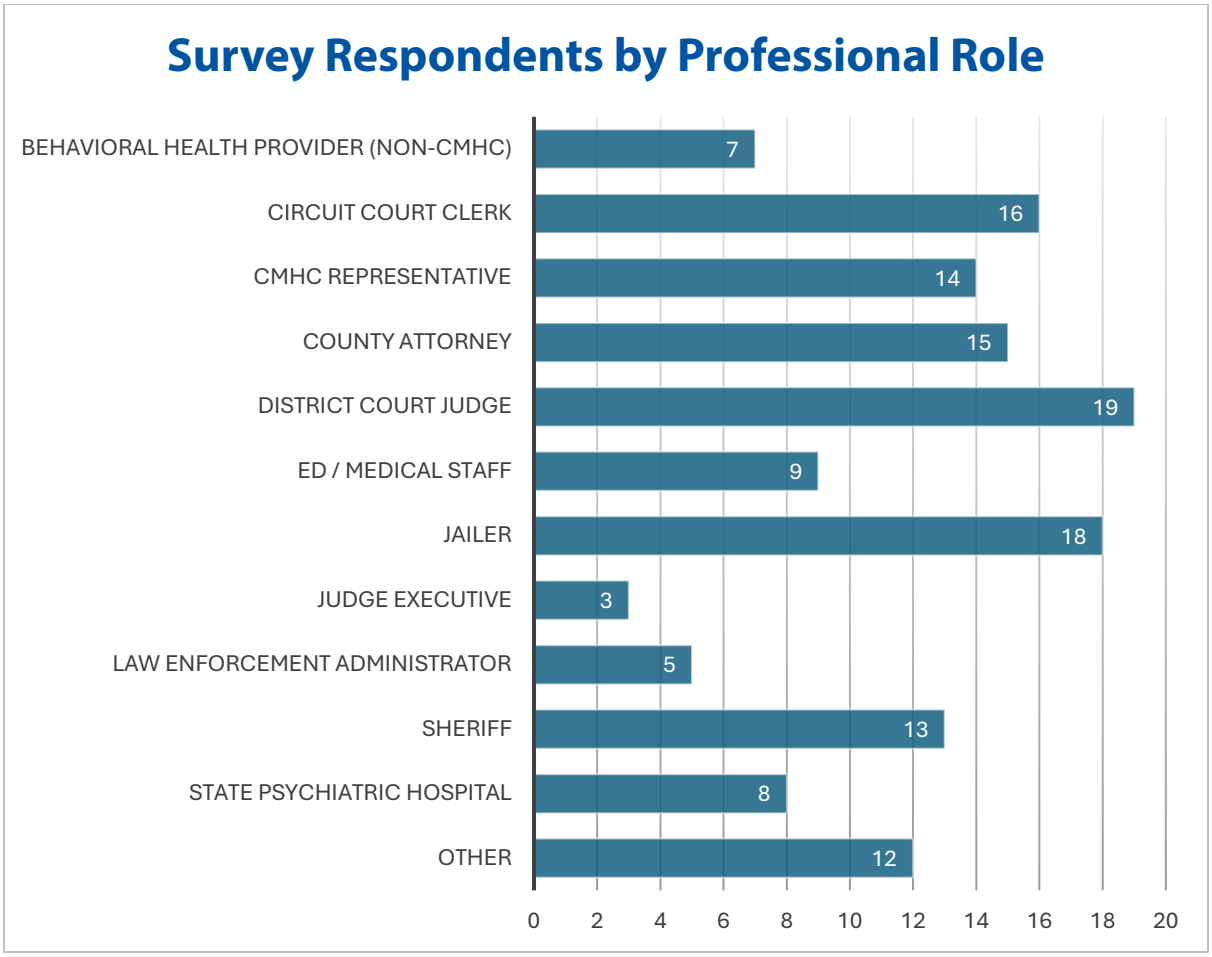
Agency	Number of Responses	Percentage
Communicare, Inc. (Grayson, Hardin, LaRue, Marion, Meade, Nelson and Washington Counties)	18	12%
Adanta (Adair, Casey, Clinton, Cumberland, Green, McCreary, Pulaski, Russell, Taylor and Wayne Counties)	17	11%
Cumberland River Behavioral Health (Bell, Clay, Harlan, Jackson, Knox, Laurel, Rockcastle and Whitley Counties)	17	11%
NorthKey (Boone, Campbell, Carroll, Gallatin, Grant, Kenton, Owen and Pendleton Counties)	15	10%
Pathways, Inc. (Bath, Boyd, Carter, Elliot, Greenup, Lawrence, Menifee, Montgomery, Morgan and Rowan Counties)	11	7%
RiverValley Behavioral Health (Daviess, Hancock, Henderson, McLean, Ohio, Union and Webster Counties)	11	7%
Seven Counties Services (Bullitt, Henry, Jefferson, Oldham, Shelby, Spencer and Trimble Counties)	10	6%
Comprehend, Inc. (Bracken, Fleming, Lewis, Mason and Robertson Counties)	9	6%
New Vista (Anderson, Bourbon, Boyle, Clark, Estill, Fayette, Franklin, Garrard, Harrison, Jessamine, Lincoln, Madison, Mercer, Nicholas, Powell, Scott and Woodford Counties)	9	6%
Pennyroyal Center (Caldwell, Christian, Crittenden, Hopkins, Lyon, Muhlenberg, Todd and Trigg Counties)	9	6%
Four Rivers Behavioral Health (Ballard, Calloway, Carlisle, Fulton, Graves, Hickman, Livingston, McCracken and Marshall Counties)	7	4%
Mountain Comprehensive Care Center (Floyd, Johnson, Magoffin, Martin and Pike Counties)	7	4%
Kentucky River Community Care (Breathitt, Knott, Lee, Leslie, Letcher, Owsley, Perry and Wolfe Counties)	6	4%
LifeSkills, Inc. (Allen, Barren, Butler, Edmonson, Hart, Logan, Metcalfe, Monroe, Simpson and Warren Counties)	6	4%
Other: Statewide	4	3%



Participation spanned all 14 CMHC regions, reflecting strong statewide engagement. The greatest representation came from Communicare, Adanta, and Cumberland River Behavioral Health, suggesting high levels of conversational involvement across central and southern Kentucky. Several eastern and south-central regions, including Kentucky River and LifeSkills, had lower response rates, highlighting opportunities for increased engagement.

2. What is your role in the 202A process?

Role	Number	Percentage
Behavioral Health Provider (Non-CMHC)	7	5%
Circuit Court Clerk	16	12%
Community Mental Health Center Representative	14	10%
County Attorney	15	11%
District Court Judge	19	14%
Emergency Department/Medical Hospital Staff	9	6%
Jailer	18	13%
Judge Executive	3	2%
Law Enforcement Administrator	5	4%
Sheriff	13	13%
State Psychiatric Hospital Representative	8	6%
Other	12	9%



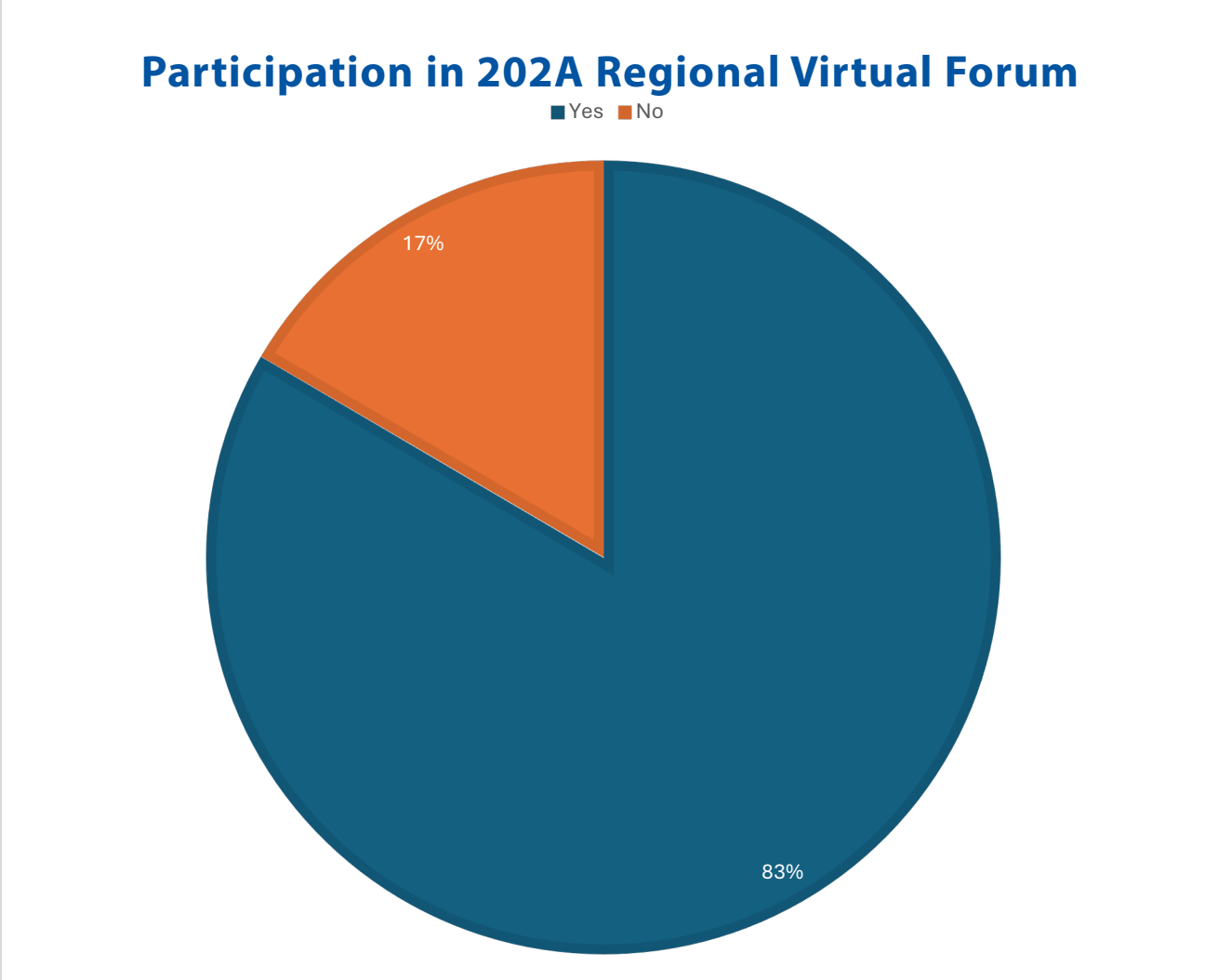
The survey captured diverse representation across justice, behavioral health, and community systems, with the largest participation from District Court Judges, Jailers, and Circuit Clerks. Together, these three roles account for over one-third of total responses, reflecting strong engagement from justice system leadership.

County Attorneys and Community Mental Health Center representatives also contributed significantly, underscoring active involvement from both legal and behavioral health partners.

Participation from Non- CMHC Behavioral Health Providers and Judge Executives was more limited, suggesting potential areas for deeper outreach and cross-sector engagement.

3. Did you attend the 202A Virtual Forum for your region?

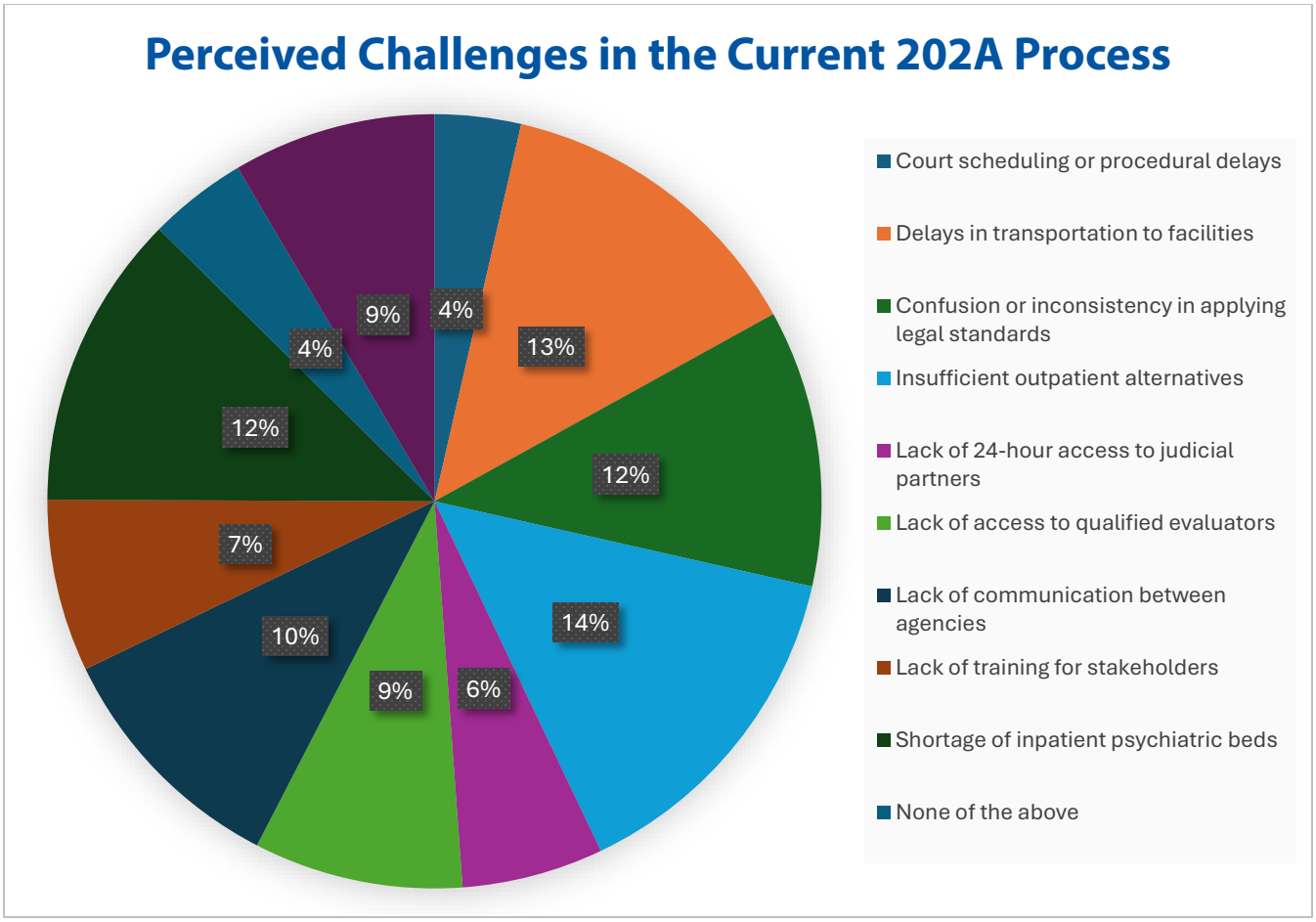
Yes	116
No	23



83% of respondents reported attending their regional forum.

4. In your experience, what are the biggest challenges in the current 202A process?

Challenge	Number of Responses	Percentage
Court scheduling or procedural delays	14	4%
Delays in transportation to facilities	52	13%
Confusion or inconsistency in applying legal standards	45	12%
Insufficient outpatient alternatives	56	14%
Lack of 24-hour access to judicial partners	23	6%
Lack of access to qualified evaluators	34	9%
Lack of communication between agencies	40	10%
Lack of training for community partners	28	7%
Shortage of inpatient psychiatric beds	48	12%
None of the above	16	4%
Other	33	8%



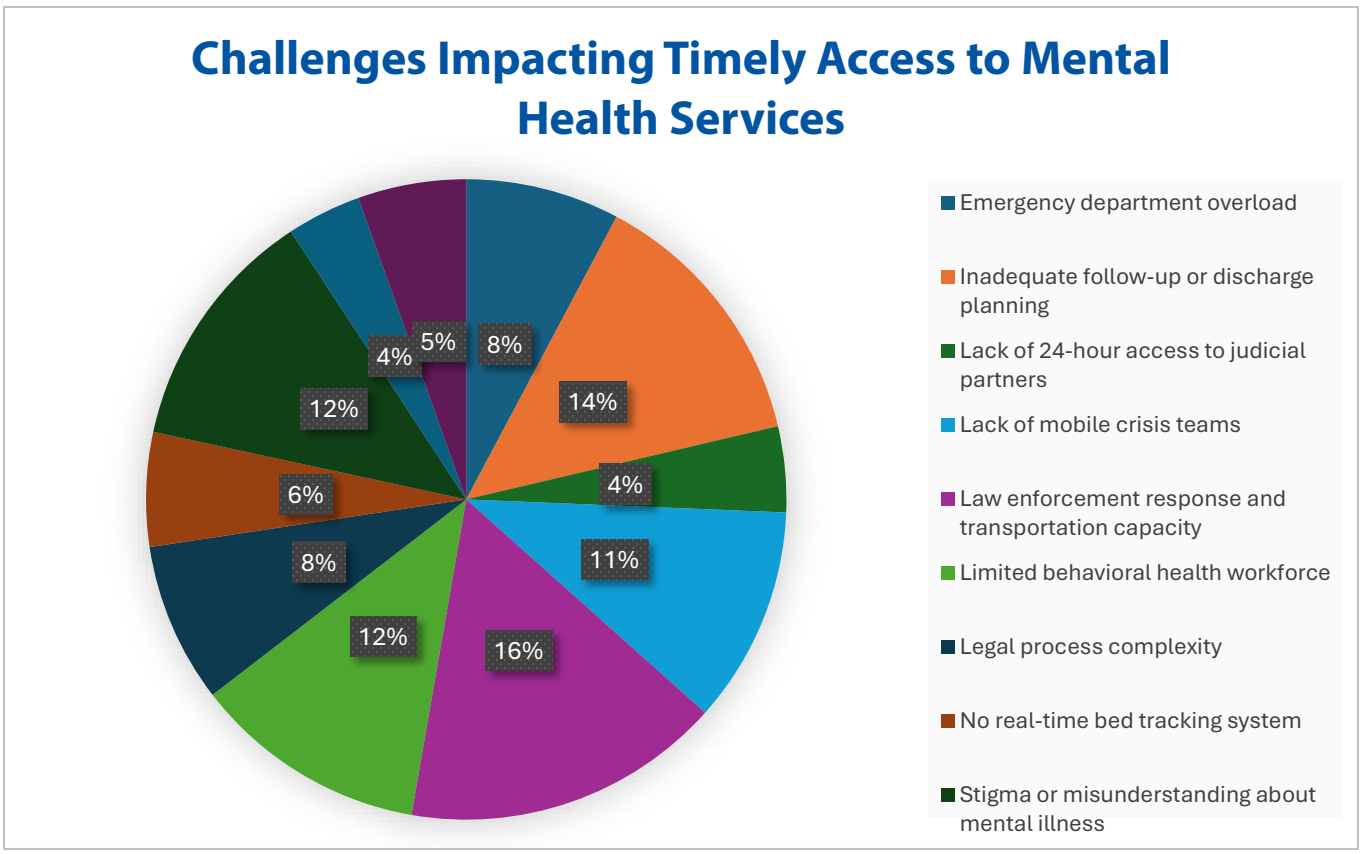
Respondents identified insufficient outpatient alternatives, delays in transportation to facilities, and shortages of inpatient psychiatric beds as the most significant challenges within the current 202A process.

Other frequently cited barriers included confusion or inconsistency in applying legal standards and lack of communication between agencies, pointing to both structural and coordination-related concerns.

Overall, the responses reflect a need to strengthen community-based options, improve interagency coordination, and address systemic delays that affect timely access to care and judicial processing.

5. What are the biggest barriers to ensuring individuals in crisis receive timely and appropriate care?

Barrier Type	Number of Responses	Percentage
Emergency department overload	27	8
Inadequate follow-up or discharge planning	47	14
Lack of 24-hour access to judicial partners	15	4
Lack of mobile crisis teams	38	11
Law enforcement response and transportation capacity	56	16
Limited behavioral health workforce	41	12
Legal process complexity	28	8
No real-time bed tracking system	20	6
Stigma or misunderstanding about mental illness	43	12
None of the above	13	4
Other	19	5



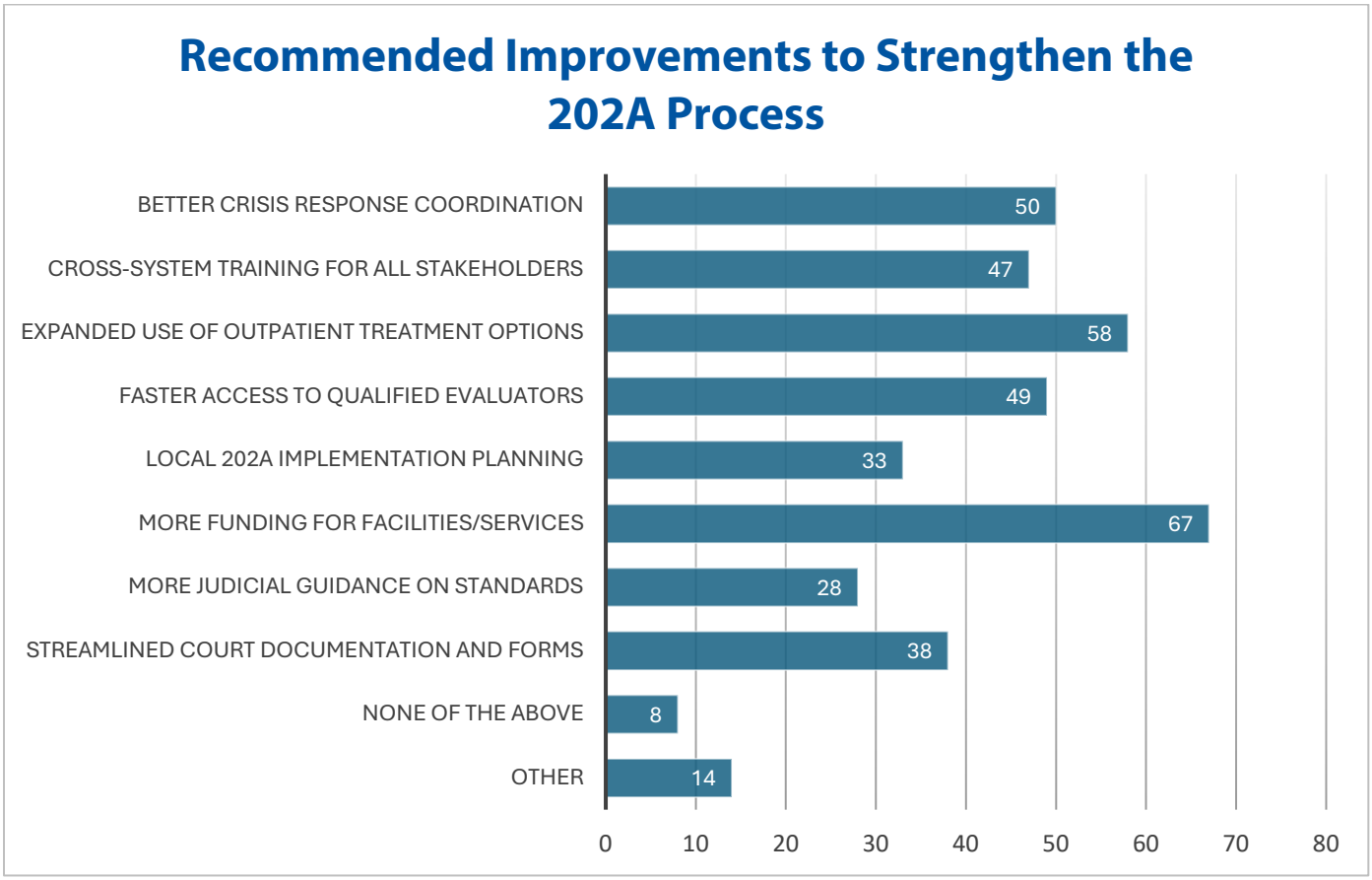
Respondents most frequently identified law enforcement response and transportation capacity, inadequate follow-up or discharge planning, and stigma or misunderstanding about mental illness as major barriers to ensuring individuals in crisis receive timely and appropriate care.

Additional significant challenges included limited behavioral health workforce and lack of mobile crisis teams, emphasizing the ongoing need for stronger crisis infrastructure and coordinated handoffs across systems.

Collectively, the results suggest that both structural capacity issues (e.g., workforce, transportation) and systemic coordination gaps (e.g., follow-up planning, stigma) contribute to delays and missed opportunities for effective crisis intervention.

6. What improvements would you most support for the 202A process?

Suggested Improvements	Number of Responses	Percentage
Better crisis response coordination	50	13%
Cross-system training for all community partners	47	12%
Expanded use of outpatient treatment options	58	15%
Faster access to qualified evaluators	49	13%
Local 202A implementation planning	33	8%
More funding for facilities/services	67	17%
More judicial guidance on standards	28	13%
Streamlined court documentation and forms	38	7%
None of the above	8	2%
Other	14	4%



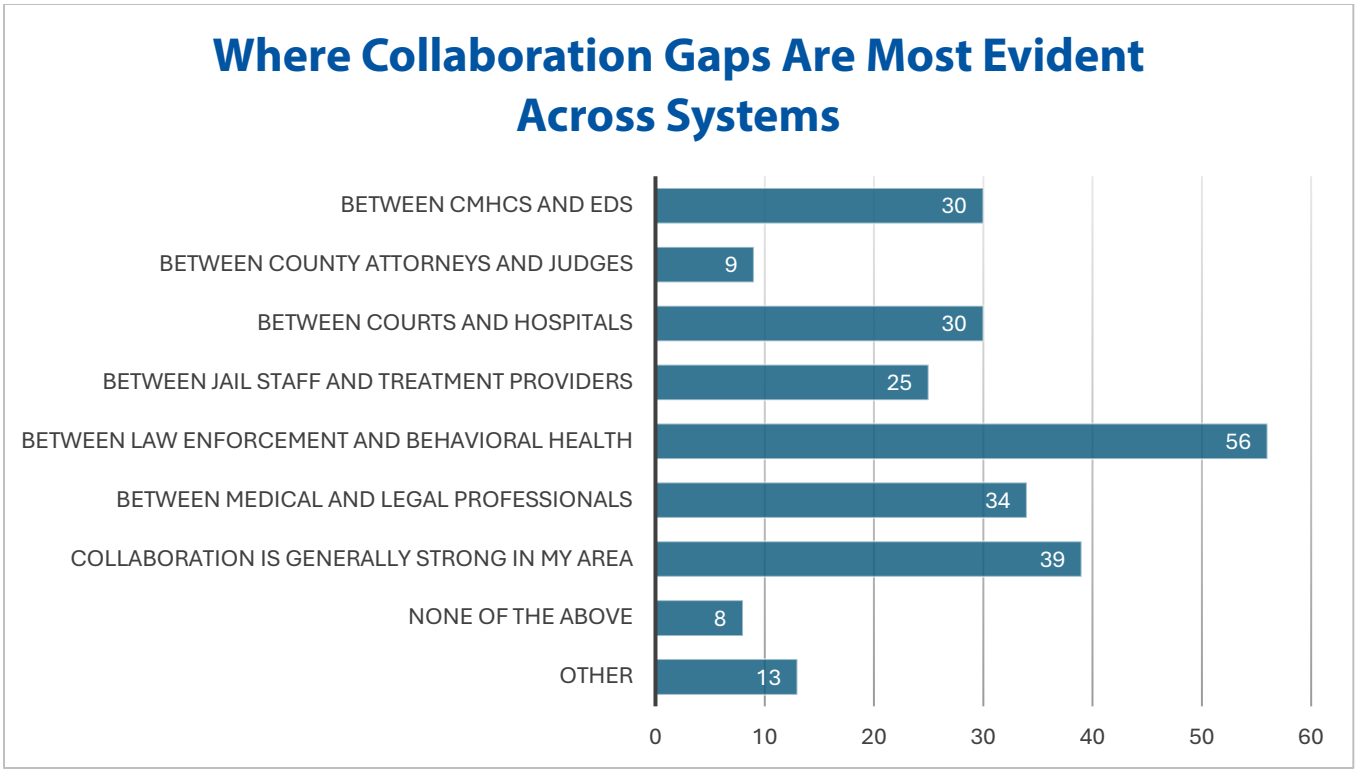
Respondents most strongly supported increased funding for facilities and services and expanded use of outpatient treatment options as key improvements to the 202A process.

Other widely endorsed priorities included better crisis response coordination, faster access to qualified evaluators, and cross-system training for all community partners.

These findings highlight broad support for additional funding to strengthen service capacity and accessibility, along with system-level coordination and training efforts that could improve consistency and reduce strain on inpatient systems.

7. Where are collaboration gaps most evident?

Gaps	Number of Responses	Percentage
Between CMHCs and emergency departments	30	12%
Between county attorneys and judges	9	4%
Between courts and hospitals	30	12%
Between jail staff and treatment providers	25	10%
Between law enforcement and behavioral health	56	23%
Between medical and legal professionals	34	14%
Collaboration is generally strong in my area	39	16%
None of the above	8	3%
Other	13	5%



Respondents most frequently identified law enforcement and behavioral health as the area where collaboration gaps are most evident. Other commonly cited areas included medical and legal professionals, courts and hospitals, and community mental health centers (CMHCs) and emergency departments.

These responses suggest that while collaboration has improved in some regions, reflected by 39 respondents noting generally strong collaboration, significant opportunities remain for strengthening cross-sector communication and coordination, particularly between first responders, healthcare, and the justice system.

Strengthening partnerships between law enforcement, behavioral health, and medical entities could help streamline crisis response, improve care transitions, and overall outcomes.

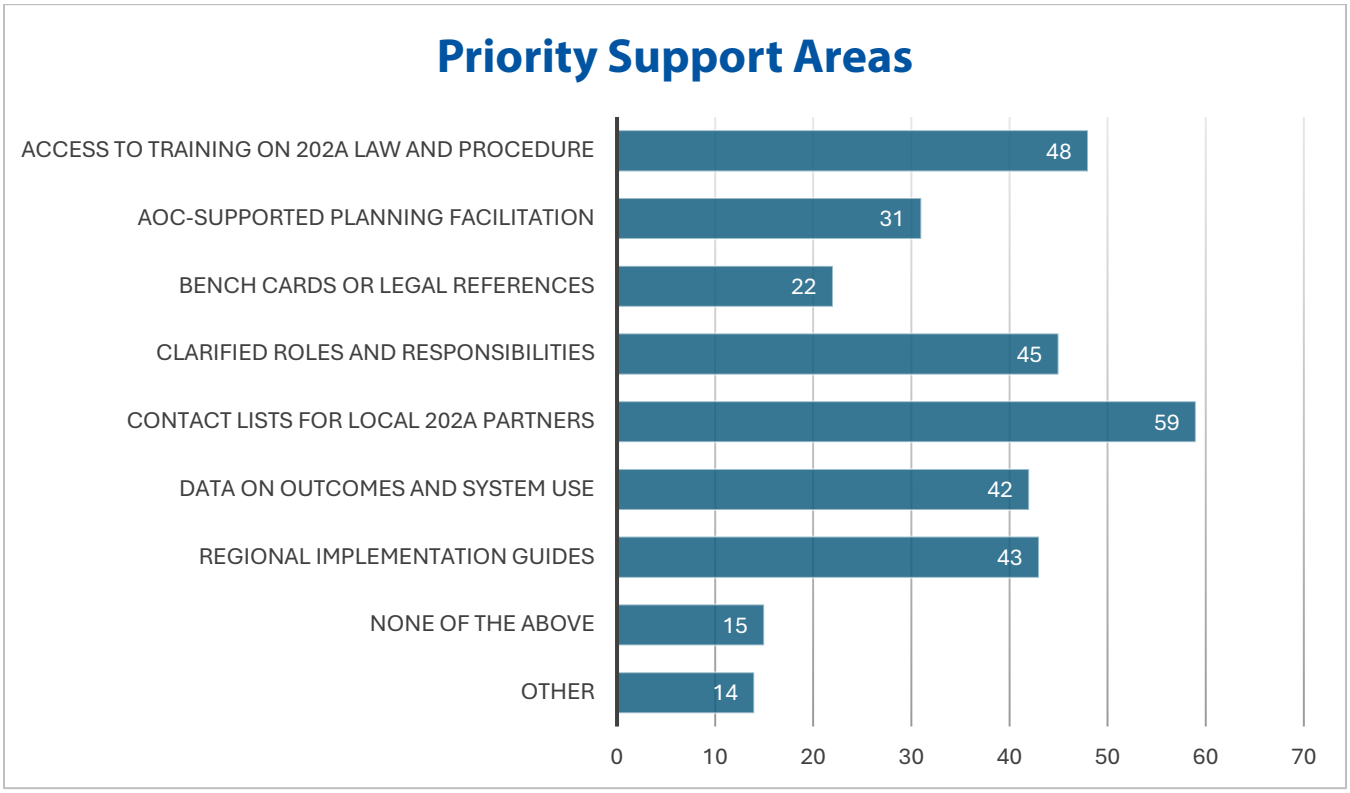
8. Are there any additional barriers or challenges impacting the 202A process that you have not yet had an opportunity to share?

Responses to this question were reviewed alongside survey data, forum discussions, and related feedback. Common themes and considerations are reflected throughout this report and integrated into the findings and recommendations where applicable.

9. What types of support or resources would help you in your role?

Support Type	Number of Responses	Percentage
Access to training on 202A law and procedure	48	15%
AOC-supported planning facilitation	31	10%
Bench cards or legal references	22	7%
Clarified roles and responsibilities	45	14%
Contact lists for local 202A partners	59	18%
Data on outcomes and system use	42	13%
Regional implementation guides	43	13%
None of the above	15	5%

Other	14	4%



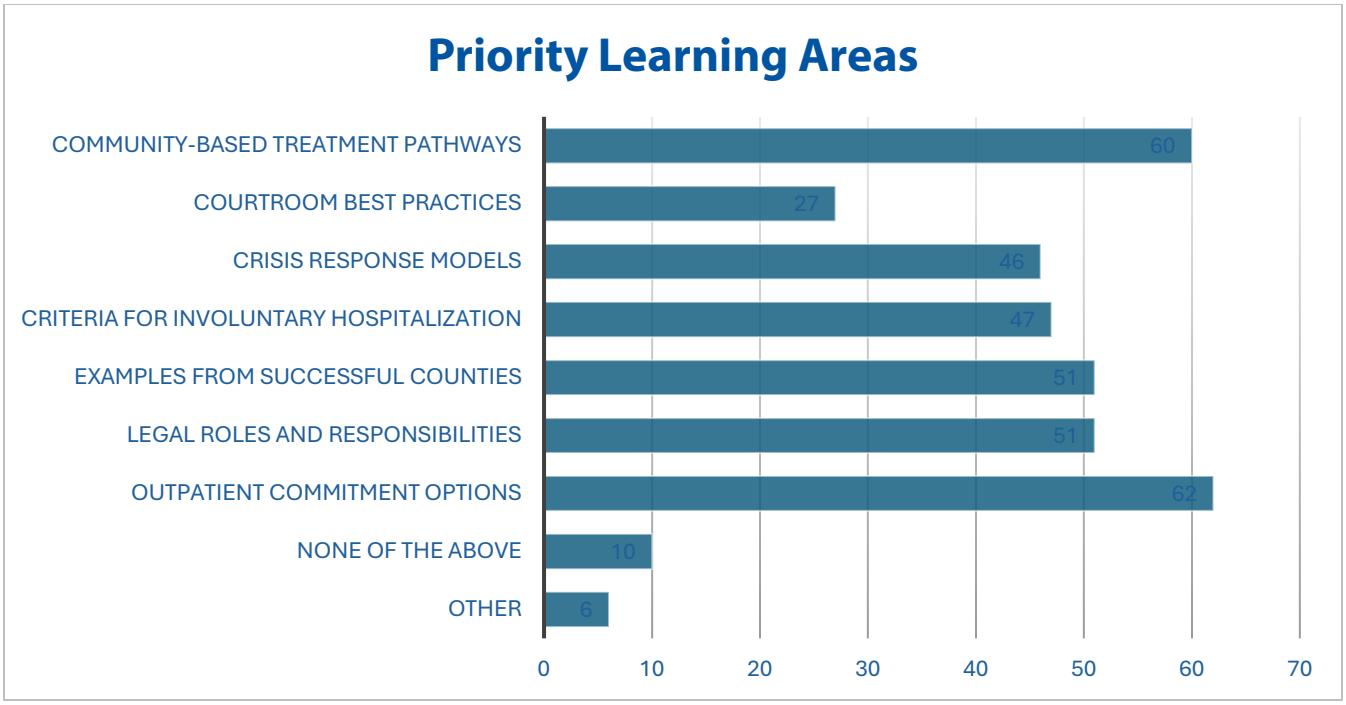
The most commonly requested resource was contact lists for local 202A partners, highlighting the need for stronger communication and easier access to cross-agency collaboration networks. Other widely supported needs included training on 202A law and procedure and clarified roles and responsibilities, both of which reflect a desire for greater clarity and consistency in system implementation.

Additional priorities included regional implementation guides and data on outcomes and system use, emphasizing interest in tools that promote data-informed planning and locally tailored solutions.

Overall, respondents expressed a strong need for practical, accessible tools that enhance collaboration, clarify expectations, and support ongoing education within the 202A process.

10. Which of these topics would you like to see addressed in future forums or trainings?

Topic Areas	Number of Responses	Percentage
Community-based treatment pathways	60	17%
Courtroom best practices	27	8%
Crisis response models	46	13%
Criteria for involuntary hospitalization	47	13%
Examples from successful counties	51	14%
Legal roles and responsibilities	51	14%
Outpatient commitment options	62	17%
None of the above	10	3%
Other	6	2%



The highest level of interest was expressed in outpatient commitment options and community-based treatment pathways, indicating a strong desire among respondents to expand understanding of alternatives to inpatient hospitalization.

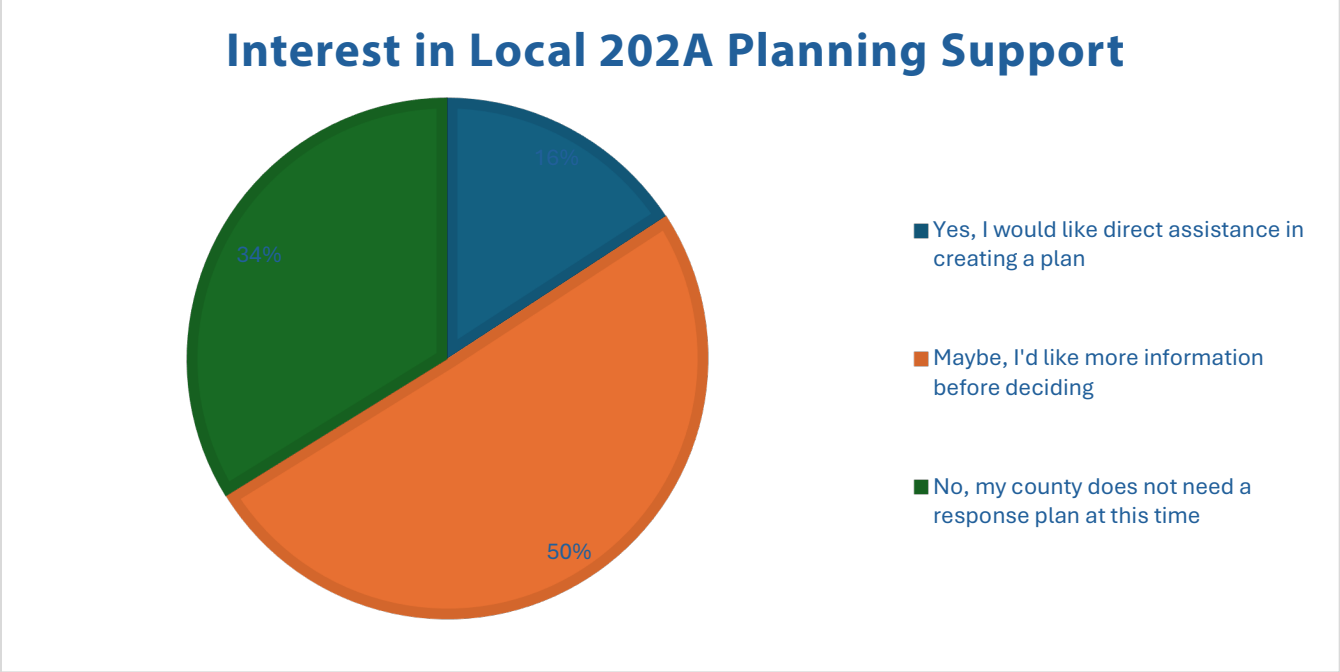
Other frequently selected topics included examples from successful counties and legal roles and responsibilities, demonstrating a shared interest in learning from peer jurisdictions and clarifying procedural expectations across roles.

Participants also emphasized the value of exploring criteria for involuntary hospitalization and crisis response models both of which reflect ongoing system challenges around access, consistency, and timely intervention.

Collectively, these responses highlight broad partner interest in practical, solution-oriented trainings that strengthen local community-based and legally sound approaches.

11. Would you like assistance in developing a local 202A response plan to improve coordination and outcomes in your county?

Assistance Requested	Number of Responses	Percentage
Yes, I would like direct assistance in creating a plan	22	16%
Maybe, I'd like more information before deciding	70	50%
No, my county does not need a response plan at this time	47	34%



The majority of respondents indicated they would like more details before deciding whether assistance is needed to develop a local 202A response plan, suggesting widespread interest but a need for additional information or clarity around what the this would entail.

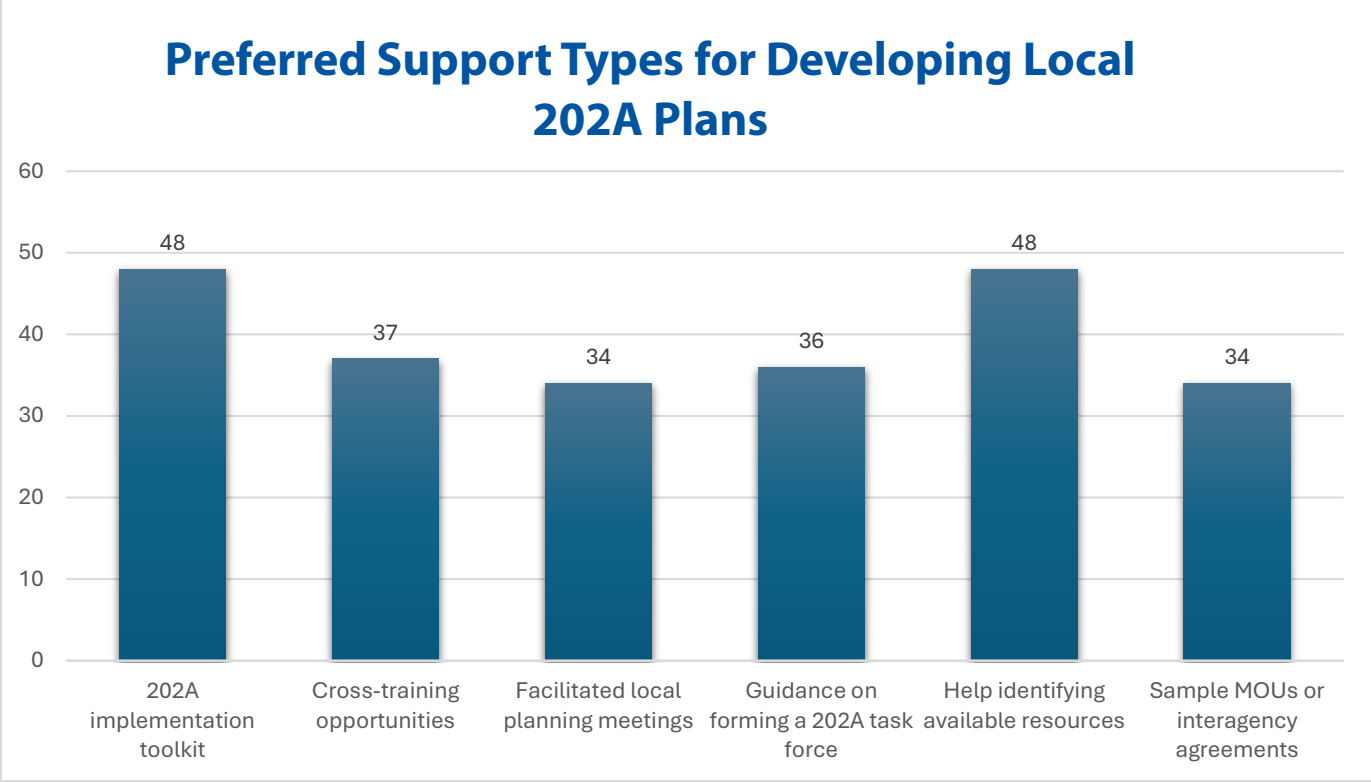
Meanwhile, 16% of respondents expressed a clear desire for direct assistance in creating a plan, reflecting readiness among some counties to move forward with structured implementation efforts.

The remaining respondents noted that their county does not currently need a plan, which may reflect existing local coordination or uncertainty about how a plan would integrate with current processes

Overall, these responses indicate a strong opportunity for targeted outreach and education to help partners and communities better understand the benefits of developing a local 202A response plan.

12. If you selected "Yes" or "Maybe," what areas of support would be most useful?

Support Area	Number of Responses	Percentage
202A implementation toolkit	48	20%
Cross-training opportunities	37	16%
Facilitated local planning meetings	34	14%
Guidance on forming a 202A task force	36	15%
Help identifying available resources	48	20%
Sample MOUs or interagency agreements	34	14%



Respondents most frequently identified the need for a 202A implementation toolkit and help identifying available resources, underscoring a strong desire for practical, ready-to-use materials and clear direction on existing supports.

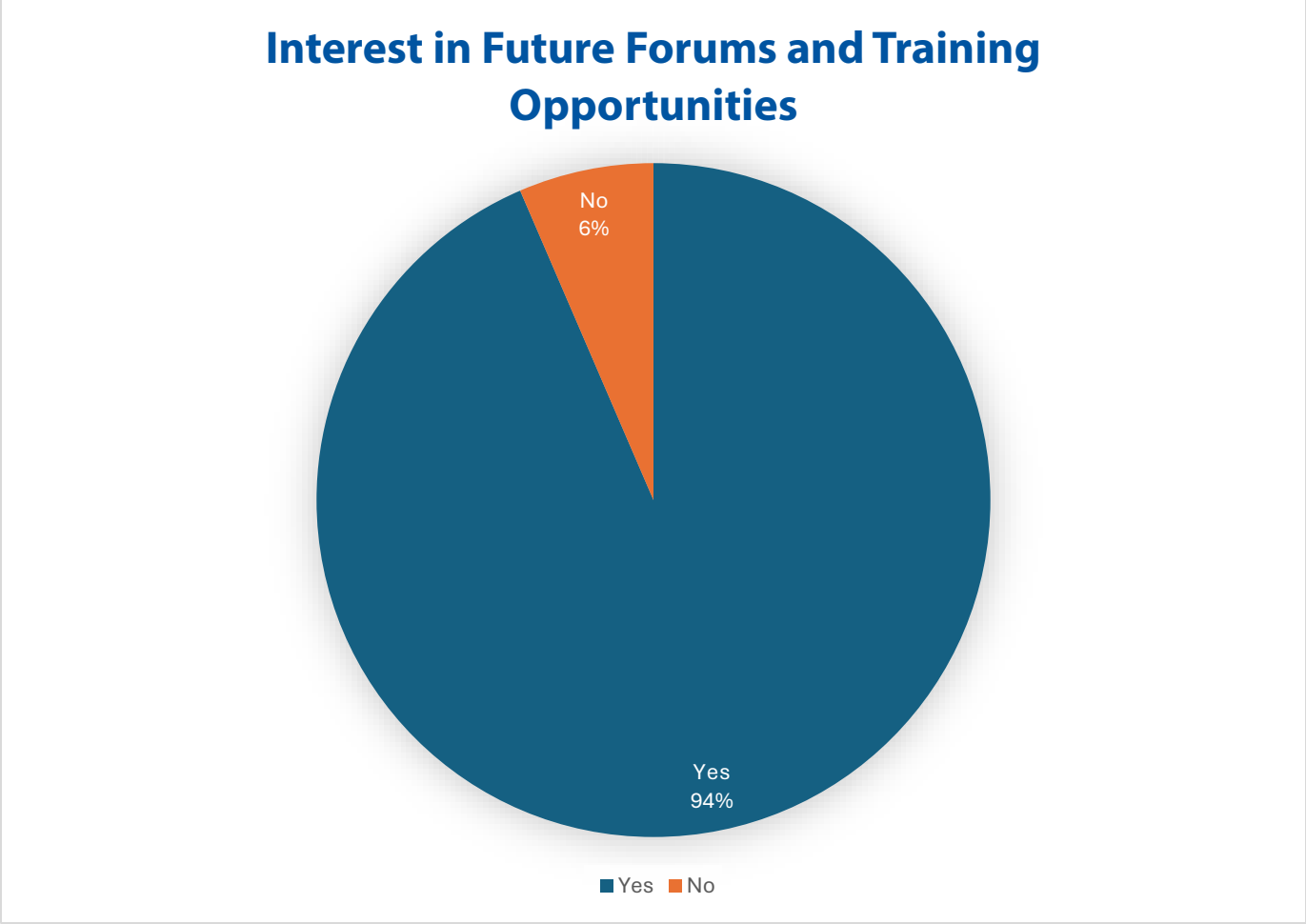
Other commonly requested areas included cross-training opportunities, guidance on forming a 202A task force, and facilitated local planning meetings, all emphasizing the value of collaboration and structured, locally led coordination.

Respondents also expressed interest in sample MOUs or interagency agreements, suggesting that model documents and templates could help streamline interagency cooperation.

Taken together, these results reflect widespread interest in hands-on, implementable tools and training that strengthen coordination and make it easier for communities to operationalize 202A response plans.

13. Would you like to receive follow-up information or updates about future forums, resources, or trainings?

Future Resource Interest	Number of Responses	Percentage
Yes	130	94%
No	9	6%



Nearly all respondents, 130 out of 139, indicated that they would like to receive follow-up information and updates about future 202A-related forums, trainings, and resources.

This strong response demonstrates sustained engagement and commitment among partners across disciplines to remain involved in improving Kentucky's 202A process.

Only 9 respondents declined additional updates, further underscoring the high level of statewide interest in collaboration, learning, and continued system improvement.

Kentucky Judicial Commission on Mental Health

Virtual Forums
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