"A Day in the Life of an Addict"

March Pupilage Group 3/15/2016

1. **Charlotte Wethington (Mother of Matthew "Casey" Wethington)- Casey's Law**
2. **A Prosecution and Defense Take on Casey's Law**

Prosecuting Casey's Law (K.R.S. 222.430-.437)

The Criminal Prosecutorial Viewpoint

Casey's Law currently has minimal litigation interpreting it. Though it is relatively equivalent to the involuntary treatment of the mentally ill (within K.R.S. 202A and K.R.S. 210), and is based on the same methodology, little has occurred in the court system, particularly when it comes to the criminal prosecutor. Should any novel legal questions arise, attorneys should use the litigation around involuntary psychiatric treatment to help their case.

Casey's Law seems generally beneficial to prosecutors, as using the involuntary treatment option eliminates the need of prosecutors to waste their time on the large amount of addictions, giving them more time for harder crimes. However, it does pose one notable issue for criminal prosecutors; it eliminates their bargaining power with heroin users, which may slow prosecutor's ability to find the heroin supply chain. Prosecutors and the police cannot pressure heroin users into giving up their sources if the users cannot be incarcerated for refusing to cooperate.

The Petitioner Viewpoint

The petitioner in this case is the person who completes the affidavit regarding the respondent's (the heroin user's) addiction. Though this presentation is focused on the heroin epidemic, Casey's Law may be used for any drug or alcohol addiction. There are three types of treatment available through Casey's Law: the 72 hour emergency plan, the 60 day plan, and the 360 day plan, all of which are modeled after the involuntary psychiatric treatment plans previously implemented years ago. Note that respondents under Casey's Law have all of the same rights that these psychiatric respondents have under K.R.S. 202A and K.R.S. 210.

72 Hours Emergency Treatment Plan (K.R.S. 222.434)

The emergency plan must be started by a qualified healthcare professional. This professional has not yet been defined in the statutes, however it is treated as roughly equivalent to the definition within K.R.S. 202A.011(12). The healthcare professional determines whether or not the respondent meets the requirements set by K.R.S. 222.431:

(1) The respondent is suffering from drug/alcohol abuse
(2) The respondent is an imminent danger for his or herself, OR there is a substantial likelihood of danger to his or herself soon **AND**
(3) The respondent can reasonably benefit from involuntary treatment.

If the healthcare professional finds that the respondent does indeed meet those requirements, the healthcare professional can ask a court to enforce a 72 hours involuntary treatment at a hospital. It should be noted that the evidentiary threshold for this method is the clear and convincing evidence standard, though this standard is not required for the 60 or 360 day treatment plans.

60/360 Day Treatment Plans (K.R.S. 222.432)

There are three requirements of the respondent in the petition for both the 60 day treatment plan and the 360 day treatment plan:

(1) The respondent is suffering from drug/alcohol abuse

(2) The respondent is an imminent danger for his or herself, OR there is a substantial likelihood of danger to his or herself soon **AND**
(3) The respondent can reasonably benefit from involuntary treatment.

The petitioner decides whether he or she thinks that the 60 or the 360 day treatment plan is necessary, checking the corresponding box on the petition. The petitioner must also state his or her relation to the respondent, the respondent's next of kin information, specific facts denoting the need for treatment as well as specific facts for the imminent danger. All of this information serves as the probable cause for the treatment. The largest problem with the use of Casey's Law is that someone has to guarantee to pay for the cost of the treatment. This guarantor can be an insurance company, including Medicaid, but unfortunately this doesn't cover all who could potentially benefit from this treatment.

Within fourteen days after the petition is filed with a court, the respondent will be given a hearing to determine whether or not the respondent fulfills the three requirements for involuntary treatment. Prior to the hearing, however, notice is needed for the attorney assigned to the respondent and the respondent denoting the allegations, content, date, and purpose of the petition. Further, within 24 hours prior to this hearing, the respondent must be examined by two qualified health professionals as evidence for this hearing. Should the respondent fail to attend these examinations, a judge may issue a bench warrant forcing the examinations (via K.R.S. 222.435). Finally, if at the hearing the court finds the respondent in need of this treatment, treatment is ordered under pain of contempt of court.

Upcoming Amendment – KY HB378 (2016 Regular Session - Introduced Feb 10, 2016)

Prosecutors should note that the Kentucky House of Representatives introduced a bill amending Casey's Law in February 2016. On March 10, 2016 it was assigned to House Health and Welfare Committee for review. The following are the current (as of March 14, 2016) proposed changes:

- Defines "Incapacitated by alcohol and other drug abuse": the [respondent], as a result of alcohol and other drug abuse, has impaired judgment resulting in the [respondent] being incapable of realizing that there are serious and highly probable risks to health and safety involved in refusing treatment and making a rational decision with respect to the need for treatment:
- Changes K.R.S. 222.431(2), the criteria for involuntary treatment, to included "incapacitated by alcohol and other drug abuse".
- Changes K.R.S. 222.432 (4)(f) to include a guarantor for costs not paid by a third party (e.g. insurance).
- Changes K.R.S. 222.433(2) to allow inclusion of previous addiction assessments with the original petition.
- Changes K.R.S. 222.433(2)(a) to say that if respondent refuses assessment by two qualified health professional, the evidence can be replaced by assessment conducted within the past six months.
- Changes K.R.S. 222.465 to include costs for this involuntary treatment under insurance/Medicaid the same as other covered behavioral health services.

Defense

Representing a person contesting a Casey's law petition is similar to any other avenue of litigation, in that the petition is heard in front of a judge. Witnesses, typically family and friends are brought in to testify under oath. Also two medical professionals are brought in to testify and provide an opinion as to whether the person being compelled to enter treatment is at a point

where treatment is necessary. This proceeding allows for the defense to properly represent their client with hopes of receiving the desired outcome of their client.

The first concern as the defense is determining whether your client, the person being compelled to enter treatment, wants to enter treatment or challenge the petition. Acting as counsel, the first priority is to adhere to the desires of our clients, and in this situation that desire may be to either enter treatment or challenge the treatment. If it has been determined that they do in fact want to enter treatment then the duty is not to challenge the petition, but rather allow the person to fully understand the implications of entering treatment. If the person does not want to enter treatment, then it the duty of counsel to represent the person to the best of their ability in challenging the petition.

The next phase is representing the client before the reviewing court. The first issue that a person representing a challenger to a petition must face is what standard is required to grant the petition. The standard required is probable cause. Probable cause is lower standard which is beneficial for those needing treatment, however, may raise a problem for individuals that are unsure that they need treatment. Once probable cause is established the court then orders an evaluation by 2 medical professionals, one of which must be a physician. Issue may arise in ensuring that the court adheres to this requirement, especially the physician requirement. After the medical opinion has been made to whether the treatment is needed the court will then issue an order either compelling treatment or finding that there is not cause to order treatment

If the court finds reason for treatment two problems may arise: (1) Person filing the petition must have the funds and secured a facility for the treatment. If this does not occur, then treatment is no longer required; and (2) The importance of the person going into treatment understanding the consequences if they do not fulfill the required time for treatment. If the person does not follow through with the treatment then they may be held in contempt, which is a jail able offense. It is important for the person to understand these ramifications because failing to convey the consequences may ultimately lead the person into serving time rather than being in a treatment facility.

Casey's law is a wonderful piece of legislation that is allowing for citizens of Kentucky to enter a treatment facility that has the ability to get them out of the cycle of drug addiction or alcoholism. This law allows for concerned family members and friends to aid someone they care for in receiving treatment. As attorneys the main priority is to help our client. In some cases it may be aiding the person in receiving in treatment. But in other cases it may be aiding the person in staying out of treatment. Ultimately it is the responsibility of the defense to adhere to the desires of the person they represent.

3. Introduction of the Good Samaritan Law- Prosecution and Defense Take on Good Sam

Prosecution

Generally, the Good Samaritan provision provides that a person cannot be prosecuted for possessing a controlled substance or the possession of drug paraphernalia if he or she in good

faith was seeking medical assistance with a drug overdose. More specifically, the immunity applies when and three qualifications are met:

1. In good faith medical assistance with a drug overdose is sought from a public safety answering point because the person needs medical assistance, acts in concert with someone who requests it or appears to need it
2. The person remains with or is the overdoser, and
3. The evidence for the charge is obtained as a result of the overdose

Governor Steve Beshear signed Kentucky's new "Heroin Bill" into law on March 25, 2015. At this point, there is little to no precedent so this is largely an issue of statutory interpretation.

There are some alarming statistics on drug overdoses in Kentucky. A report from the KY Office of Drug Control Policy indicates that Campbell, Kenton, and Boone counties are all in the top 5 counties in KY for heroin detected in overdose deaths (data from KY medical examiner and coroner reports). Also according to the CDC Kentucky ranks 5th worse in the nation for drug overdose deaths. The statistics show the extent of the issue and a gives us a better understanding of why such a law would be passed that provides immunity to drug users. The goal of the statute is saving lives. Without this law, a person who is in the presence of someone who is overdosing (or even who is overdosing himself) may hesitate to call for help because they face prosecution for possession when police arrive.

Issues:
To whom does the immunity extend?

- Extends to any caller who remains with the victim of the overdose whether the caller is with the victim or the person does not know the victim. Immunity will also extend to the victim.
    - Won't apply to someone who leaves the victim
        - Scenario: if two people are at a party and that person stays→immunity applies, vs. if the caller leaves the person overdosing→immunity does not apply
- A person can call for assistance for themselves too.

Immunity will NOT extend if medical assistance is sought during the course of an execution of an arrest warrant, search warrant, or lawful search. Will only apply if you're calling 911 for an overdose.

- Scenario: what if the police are on the way and the call is for the same house- from a Prosecution standpoint because they would have been there for reasons other than the overdose and they're not there because of the request for medical assistance- it's for a search warrant- immunity does not apply.

What if the caller calls for something other than the overdose and need for medical assistance (i.e. a wreck)? Prosecution will argue that immunity will NOT apply.

- The prosecutor argues that the medical assistance must be for assistance with a drug overdose—this is one issue that is litigated in hearings because of the different statutory interpretations

Immunity does NOT apply to trafficking, tampering with evidence, wanton endangerment, DUI, burglary, or other crimes. Only applies to possession of a controlled substance or of drug paraphernalia.

- The law is very clear that immunity will only apply with possession.
- Scenario: person is overdosing, friend calls, and flushes the drugs down the toilet- then that's going to be a tampering with evidence charge and immunity statute will not apply.

What if police arrive and see evidence of another crime? Evidence of other crimes may still be seized. Likewise, contraband should be seized and submitted into evidence for future destruction even if immunity bars arrest.

An important issue being litigated right now is whether the statute requires the medical assistance be sought for an overdose. The prosecution argues that the statute requires the medical assistance be sought for an overdose. Opinions differ as to whether the "overdose" has to be explicit (i.e. say calling because of the overdose) or if it is sufficient to infer there's an overdose situation if the circumstances indicate so (i.e. a description the victim is foaming at the mouth).

> Issue: do you have to be seeking assistance for a drug overdose or just medical assistance?
>
> Most prosecutors will say read as close to the words of the statute. The statute says seeking help for an overdose- must be explicit.

Issue: the victims/callers are being excused with no ramifications- the Heroin Bill doesn't provide treatment to overdoes victims. They are released from the hospital into the same environment from which they left.

Based on the research and work with the Commonwealth, the overarching goal of the Good Samaritan provision is to encourage persons to seek medical assistance- what we don't want is people who are scared to call. On the converse, we want to look at each case very fact intensive and we don't want the provision to be misused. When a person doesn't meet immunity want to move forward with prosecution.

Defense

The purpose of the law is to encourage individuals that are using together to call the police in the event of a medical emergency**.**

So many times, individuals using are together when one of them goes into a medical emergency and is in need of immediate assistance. Out of fear of being arrested and being prosecuted, those individuals will watch their "friend" continue having a medical episode, hoping that they come out of it, until the overdosing individual dies. This is the reality for so many heroin users. Again out of fear of being associated with the body of this individual, many addicts first instinct is to take the body and dump it.

Tri-state police are responding to an increasing number of overdose fatality calls and the numbers are only going to continue to rise.

It is the responsibility of police and prosecutors to hold those that are breaking the law accountable for their actions. A law that effectively provides immunity for those trying to get help for themselves or others can complicate this natural responsibility. There is a concern that such a law will encourage users to have "heroin parties" to use so that in the event that someone overdoses they can be immune from arrest and prosecution. The problem with this is that the law is so new that most addicts are unaware of it and its immunity potential. Additionally, heroin users are focused on getting their next fix so that they can function on a daily basis, and not on the ability to have immunity from prosecution in the event they are arrested. Lastly, it is against human nature to call the police to get yourself into trouble. Because of this, heroin users are more likely to watch another human being lose their life to drugs than call for help out of fear of being arrested.

There are two ways in which the Good Sam law can be utilized. First being that when the police respond to a call where a user is in need of medical assistance, the police refrain from arresting the individuals that called on the overdosers behalf. This is how the law was intended to be executed. The Second way in which the law can be utilized, is if the police arrest the good faith caller, in that case the arrested individual can raise an immunity defense. The problem with this second use of the law is that many times the good faith caller will spend a month if not more incarcerated prior to being able to raise this legitimate defense. Additionally, there is some procedural question as to when a defendant can and should raise this issue.

While the Good Samaritan Law is still in its infancy, the law has great potential to save the lives of many individuals right here in Northern Kentucky.

4. **Jason Merrick- SUITS (JSAP) program**
5. **Narcan Demonstration**

Baldwin's Kentucky Revised Statutes Annotated
Title XVIII. Public Health
Chapter 222. Kentucky Alcohol and Other Drug Abuse Prevention, Intervention, and Treatment Law (Refs & Annos)
Involuntary Treatment for Alcohol and Other Drug Abuse

KRS § 222.430

222.430 Involuntary treatment for alcohol and other drug abuse; rights of patient

Currentness

(1) Involuntary treatment ordered for a person suffering from alcohol and other drug abuse shall follow the procedures set forth in KRS 222.430 to 222.437.

(2) Except as otherwise provided for in KRS 222.430 to 222.437, all rights guaranteed by KRS Chapters 202A and 210 to involuntarily hospitalized mentally ill persons shall be guaranteed to a person ordered to undergo treatment for alcohol and other drug abuse.

Credits

HISTORY: 2004 c 116, § 1, eff. 7-13-04; 1994 c 334, § 17, eff. 7-15-94; 1982 c 141, § 40, 146, eff. 7-1-82; 1980 c 396, § 41; 1976 c 332, § 29; 1972 c 166, § 6

KRS § 222.430, KY ST § 222.430
Current through the end of the 2015 regular session

End of Document

KeyCite Yellow Flag - Negative Treatment
Proposed Legislation

Baldwin's Kentucky Revised Statutes Annotated
Title XVIII. Public Health
Chapter 222. Kentucky Alcohol and Other Drug Abuse Prevention, Intervention, and Treatment Law (Refs & Annos)
Involuntary Treatment for Alcohol and Other Drug Abuse

KRS § 222.431

222.431 Criteria for involuntary treatment

Currentness

No person suffering from alcohol and other drug abuse shall be ordered to undergo treatment unless that person:

(1) Suffers from alcohol and other drug abuse;

(2) Presents an imminent threat of danger to self, family, or others as a result of alcohol and other drug abuse, or there exists a substantial likelihood of such a threat in the near future; and

(3) Can reasonably benefit from treatment.

Credits
HISTORY: 2004 c 116, § 2, eff. 7-13-04

KRS § 222.431, KY ST § 222.431
Current through the end of the 2015 regular session

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 KeyCite Yellow Flag - Negative Treatment
Proposed Legislation

Baldwin's Kentucky Revised Statutes Annotated
Title XVIII. Public Health
Chapter 222. Kentucky Alcohol and Other Drug Abuse Prevention, Intervention, and Treatment Law (Refs & Annos)
Involuntary Treatment for Alcohol and Other Drug Abuse

KRS § 222.432

222.432 Petition for 60-day and 360-day involuntary treatment; contents; guarantee for costs

Currentness

(1) Proceedings for sixty (60) days or three hundred sixty (360) days of treatment for an individual suffering from alcohol and other drug abuse shall be initiated by the filing of a verified petition in District Court.

(2) The petition and all subsequent court documents shall be entitled: “In the interest of (name of respondent).”

(3) The petition shall be filed by a spouse, relative, friend, or guardian of the individual concerning whom the petition is filed.

(4) The petition shall set forth:

(a) Petitioner's relationship to the respondent;

(b) Respondent's name, residence, and current location, if known;

(c) The name and residence of respondent's parents, if living and if known, or respondent's legal guardian, if any and if known;

(d) The name and residence of respondent's husband or wife, if any and if known;

(e) The name and residence of the person having custody of the respondent, if any, or if no such person is known, the name and residence of a near relative or that the person is unknown; and

(f) Petitioner's belief, including the factual basis therefor, that the respondent is suffering from an alcohol and other drug abuse disorder and presents a danger or threat of danger to self, family, or others if not treated for alcohol or other drug abuse.

Any petition filed pursuant to this subsection shall be accompanied by a guarantee, signed by the petitioner or other person authorized under subsection (3) of this section, obligating that person to pay all costs for treatment of the respondent for alcohol and other drug abuse that is ordered by the court.

Credits

HISTORY: 2004 c 116, § 3, eff. 7-13-04

KRS § 222.432, KY ST § 222.432

Current through the end of the 2015 regular session

End of Document

 KeyCite Yellow Flag - Negative Treatment
Proposed Legislation

Baldwin's Kentucky Revised Statutes Annotated
Title XVIII. Public Health
Chapter 222. Kentucky Alcohol and Other Drug Abuse Prevention, Intervention, and Treatment Law (Refs & Annos)
Involuntary Treatment for Alcohol and Other Drug Abuse

KRS § 222.433

222.433 Proceedings for involuntary treatment; duties of court; disposition

Currentness

(1) Upon receipt of the petition, the court shall examine the petitioner under oath as to the contents of the petition.

(2) If, after reviewing the allegations contained in the petition and examining the petitioner under oath, it appears to the court that there is probable cause to believe the respondent should be ordered to undergo treatment, then the court shall:

(a) Set a date for a hearing within fourteen (14) days to determine if there is probable cause to believe the respondent should be ordered to undergo treatment for alcohol and other drug abuse;

(b) 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 hearing; and the name, address, and telephone number of the attorney appointed to represent the respondent; and

(c) Cause the respondent to be examined no later than twenty-four (24) hours before the hearing date by two (2) qualified health professionals, at least one (1) of whom is a physician. The qualified health professionals shall certify their findings to the court within twenty-four (24) hours of the examinations.

(3) If, upon completion of the hearing, the court finds the respondent should be ordered to undergo treatment, then the court shall order such treatment for a period not to exceed sixty (60) consecutive days from the date of the court order or a period not to exceed three hundred sixty (360) consecutive days from the date of the court order, whatever was the period of time that was requested in the petition or otherwise agreed to at the hearing. Failure of a respondent to undergo treatment ordered pursuant to this subsection may place the respondent in contempt of court.

(4) If, at any time after the petition is filed, the court finds that there is no probable cause to continue treatment or if the petitioner withdraws the petition, then the proceedings against the respondent shall be dismissed.

Credits
HISTORY: 2004 c 116, § 4, eff. 7-13-04

KRS § 222.433, KY ST § 222.433
Current through the end of the 2015 regular session

End of Document

Baldwin's Kentucky Revised Statutes Annotated
Title XVIII. Public Health
Chapter 222. Kentucky Alcohol and Other Drug Abuse Prevention, Intervention, and Treatment Law (Refs & Annos)
Involuntary Treatment for Alcohol and Other Drug Abuse

KRS § 222.434

222.434 Seventy-two-hour emergency involuntary treatment

Currentness

(1) Following an examination by a qualified health professional and a certification by that professional that the person meets the criteria specified in KRS 222.431, the court may order the person hospitalized for a period not to exceed seventy-two (72) hours if the court finds, by clear and convincing evidence, that the respondent presents an imminent threat of danger to self, family, or others as a result of alcohol and other drug abuse.

(2) Any person who has been admitted to a hospital under subsection (1) of this section shall be released from the hospital within seventy-two (72) hours of admittance.

(3) No respondent ordered hospitalized under this section shall be held in jail pending transportation to the hospital or evaluation unless the court has previously found the respondent to be in contempt of court for either failure to undergo treatment or failure to appear at the evaluation ordered pursuant to KRS 222.433.

Credits
HISTORY: 2004 c 116, § 5, eff. 7-13-04

KRS § 222.434, KY ST § 222.434
Current through the end of the 2015 regular session

End of Document

Baldwin's Kentucky Revised Statutes Annotated
Title XVIII. Public Health
Chapter 222. Kentucky Alcohol and Other Drug Abuse Prevention, Intervention, and Treatment Law (Refs & Annos)
Involuntary Treatment for Alcohol and Other Drug Abuse

KRS § 222.435

222.435 Failure to attend examination; summons; transportation to hospital or psychiatric facility

Currentness

When the court is authorized to issue an order that the respondent be transported to a hospital, the court may, or if the respondent fails to attend an examination scheduled before the hearing provided for in KRS 222.433 then the court shall, issue a summons. A summons so issued shall be directed to the respondent and shall command the respondent to appear at a time and place therein specified. If a respondent who has been summoned fails to appear at the hospital or the examination, then the court may order the sheriff or other peace officer to transport the respondent to a hospital or psychiatric facility designated by the cabinet for treatment under KRS 210.485. The sheriff or other peace officer may, upon agreement of a person authorized by the peace officer, authorize the cabinet, a private agency on contract with the cabinet, or an ambulance service designated by the cabinet to transport the respondent to the hospital. The transportation costs of the sheriff, other peace officer, ambulance service, or other private agency on contract with the cabinet shall be included in the costs of treatment for alcohol and other drug abuse to be paid by the petitioner.

Credits

HISTORY: 2004 c 116, § 6, eff. 7-13-04

KRS § 222.435, KY ST § 222.435
Current through the end of the 2015 regular session

End of Document

KRS § 222.436

222.436 Application of KRS Chapter 202A

Currentness

The definitions in KRS 202A.011 and the procedures in KRS Chapter 202A apply to KRS 222.430 to 222.437 except where terms or procedures used therein are defined in KRS 222.005 or are otherwise provided for in KRS 222.430 to 222.437, respectively.

Credits

HISTORY: 2004 c 116, § 7, eff. 7-13-04

KRS § 222.436, KY ST § 222.436
Current through the end of the 2015 regular session

End of Document

Baldwin's Kentucky Revised Statutes Annotated
Title XVIII. Public Health
Chapter 222. Kentucky Alcohol and Other Drug Abuse Prevention, Intervention, and Treatment Law (Refs & Annos)
Involuntary Treatment for Alcohol and Other Drug Abuse

KRS § 222.437

222.437 Short title for KRS 222.430 to 222.437

Currentness

KRS 222.430 to 222.437 may be cited as the Matthew Casey Wethington Act for Substance Abuse Intervention.

Credits
HISTORY: 2004 c 116, § 8, eff. 7-13-04

KRS § 222.437, KY ST § 222.437
Current through the end of the 2015 regular session

End of Document

 KeyCite Yellow Flag - Negative Treatment
Proposed Legislation

Baldwin's Kentucky Revised Statutes Annotated
Title XVIII. Public Health
Chapter 218A. Controlled Substances (Refs & Annos)

KRS § 218A.133

218A.133 Exemption from prosecution for possession of controlled substance or drug paraphernalia if seeking assistance with drug overdose

Effective: March 25, 2015
Currentness

(1) As used in this section:

(a) "Drug overdose" means an acute condition of physical illness, coma, mania, hysteria, seizure, cardiac arrest, cessation of breathing, or death which reasonably appears to be the result of consumption or use of a controlled substance, or another substance with which a controlled substance was combined, and that a layperson would reasonably believe requires medical assistance; and

(b) "Good faith" does not include seeking medical assistance during the course of the execution of an arrest warrant, or search warrant, or a lawful search.

(2) A person shall not be charged with or prosecuted for a criminal offense prohibiting the possession of a controlled substance or the possession of drug paraphernalia if:

(a) In good faith, medical assistance with a drug overdose is sought from a public safety answering point, emergency medical services, a law enforcement officer, or a health practitioner because the person:

1. Requests emergency medical assistance for himself or herself or another person;

2. Acts in concert with another person who requests emergency medical assistance; or

3. Appears to be in need of emergency medical assistance and is the individual for whom the request was made;

(b) The person remains with, or is, the individual who appears to be experiencing a drug overdose until the requested assistance is provided; and

(c) The evidence for the charge or prosecution is obtained as a result of the drug overdose and the need for medical assistance.

(3) The provisions of subsection (2) of this section shall not extend to the investigation and prosecution of any other crimes committed by a person who otherwise qualifies under this section.

(4) When contact information is available for the person who requested emergency medical assistance, it shall be reported to the local health department. Health department personnel shall make contact with the person who requested emergency medical assistance in order to offer referrals regarding substance abuse treatment, if appropriate.

(5) A law enforcement officer who makes an arrest in contravention of this section shall not be criminally or civilly liable for false arrest or false imprisonment if the arrest was based on probable cause.

Credits

HISTORY: 2015 c 66, § 11, eff. 3-25-15

KRS § 218A.133, KY ST § 218A.133
Current through the end of the 2015 regular session

End of Document

AN ACT relating to controlled substances and declaring an emergency.

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

➔Section 1. KRS 72.026 is amended to read as follows:

(1) ~~[Unless another cause of death is clearly established,]~~In cases requiring a post-mortem examination under KRS 72.025**,** the coroner or medical examiner shall take a ***biological***~~[blood]~~ sample and have it tested for the presence of any controlled substances which were in the body at the time of death ***and which at the scene may have contributed to the cause of death***.

(2) If a coroner or medical examiner determines that a drug overdose is the cause of death of a person, he or she shall provide notice of the death to:

(a) The state registrar of vital statistics and the Department of Kentucky State Police. The notice shall include any information relating to the drug that resulted in the overdose. The state registrar of vital statistics shall not enter the information on the deceased person's death certificate unless the information is already on the death certificate;~~[and]~~

(b) The licensing board for the individual who prescribed or dispensed the medication, if known. The notice shall include any information relating to the drug that resulted in the overdose, including the individual authorized by law to prescribe or dispense drugs who dispensed or prescribed the drug to the decedent***; and***

(c) For coroners only, the Commonwealth's attorney and a local law enforcement agency in the circuit where the death occurred, if the death resulted from the use of a Schedule I controlled substance. The notice shall include all information as to the types and concentrations of Schedule I drugs detected.

This subsection shall not apply to reporting the name of a pharmacist who dispensed a drug based on a prescription.

(3) The state registrar of vital statistics shall report, within five (5) business days of the receipt of a certified death certificate or amended death certificate, to the Division of Kentucky State Medical Examiners Office, any death which has resulted from the use of drugs or a drug overdose.

(4) The Justice and Public Safety Cabinet in consultation with the Kentucky State Medical Examiners Office shall promulgate administrative regulations necessary to administer this section.

➔Section 2. KRS 100.982 is amended to read as follows:

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

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

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

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

➔Section 3. KRS 196.288 is amended to read as follows:

(1) The department shall measure and document cost savings resulting from amendments to or creation of statutes in KRS Chapters 27A, 196, 197, 431, 439, 532, 533, and 534 contained in 2011 Ky. Acts ch. 2. Measured and documented

savings shall be reinvested or distributed as provided in this section.

(2) The department shall establish a baseline for measurement using the average number of inmates incarcerated at each type of penitentiary as defined in KRS 197.010 and at local jails in fiscal year 2010-2011.

(3) The department shall determine the average cost of:

(a) Incarceration for each type of penitentiary as defined in KRS 197.010 and for local jails, including health care costs, transportation costs, and other related costs, for one (1) inmate for one (1) year for the immediately preceding fiscal year;~~[and]~~

(b) Providing probation and parole services for one (1) parolee for one (1) year for the immediately preceding fiscal year***; and***

(c) Reentry services and peer support as a condition of parole for those with opiate addiction and other substance abuse disorders.

(4) Beginning with the budget request for the 2012-2014 fiscal biennium, savings shall be estimated from the baseline established in subsection (2) of this section as follows:

(a) The estimated average reduction of inmates due to mandatory reentry supervision as required by KRS 439.3406 multiplied by the appropriate average cost as determined in subsection (3)(a) of this section;

(b) The estimated average reduction of inmates due to accelerated parole hearings as required by KRS 439.340 multiplied by the appropriate average cost as determined in subsection (3)(a) of this section;

(c) The estimated average increase of parolees due to paragraphs (a) and (b) of this subsection multiplied by the average cost as determined in subsection (3)(b) of this section; and

(d) The estimated average reduction of parolees due to parole credit for good behavior as provided in KRS 439.345 multiplied by the average cost as

determined in subsection (3)(b) of this section.

(5) The following amounts shall be allocated or distributed from the estimated amount of savings that would otherwise remain in the general fund:

(a) Twenty-five percent (25%) shall be distributed to the local corrections assistance fund established by KRS 441.207;~~[and]~~

(b) ***Fifty percent (50%) shall be distributed for the following purposes:***

1. To the department to provide or to contract for the provision of substance abuse treatment in county jails, regional jails, or other local detention centers that employ evidence-based practices in behavioral health treatment or medically assisted treatment for nonstate inmates with opiate addiction or other substance abuse disorders;

2. For KY-ASAP programs operating under KRS Chapter 15A in county jails or in facilities under the supervision of county jails that employ evidence-based behavioral health treatment or medically assisted treatment for inmates with opiate addiction or other substance abuse disorders;

3. To KY-ASAP to provide supplemental grant funding to community mental health centers for the purpose of offering additional substance abuse treatment resources through programs that employ evidence-based behavioral health treatment or medically assisted treatment;

4. To KY-ASAP to address neonatal abstinence syndrome by providing supplemental grant funding to community substance abuse treatment providers to offer residential treatment services to pregnant women through programs that employ evidence-based behavioral health treatment or medically assisted treatment;

5. To provide supplemental funding for traditional KY-ASAP substance abuse programming under KRS Chapter 15A;

6. To the department for the purchase of an FDA-approved extended-release treatment for the prevention of relapse to opiate dependence with a minimum of fourteen (14) days effectiveness with an opioid antagonist function for use as a component of evidence-based medically assisted treatment for inmates with opiate addiction or substance abuse disorders participating in a substance abuse treatment program operated or supervised by the department;

7. To the Department for Public Advocacy to provide supplemental funding to the Social Worker Program for the purpose of creating additional social worker positions to develop individualized alternative sentencing plans; and

8. To the Prosecutors Advisory Council to enhance the use of rocket docket prosecutions in controlled substance cases; and

(c) In enacting the budget for the department and the judicial branch, beginning in the 2012-2014 fiscal biennium and each fiscal biennium thereafter, the General Assembly shall:

1. Determine the estimated amount necessary for reinvestment in:
   a. Expanded treatment programs and expanded probation and parole services provided by or through the department; and
   b. Additional pretrial services and drug court case specialists provided by or through the Administrative Office of the Courts; and
2. Shall allocate and appropriate sufficient amounts to fully fund these reinvestment programs.

(6) The amount of savings shall be estimated each year of the 2012-2014 fiscal biennium, and for each year of each fiscal biennium thereafter, as specified in subsection (4) of this section.

(7) (a) In submitting its budget request for the 2012-2014 fiscal biennium and each fiscal biennium thereafter, the department shall estimate the amount of savings measured under this section and shall request the amount necessary to distribute or allocate those savings as provided in subsection (5) of this section.

(b) In submitting its budget request for the 2012-2014 fiscal biennium and each fiscal biennium thereafter, the judicial branch shall request the amount necessary to distribute or allocate those savings as provided in subsection (5) of this section.

➔Section 4. KRS 205.560 is amended to read as follows:

(1) The scope of medical care for which the Cabinet for Health and Family Services undertakes to pay shall be designated and limited by regulations promulgated by the cabinet, pursuant to the provisions in this section. Within the limitations of any appropriation therefor, the provision of complete upper and lower dentures to recipients of Medical Assistance Program benefits who have their teeth removed by a dentist resulting in the total absence of teeth shall be a mandatory class in the scope of medical care. Payment to a dentist of any Medical Assistance Program benefits for complete upper and lower dentures shall only be provided on the condition of a preauthorized agreement between an authorized representative of the Medical Assistance Program and the dentist prior to the removal of the teeth. The selection of another class or other classes of medical care shall be recommended by the council to the secretary for health and family services after taking into consideration, among other things, the amount of federal and state funds available, the most essential needs of recipients, and the meeting of such need on a basis insuring the greatest amount of medical care as defined in KRS 205.510 consonant with the funds available, including but not limited to the following categories, except where the aid is for the purpose of obtaining an abortion:

(a) Hospital care, including drugs, and medical supplies and services during any period of actual hospitalization;

(b) Nursing-home care, including medical supplies and services, and drugs during confinement therein on prescription of a physician, dentist, or podiatrist;

(c) Drugs, nursing care, medical supplies, and services during the time when a recipient is not in a hospital but is under treatment and on the prescription of a physician, dentist, or podiatrist. For purposes of this paragraph, drugs shall include products for the treatment of inborn errors of metabolism or genetic conditions, consisting of therapeutic food, formulas, supplements, or low-protein modified food products that are medically indicated for therapeutic treatment and are administered under the direction of a physician, and include but are not limited to the following conditions:

1. Phenylketonuria;
2. Hyperphenylalaninemia;
3. Tyrosinemia (types I, II, and III);
4. Maple syrup urine disease;
5. A-ketoacid dehydrogenase deficiency;
6. Isovaleryl-CoA dehydrogenase deficiency;
7. 3-methylcrotonyl-CoA carboxylase deficiency;
8. 3-methylglutaconyl-CoA hydratase deficiency;
9. 3-hydroxy-3-methylglutaryl-CoA lyase deficiency (HMG-CoA lyase deficiency);
10. B-ketothiolase deficiency;
11. Homocystinuria;
12. Glutaric aciduria (types I and II);
13. Lysinuric protein intolerance;
14. Non-ketotic hyperglycinemia;

15. Propionic acidemia;
16. Gyrate atrophy;
17. Hyperornithinemia/hyperammonemia/homocitrullinuria syndrome;
18. Carbamoyl phosphate synthetase deficiency;
19. Ornithine carbamoyl transferase deficiency;
20. Citrullinemia;
21. Arginosuccinic aciduria;
22. Methylmalonic acidemia; and
23. Argininemia;

(d) Physician, podiatric, and dental services;

(e) Optometric services for all age groups shall be limited to prescription services, services to frames and lenses, and diagnostic services provided by an optometrist, to the extent the optometrist is licensed to perform the services and to the extent the services are covered in the ophthalmologist portion of the physician's program. Eyeglasses shall be provided only to children under age twenty-one (21);

(f) Drugs on the prescription of a physician used to prevent the rejection of transplanted organs if the patient is indigent;

(g) Nonprofit neighborhood health organizations or clinics where some or all of the medical services are provided by licensed registered nurses or by advanced medical students presently enrolled in a medical school accredited by the Association of American Medical Colleges and where the students or licensed registered nurses are under the direct supervision of a licensed physician who rotates his services in this supervisory capacity between two (2) or more of the nonprofit neighborhood health organizations or clinics specified in this paragraph;

(h) Services provided by health-care delivery networks as defined in KRS

216.900;

(i) Services provided by midlevel health-care practitioners as defined in KRS 216.900; and

(j) Smoking cessation treatment interventions or programs prescribed by a physician, advanced practice registered nurse, physician assistant, or dentist, including but not limited to counseling, telephone counseling through a quitline, recommendations to the recipient that smoking should be discontinued, and prescription and over-the-counter medications and nicotine replacement therapy approved by the United States Food and Drug Administration for smoking cessation.

(2) Payments for hospital care, nursing-home care, and drugs or other medical, ophthalmic, podiatric, and dental supplies shall be on bases which relate the amount of the payment to the cost of providing the services or supplies. It shall be one (1) of the functions of the council to make recommendations to the Cabinet for Health and Family Services with respect to the bases for payment. In determining the rates of reimbursement for long-term-care facilities participating in the Medical Assistance Program, the Cabinet for Health and Family Services shall, to the extent permitted by federal law, not allow the following items to be considered as a cost to the facility for purposes of reimbursement:

(a) Motor vehicles that are not owned by the facility, including motor vehicles that are registered or owned by the facility but used primarily by the owner or family members thereof;

(b) The cost of motor vehicles, including vans or trucks, used for facility business shall be allowed up to fifteen thousand dollars ($15,000) per facility, adjusted annually for inflation according to the increase in the consumer price index-u for the most recent twelve (12) month period, as determined by the United States Department of Labor. Medically equipped motor vehicles, vans, or

trucks shall be exempt from the fifteen thousand dollar ($15,000) limitation. Costs exceeding this limit shall not be reimbursable and shall be borne by the facility. Costs for additional motor vehicles, not to exceed a total of three (3) per facility, may be approved by the Cabinet for Health and Family Services if the facility demonstrates that each additional vehicle is necessary for the operation of the facility as required by regulations of the cabinet;

(c) Salaries paid to immediate family members of the owner or administrator, or both, of a facility, to the extent that services are not actually performed and are not a necessary function as required by regulation of the cabinet for the operation of the facility. The facility shall keep a record of all work actually performed by family members;

(d) The cost of contracts, loans, or other payments made by the facility to owners, administrators, or both, unless the payments are for services which would otherwise be necessary to the operation of the facility and the services are required by regulations of the Cabinet for Health and Family Services. Any other payments shall be deemed part of the owner's compensation in accordance with maximum limits established by regulations of the Cabinet for Health and Family Services. Interest paid to the facility for loans made to a third party may be used to offset allowable interest claimed by the facility;

(e) Private club memberships for owners or administrators, travel expenses for trips outside the state for owners or administrators, and other indirect payments made to the owner, unless the payments are deemed part of the owner's compensation in accordance with maximum limits established by regulations of the Cabinet for Health and Family Services; and

(f) Payments made to related organizations supplying the facility with goods or services shall be limited to the actual cost of the goods or services to the related organization, unless it can be demonstrated that no relationship

between the facility and the supplier exists. A relationship shall be considered to exist when an individual, including brothers, sisters, father, mother, aunts, uncles, and in-laws, possesses a total of five percent (5%) or more of ownership equity in the facility and the supplying business. An exception to the relationship shall exist if fifty-one percent (51%) or more of the supplier's business activity of the type carried on with the facility is transacted with persons and organizations other than the facility and its related organizations.

(3) No vendor payment shall be made unless the class and type of medical care rendered and the cost basis therefor has first been designated by regulation.

(4) The rules and regulations of the Cabinet for Health and Family Services shall require that a written statement, including the required opinion of a physician, shall accompany any claim for reimbursement for induced premature births. This statement shall indicate the procedures used in providing the medical services.

(5) The range of medical care benefit standards provided and the quality and quantity standards and the methods for determining cost formulae for vendor payments within each category of public assistance and other recipients shall be uniform for the entire state, and shall be designated by regulation promulgated within the limitations established by the Social Security Act and federal regulations. It shall not be necessary that the amount of payments for units of services be uniform for the entire state but amounts may vary from county to county and from city to city, as well as among hospitals, based on the prevailing cost of medical care in each locale and other local economic and geographic conditions, except that insofar as allowed by applicable federal law and regulation, the maximum amounts reimbursable for similar services rendered by physicians within the same specialty of medical practice shall not vary according to the physician's place of residence or place of practice, as long as the place of practice is within the boundaries of the state.

(6) Nothing in this section shall be deemed to deprive a woman of all appropriate

medical care necessary to prevent her physical death.

(7) To the extent permitted by federal law, no medical assistance recipient shall be recertified as qualifying for a level of long-term care below the recipient's current level, unless the recertification includes a physical examination conducted by a physician licensed pursuant to KRS Chapter 311 or by an advanced practice registered nurse licensed pursuant to KRS Chapter 314 and acting under the physician's supervision.

(8) If payments made to community mental health centers, established pursuant to KRS Chapter 210, for services provided to the intellectually disabled exceed the actual cost of providing the service, the balance of the payments shall be used solely for the provision of other services to the intellectually disabled through community mental health centers.

(9) No long-term-care facility, as defined in KRS 216.510, providing inpatient care to recipients of medical assistance under Title XIX of the Social Security Act on July 15, 1986, shall deny admission of a person to a bed certified for reimbursement under the provisions of the Medical Assistance Program solely on the basis of the person's paying status as a Medicaid recipient. No person shall be removed or discharged from any facility solely because they became eligible for participation in the Medical Assistance Program, unless the facility can demonstrate the resident or the resident's responsible party was fully notified in writing that the resident was being admitted to a bed not certified for Medicaid reimbursement. No facility may decertify a bed occupied by a Medicaid recipient or may decertify a bed that is occupied by a resident who has made application for medical assistance.

(10) Family-practice physicians practicing in geographic areas with no more than one (1) primary-care physician per five thousand (5,000) population, as reported by the United States Department of Health and Human Services, shall be reimbursed one hundred twenty-five percent (125%) of the standard reimbursement rate for

physician services.

(11) The Cabinet for Health and Family Services shall make payments under the Medical Assistance program for services which are within the lawful scope of practice of a chiropractor licensed pursuant to KRS Chapter 312, to the extent the Medical Assistance Program pays for the same services provided by a physician.

(12) ***(a)*** The Medical Assistance Program shall use the ***appropriate*** form and guidelines ~~[established pursuant to KRS 304.17A-545(5)]~~for ***enrolling***~~[assessing the credentials of]~~ those ***providers*** applying for participation in the Medical Assistance Program, including those licensed and regulated under KRS Chapters 311, 312, 314, 315, and 320, any facility required to be licensed pursuant to KRS Chapter 216B, and any other health care practitioner or facility as determined by the Department for Medicaid Services through an administrative regulation promulgated under KRS Chapter 13A. ***A Medicaid managed care organization shall use the forms and guidelines established under KRS 304.17A-545(5) to credential a provider.*** For any provider who ***contracts with and*** is credentialed by a Medicaid managed care organization ***prior to enrollment,*** the cabinet shall complete the enrollment ~~[and credentialing]~~ process and deny, or approve and issue a ***Provider Identification Number (PID)***~~[Medical Assistance Identification Number (MAID)]~~ within fifteen (15) business days from the time all necessary completed ***enrollment***~~[credentialing]~~ forms have been submitted and all outstanding accounts receivable have been satisfied.

(b) Within forty-five (45) days of receiving a correct and complete provider application, the Department for Medicaid Services shall complete the enrollment process by either denying or approving and issuing a Provider Identification Number (PID) for a behavioral health provider who provides substance use disorder services, unless the department notifies the provider

that additional time is needed to render a decision for resolution of an issue or dispute.

(c) Within forty-five (45) days of receipt of a correct and complete application for credentialing by a behavioral health provider providing substance use disorder services, a Medicaid managed care organization shall complete its contracting and credentialing process, unless the Medicaid managed care organization notifies the provider that additional time is needed to render a decision. If additional time is needed, the Medicaid managed care organization shall not take any longer than ninety (90) days from receipt of the credentialing application to deny or approve and contract with the provider.

(d) A Medicaid managed care organization shall adjudicate any clean claims submitted for a substance use disorder service from an enrolled and credentialed behavioral health provider who provides substance use disorder services in accordance with KRS 304.17A-700 to 304.17A-730.

(e) The Department of Insurance may impose a civil penalty of one hundred dollars ($100) per violation when a Medicaid managed care organization fails to comply with this section. Each day that a Medicaid managed care organization fails to pay a claim may count as a separate violation.

(13) Dentists licensed under KRS Chapter 313 shall be excluded from the requirements of subsection (12) of this section. The Department for Medicaid Services shall develop a specific form and establish guidelines for assessing the credentials of dentists applying for participation in the Medical Assistance Program.

➔SECTION 5. A NEW SECTION OF KRS CHAPTER 205 IS CREATED TO READ AS FOLLOWS:

(1) The Department for Medicaid Services shall provide a substance use disorder benefit consistent with federal laws and regulations which shall include a broad

array of treatment options for those with heroin and other substance use disorders.

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

(3) Providers of peer-mediated, recovery-oriented, therapeutic community models of care shall have the opportunity to contract with managed care organizations to be reimbursed for any portion of those services that are provided by licensed or certified providers in accordance with approved billing codes.

(4) A Medicaid managed care organization shall:

(a) Authorize treatment for each diagnosis related to substance use disorder and co-occurring mental health and substance use disorder covered by Medicaid that is identified within the most updated edition of the Diagnostic and Statistical Manual of Mental Disorders issued by the American Psychiatric Association that meets the criteria for medical necessity and level of care; and

(b) Approve coverage and payment for continuing care at the appropriate level of care.

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

➔Section 6. KRS 216B.020 is amended to read as follows:

(1) The provisions of this chapter that relate to the issuance of a certificate of need shall not apply to abortion facilities as defined in KRS 216B.015; any hospital which does not charge its patients for hospital services and does not seek or accept

Medicare, Medicaid, or other financial support from the federal government or any state government; assisted living residences; family care homes; state veterans' nursing homes; services provided on a contractual basis in a rural primary-care hospital as provided under KRS 216.380; community mental health centers for services as defined in KRS Chapter 210; primary care centers; rural health clinics; private duty nursing services licensed as nursing pools; group homes; ***licensed residential crisis stabilization units, which may be part of a licensed psychiatric hospital; licensed free-standing residential substance use disorder treatment programs with sixteen (16) or fewer beds, but not including Levels I and II psychiatric residential treatment facilities or licensed psychiatric inpatient beds; outpatient behavioral health treatment, but not including partial hospitalization programs;*** end stage renal disease dialysis facilities, freestanding or hospital based; swing beds; special clinics, including but not limited to wellness, weight loss, family planning, disability determination, speech and hearing, counseling, pulmonary care, and other clinics which only provide diagnostic services with equipment not exceeding the major medical equipment cost threshold and for which there are no review criteria in the state health plan; nonclinically related expenditures; nursing home beds that shall be exclusively limited to on-campus residents of a certified continuing care retirement community; home health services provided by a continuing care retirement community to its on-campus residents; the relocation of hospital administrative or outpatient services into medical office buildings which are on or contiguous to the premises of the hospital; residential hospice facilities established by licensed hospice programs; or the following health services provided on site in an existing health facility when the cost is less than six hundred thousand dollars ($600,000) and the services are in place by December 30, 1991: psychiatric care where chemical dependency services are provided, level one (1) and level two (2) of neonatal care, cardiac catheterization, and open heart

surgery where cardiac catheterization services are in place as of July 15, 1990. The provisions of this section shall not apply to nursing homes, personal care homes, intermediate care facilities, and family care homes; or nonconforming ambulance services as defined by administrative regulation. These listed facilities or services shall be subject to licensure, when applicable.

(2) Nothing in this chapter shall be construed to authorize the licensure, supervision, regulation, or control in any manner of:

(a) Private offices and clinics of physicians, dentists, and other practitioners of the healing arts, except any physician's office that meets the criteria set forth in KRS 216B.015(5) or that meets the definition of an ambulatory surgical center as set out in KRS 216B.015;

(b) Office buildings built by or on behalf of a health facility for the exclusive use of physicians, dentists, and other practitioners of the healing arts; unless the physician's office meets the criteria set forth in KRS 216B.015(5), or unless the physician's office is also an abortion facility as defined in KRS 216B.015, except no capital expenditure or expenses relating to any such building shall be chargeable to or reimbursable as a cost for providing inpatient services offered by a health facility;

(c) Dispensaries and first-aid stations located within business or industrial establishments maintained solely for the use of employees, if the facility does not contain inpatient or resident beds for patients or employees who generally remain in the facility for more than twenty-four (24) hours;

(d) Establishments, such as motels, hotels, and boarding houses, which provide domiciliary and auxiliary commercial services, but do not provide any health related services and boarding houses which are operated by persons contracting with the United States Veterans Administration for boarding services;

(e) The remedial care or treatment of residents or patients in any home or institution conducted only for those who rely solely upon treatment by prayer or spiritual means in accordance with the creed or tenets of any recognized church or religious denomination and recognized by that church or denomination; and

(f) On-duty police and fire department personnel assisting in emergency situations by providing first aid or transportation when regular emergency units licensed to provide first aid or transportation are unable to arrive at the scene of an emergency situation within a reasonable time.

(3) An existing facility licensed as skilled nursing, intermediate care, or nursing home shall notify the cabinet of its intent to change to a nursing facility as defined in Public Law 100-203. A certificate of need shall not be required for conversion of skilled nursing, intermediate care, or nursing home to the nursing facility licensure category.

(4) Notwithstanding any other provision of law to the contrary, dual-license acute care beds licensed as of December 31, 1995, and those with a licensure application filed and in process prior to February 10, 1996, may be converted to nursing facility beds by December 31, 1996, without applying for a certificate of need. Any dual-license acute care beds not converted to nursing facility beds by December 31, 1996, shall, as of January 1, 1997, be converted to licensed acute care beds.

(5) Notwithstanding any other provision of law to the contrary, no dual-license acute care beds or acute care nursing home beds that have been converted to nursing facility beds pursuant to the provisions of subsection (3) of this section may be certified as Medicaid eligible after December 31, 1995, without the written authorization of the secretary.

(6) Notwithstanding any other provision of law to the contrary, total dual-license acute care beds shall be limited to those licensed as of December 31, 1995, and those with

a licensure application filed and in process prior to February 10, 1996. No acute care hospital may obtain a new dual license for acute care beds unless the hospital had a licensure application filed and in process prior to February 10, 1996.

(7) Ambulance services owned and operated by a city government, which propose to provide services in coterminous cities outside of the ambulance service's designated geographic service area, shall not be required to obtain a certificate of need if the governing body of the city in which the ambulance services are to be provided enters into an agreement with the ambulance service to provide services in the city.

(8) Notwithstanding any other provision of law, a continuing care retirement community's nursing home beds shall not be certified as Medicaid eligible unless a certificate of need has been issued authorizing applications for Medicaid certification. The provisions of subsection (3) of this section notwithstanding, a continuing care retirement community shall not change the level of care licensure status of its beds without first obtaining a certificate of need.

➔SECTION 7. A NEW SECTION OF KRS CHAPTER 216B IS CREATED TO READ AS FOLLOWS:

When a person is admitted to a hospital emergency department or hospital emergency room for treatment of a drug overdose:

(1) The person shall be informed of available substance use disorder treatment services known to the hospital that are provided by that hospital, other local hospitals, the local community mental health center, and any other local treatment programs licensed pursuant to KRS 222.231;

(2) The hospital may obtain permission from the person when stabilized, or the person's legal representative, to contact any available substance use disorder treatment programs offered by that hospital, other local hospitals, the local community mental health center, or any other local treatment programs licensed pursuant to KRS 222.231, on behalf of the person to connect him or her to

treatment; and

(3) The local community mental health center may provide an on-call service in the hospital emergency department or hospital emergency room for the person who was treated for a drug overdose to provide information about services and connect the person to substance use disorder treatment, as funds are available. These services, when provided on the grounds of a hospital, shall be coordinated with appropriate hospital staff.

➔Section 8. KRS 217.186 is amended to read as follows:

(1) A licensed health-care provider who, acting in good faith, directly or by standing order, prescribes or dispenses the drug naloxone to a ***person or agency***~~[patient]~~ who, in the judgment of the health-care provider, is capable of administering the drug for an emergency opioid overdose, shall not, as a result of his or her acts or omissions, be subject to disciplinary or other adverse action under KRS Chapter 311, 311A, 314, or 315 or any other professional licensing statute***. As used in this subsection, "licensed health-care provider" includes a pharmacist as defined in KRS 315.010 who holds a separate certification issued by the Kentucky Board of Pharmacy authorizing the initiation of the dispensing of naloxone under subsection (5) of this section***.

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

(3) A person or agency, including a peace officer, jailer, firefighter, paramedic, or emergency medical technician or a school employee authorized to administer medication under KRS 156.502, may:

(a) Receive a prescription for the drug naloxone;

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

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

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

(5) (a) The Board of Pharmacy, in consultation with the Kentucky Board of Medical Licensure, shall promulgate administrative regulations to establish certification, educational, operational, and protocol requirements to implement this section.

(b) Administrative regulations promulgated under this subsection shall:

1. Require that any dispensing under this section be done only in accordance with a physician-approved protocol and specify the minimum required components of any such protocol;

2. Include a required mandatory education requirement as to the mechanism and circumstances for the administration of naloxone for the person to whom the naloxone is dispensed; and

3. Require that a record of the dispensing be made available to a physician signing a protocol under this subsection, if desired by the physician.

(c) Administrative regulations promulgated under this subsection may include:

1. A supplemental educational or training component for a pharmacist seeking certification under this subsection; and

2. A limitation on the forms of naloxone and means of its administration that may be dispensed pursuant to this subsection.

(6) (a) The board of each local public school district and the governing body of each private and parochial school or school district may permit a school to keep naloxone on the premises and regulate the administration of naloxone to any individual suffering from an apparent opiate-related overdose.

(b) In collaboration with local health departments, local health providers, and local schools and school districts, the Kentucky Department for Public Health shall develop clinical protocols to address supplies of naloxone kept by schools under this section and to advise on the clinical administration of naloxone.

➔SECTION 9. A NEW SECTION OF KRS CHAPTER 218A IS CREATED TO READ AS FOLLOWS:

(1) For the purposes of this section:

(a) "Analyze" means to apply scientific and mathematical measures to determine meaningful patterns and associations in data. "Analyze" includes descriptive analysis to examine historical data, predictive analysis to examine future probabilities and trends, and prescriptive analysis to examine how future decisions may impact the population and trends; and

(b) "Pilot program" means a program in a county or set of counties, or a subset or subsets of the population, as designated by the Cabinet for Health and Family Services and the Office of Drug Control Policy for analyzing the effectiveness of substance abuse treatment services in Kentucky.

(2) The general purpose of this section is to assist in the development of a pilot program to analyze the outcomes and effectiveness of substance abuse treatment programs in order to ensure that the Commonwealth is:

(a) Addressing appropriate risk and protective factors for substance abuse in a defined population;

(b) Using approaches that have been shown to be effective;

(c) Intervening early at important stages and transitions;

(d) Intervening in appropriate settings and domains; and

(e) Managing programs effectively.

(3) Sources of data for the pilot program shall include, at a minimum, claims under the Kentucky Department for Medicaid Services, the electronic monitoring system for controlled substances established under KRS 218A.202, and the Department of Workers' Claims within the Labor Cabinet.

(4) As funds are available, the Cabinet for Health and Family Services and the Office of Drug Control Policy shall initiate a pilot program to determine, collect, and analyze performance measurement data for substance abuse treatment services to determine practices that reduce frequency of relapse, provide better outcomes for patients, hold patients accountable, and control health costs related to substance abuse.

(5) By December 31, 2016, the Cabinet for Health and Family Services and the Office of Drug Control Policy shall issue a joint report to the Legislative Research Commission and the Office of the Governor that:

(a) Details the findings of the pilot program;

(b) Includes recommendations based on the pilot program's results for optimizing substance abuse treatment services; and

(c) Includes recommendations for the continued application of analytics to further augment Kentucky's approach to fighting substance abuse in the future.

➔Section 10. KRS 218A.050 is amended to read as follows:

Unless otherwise rescheduled by administrative regulation of the Cabinet for Health and Family Services, the controlled substances listed in this section are included in Schedule I:

(1) Any material, compound, mixture, or preparation which contains any quantity of the

following opiates, including their isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, unless specifically excepted, whenever the existence of these isomers, esters, ethers, or salts is possible within the specific chemical designation: ***Acetylfentanyl;*** Acetylmethadol; Allylprodine; Alphacetylmethadol; Alphameprodine; Alphamethadol; Benzethidine; Betacetylmethadol; Betameprodine; Betamethadol; Betaprodine; Clonitazene; Dextromoramide; Dextrorphan; Diampromide; Diethylthiambutene; Dimenoxadol; Dimepheptanol; Dimethylthiambutene; Dioxaphetyl butyrate; Dipipanone; Ethylmethylthiambutene; Etonitazene; Etoxeridine; Furethidine; Hydroxypethidine; Ketobemidone; Levomoramide; Levophenacylmorphan; Morpheridine; Noracymethadol; Norlevorphanol; Normethadone; Norpipanone; Phenadoxone; Phenampromide; Phenomorphan; Phenoperidine; Piritramide; Proheptazine; Properidine; Propiram; Racemoramide; Trimeperidine;

(2) Any material, compound, mixture, or preparation which contains any quantity of the following opium derivatives, including their salts, isomers, and salts of isomers, unless specifically excepted, whenever the existence of these salts, isomers, or salts of isomers is possible within the specific chemical designation: Acetorphine; Acetyldihydrocodeine; Benzylmorphine; Codeine methylbromide; Codeine-N-Oxide; Cyprenorphine; Desomorphine; Dihydromorphine; Etorphine; Heroin; Hydromorphinol; Methyldesorphine; Methyldihydromorphine; Morphine methylbromide; Morphine methylsulfonate; Morphine-N-Oxide; Myrophine; Nicocodeine; Nicomorphine; Normorphine; Pholcodine; Thebacon;

(3) Any material, compound, mixture, or preparation which contains any quantity of the following hallucinogenic substances, their salts, isomers, or salts of isomers, unless specifically excepted, whenever the existence of these salts, isomers, and salts of isomers is possible within the specific chemical designation: 3, 4-methylenedioxyamphetamine; 5-methoxy-3, 4-methylenedioxy amphetamine; 3, 4,

5-trimethoxyamphetamine; Bufotenine; Diethyltryptamine; Dimethyltryptamine; 4-methyl-2, 5-dimethoxyamphetamine; Ibogaine; Lysergic acid diethylamide; Marijuana; Mescaline; Peyote; N-ethyl-3-piperidyl benzilate; N-methyl-3-piperidyl benzilate; Psilocybin; Psilocyn; Tetrahydrocannabinols; Hashish; Phencyclidine, 2 Methylamino-1-phenylpropan-1-one (including but not limited to Methcathinone, Cat, and Ephedrone); synthetic drugs; or salvia;

(4) Any material, compound, mixture, or preparation which contains any quantity of the following substance having a depressant effect on the central nervous system, including its salts, isomers, and salts of isomers, unless specifically excepted, whenever the existence of these salts, isomers, or salts of isomers is possible within the specific chemical designation: gamma hydroxybutyric acid; and

(5) Any material, compound, mixture, or preparation which contains any quantity of the following substances:

(a) 2-(2,5-dimethoxyphenyl)-N-[(2-methoxyphenyl)methyl]ethanamine (2,5H-NBOMe);

(b) 2-(4-iodo-2,5-dimethoxyphenyl)-N-[(2-methoxyphenyl)methyl]ethanamine (2,5I-NBOMe);

(c) 2-(4-bromo-2,5-dimethoxyphenyl)-N-[(2-methoxyphenyl)methyl]ethanamine (2,5B-NBOMe); or

(d) 2-(4-chloro-2,5-dimethoxyphenyl)-N-[(2-methoxyphenyl)methyl]ethanamine (2,5C-NBOMe).

➔SECTION 11. A NEW SECTION OF KRS CHAPTER 218A IS CREATED TO READ AS FOLLOWS:

(1) As used in this section:

(a) "Drug overdose" means an acute condition of physical illness, coma, mania, hysteria, seizure, cardiac arrest, cessation of breathing, or death which reasonably appears to be the result of consumption or use of a

controlled substance, or another substance with which a controlled substance was combined, and that a layperson would reasonably believe requires medical assistance; and

(b) "Good faith" does not include seeking medical assistance during the course of the execution of an arrest warrant, or search warrant, or a lawful search.

(2) A person shall not be charged with or prosecuted for a criminal offense prohibiting the possession of a controlled substance or the possession of drug paraphernalia if:

(a) In good faith, medical assistance with a drug overdose is sought from a public safety answering point, emergency medical services, a law enforcement officer, or a health practitioner because the person:

1. Requests emergency medical assistance for himself or herself or another person; or

2. Acts in concert with another person who requests emergency medical assistance; or

3. Appears to be in need of emergency medical assistance and is the individual for whom the request was made;

(b) The person remains with, or is, the individual who appears to be experiencing a drug overdose until the requested assistance is provided; and

(c) The evidence for the charge or prosecution is obtained as a result of the drug overdose and the need for medical assistance.

(3) The provisions of subsection (2) of this section shall not extend to the investigation and prosecution of any other crimes committed by a person who otherwise qualifies under this section.

(4) When contact information is available for the person who requested emergency medical assistance, it shall be reported to the local health department. Health department personnel shall make contact with the person who requested

emergency medical assistance in order to offer referrals regarding substance abuse treatment, if appropriate.

(5) A law enforcement officer who makes an arrest in contravention of this section shall not be criminally or civilly liable for false arrest or false imprisonment if the arrest was based on probable cause.

➔SECTION 12. A NEW SECTION OF KRS CHAPTER 218A IS CREATED TO READ AS FOLLOWS:

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

➔SECTION 13. A NEW SECTION OF KRS CHAPTER 218A IS CREATED TO READ AS FOLLOWS:

(1) A person is guilty of importing heroin when he or she knowingly and unlawfully transports any quantity of heroin into the Commonwealth by any means with the intent to sell or distribute the heroin.

(2) The provisions of this section are intended to be a separate offense from others in this chapter, and shall be punished in addition to violations of this chapter occurring during the same course of conduct.

(3) Importing heroin is a Class C felony, and the defendant shall not be released on probation, shock probation, conditional discharge, or parole until he or she has served at least fifty percent (50%) of the sentence imposed.

➔Section 14. KRS 218A.1412 is amended to read as follows:

(1) A person is guilty of trafficking in a controlled substance in the first degree when he or she knowingly and unlawfully traffics in:

(a) Four (4) grams or more of cocaine;

(b) Two (2) grams or more of heroin***, fentanyl,*** or methamphetamine;

(c) Ten (10) or more dosage units of a controlled substance that is classified in Schedules I or II and is a narcotic drug, or a controlled substance analogue;

(d) Any quantity of lysergic acid diethylamide; phencyclidine; gamma hydroxybutyric acid (GHB), including its salts, isomers, salts of isomers, and analogues; or flunitrazepam, including its salts, isomers, and salts of isomers; or

(e) Any quantity of a controlled substance specified in paragraph (a), (b), or (c) of this subsection in an amount less than the amounts specified in those paragraphs.

(2) The amounts specified in subsection (1) of this section may occur in a single transaction or may occur in a series of transactions over a period of time not to exceed ninety (90) days that cumulatively result in the quantities specified in this section.

(3) (a) ~~[Except as provided in paragraph (b) of this subsection,]~~Any person who violates the provisions of ***subsection (1)(a), (b), (c), or (d) of*** this section shall be guilty of a Class C felony for the first offense and a Class B felony for a second or subsequent offense.

(b) Any person who violates the provisions of subsection (1)(e) of this section***:***

1. Shall be guilty of a Class D felony for the first offense and a Class C felony for a second~~[offense]~~ or subsequent offense***; and***

2. a. Except as provided in subdivision b. of this subparagraph, where the trafficked substance was heroin and the defendant committed the offense while possessing more than one (1) items of paraphernalia, including but not limited to scales, ledgers, instruments and material to cut, package, or mix the final product, excess cash, multiple subscriber identity modules in excess of the number of communication devices possessed by the

person at the time of arrest, or weapons, which given the totality of the circumstances, indicate the trafficking to have been a commercial activity, shall not be released on parole until he or she has served at least fifty percent (50%) of the sentence imposed.

b. This subparagraph shall not apply to a person who has been determined by a court to have had a substance use disorder relating to a controlled substance at the time of the offense. "Substance use disorder" shall have the same meaning as in the current edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders.

(c) Any person convicted of a Class C felony offense or higher under this section shall not be released on probation, shock probation, parole, conditional discharge, or other form of early release until he or she has served at least fifty percent (50%) of the sentence imposed in cases where the trafficked substance was heroin.

➔SECTION 15. A NEW SECTION OF KRS CHAPTER 218A IS CREATED TO READ AS FOLLOWS:

(1) A person is guilty of aggravated trafficking in a controlled substance in the first degree when he or she knowingly and unlawfully traffics in one hundred (100) grams or more of heroin.

(2) Aggravated trafficking in a controlled substance in the first degree is a Class B felony, and the defendant shall not be released on probation, shock probation, conditional discharge, or parole until he or she has served at least fifty percent (50%) of the sentence imposed.

➔Section 16. KRS 218A.1414 is amended to read as follows:

(1) A person is guilty of trafficking in a controlled substance in the third degree when

he or she knowingly and unlawfully traffics in:

(a) Twenty (20) or more dosage units of a controlled substance classified in Schedules IV or V; or

(b) Any quantity of a controlled substance specified in paragraph (a) of this subsection in an amount less than the amount specified in that paragraph.

(2) (a) Any person who violates the provisions of subsection (1)(a) of this section shall be guilty of***:***

1. A Class A misdemeanor for ***a*** ~~[the]~~ first offense ***involving one hundred twenty (120) or fewer dosage units;***

2. A Class D felony for a first offense involving more than one hundred twenty (120) dosage units; and

3. A Class D felony for a second or subsequent offense.

(b) Any person who violates the provisions of subsection (1)(b) of this section shall be guilty of:

1. A Class A misdemeanor for the first offense, subject to the imposition of presumptive probation; and

2. A Class D felony for a second or subsequent offense, except that KRS Chapter 532 to the contrary notwithstanding, the maximum sentence to be imposed shall be no greater than three (3) years.

➔SECTION 17. A NEW SECTION OF KRS CHAPTER 218A IS CREATED TO READ AS FOLLOWS:

(1) An offender charged with a felony pursuant to this chapter who is not charged with a violent offense, who is eligible for diversion or deferred prosecution of his or her sentence, and whose diversion or deferred prosecution plan involves substance use disorder treatment may be afforded the opportunity to utilize a faith-based residential treatment program.

(2) If an offender and judge support this faith-based residential treatment program,

and the cost of the program is less than that of the substance use disorder treatment that would otherwise be provided, then the court may approve the faith-based residential treatment program for a specified period of time. An offender shall sign a commitment to comply by the terms of the faith-based residential treatment program.

(3) If an offender violates the terms of the commitment he or she has signed with the faith-based residential treatment program, then the offender shall be returned to the court for additional proceedings.

➔Section 18. KRS 218A.500 is amended to read as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(5) ***(a) This section shall not prohibit a local health department from operating a substance abuse treatment outreach program which allows participants to exchange hypodermic needles and syringes.***

(b) To operate a substance abuse treatment outreach program under this subsection, the local health department shall have the consent, which may be revoked at any time, of the local board of health and:

1. The legislative body of the first or home rule class city in which the program would operate if located in such a city; and

2. The legislative body of the county, urban-county government, or consolidated local government in which the program would operate.

(c) Items exchanged at the program shall not be deemed drug paraphernalia under this section while located at the program.

(6) (a) Prior to searching a person, a person's premises, or a person's vehicle, a peace officer may inquire as to the presence of needles or other sharp objects in the areas to be searched that may cut or puncture the officer and offer to not charge a person with possession of drug paraphernalia if the person declares to the officer the presence of the needle or other sharp object. If, in response to the offer, the person admits to the presence of the needle or other sharp object prior to the search, the person shall not be charged with or prosecuted for possession of drug paraphernalia for the needle or sharp object or for possession of a controlled substance for residual or trace drug amounts present on the needle or sharp object.

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

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

➔Section 19. KRS 439.3401 is amended to read as follows:

(1) As used in this section, "violent offender" means any person who has been convicted of or pled guilty to the commission of:

(a) A capital offense;

(b) A Class A felony;

(c) A Class B felony involving the death of the victim or serious physical injury to a victim;

(d) An offense described in KRS 507.040 or 507.050 where the offense involves the killing of a peace officer or firefighter while the officer or firefighter was acting in the line of duty;

(e) The commission or attempted commission of a felony sexual offense described in KRS Chapter 510;

(f) Use of a minor in a sexual performance as described in KRS 531.310;

(g) Promoting a sexual performance by a minor as described in KRS 531.320;

(h) Unlawful transaction with a minor in the first degree as described in KRS 530.064(1)(a);

(i) Human trafficking under KRS 529.100 involving commercial sexual activity where the victim is a minor;

(j) Criminal abuse in the first degree as described in KRS 508.100;

(k) Burglary in the first degree accompanied by the commission or attempted commission of an assault described in KRS 508.010, 508.020, 508.032, or 508.060;

(l) Burglary in the first degree accompanied by commission or attempted commission of kidnapping as prohibited by KRS 509.040; or

(m) Robbery in the first degree.

The court shall designate in its judgment if the victim suffered death or serious physical injury.

(2) A violent offender who has been convicted of a capital offense and who has received a life sentence (and has not been sentenced to twenty-five (25) years without parole or imprisonment for life without benefit of probation or parole), or a Class A felony and receives a life sentence, or to death and his or her sentence is commuted to a life sentence shall not be released on probation or parole until he or she has served at least twenty (20) years in the penitentiary. Violent offenders may have a greater minimum parole eligibility date than other offenders who receive longer sentences, including a sentence of life imprisonment.

(3) (a) A violent offender who has been convicted of a capital offense or Class A felony with a sentence of a term of years or Class B felony shall not be

released on probation or parole until he has served at least eighty-five percent (85%) of the sentence imposed.

(b) A violent offender who has been convicted of a violation of KRS 507.040 where the victim of the offense was clearly identifiable as a peace officer or a firefighter and the victim was acting in the line of duty shall not be released on probation or parole until he or she has served at least eighty-five percent (85%) of the sentence imposed.

(c) A violent offender who has been convicted of a violation of KRS 507.040 or 507.050 where the victim of the offense was a peace officer or a firefighter and the victim was acting in the line of duty shall not be released on probation or parole until he or she has served at least fifty percent (50%) of the sentence imposed.

(d) Any offender who has been convicted of a homicide or fetal homicide offense under KRS Chapter 507 or 507A in which the victim of the offense died as the result of an overdose of a Schedule I controlled substance and who is not otherwise subject to paragraph (a), (b), or (c) of this subsection shall not be released on probation, shock probation, parole, conditional discharge, or other form of early release until he or she has served at least fifty percent (50%) of the sentence imposed.

(4) A violent offender shall not be awarded any credit on his sentence authorized by KRS 197.045(1)(b)1. In no event shall a violent offender be given credit on his or her sentence if the credit reduces the term of imprisonment to less than eighty-five percent (85%) of the sentence.

(5) This section shall not apply to a person who has been determined by a court to have been a victim of domestic violence or abuse pursuant to KRS 533.060 with regard to the offenses involving the death of the victim or serious physical injury to the victim. The provisions of this subsection shall not extend to rape in the first degree

or sodomy in the first degree by the defendant.

(6) This section shall apply only to those persons who commit offenses after July 15, 1998.

(7) For offenses committed prior to July 15, 1998, the version of this statute in effect immediately prior to that date shall continue to apply.

(8) The provisions of subsection (1) of this section extending the definition of "violent offender" to persons convicted of or pleading guilty to robbery in the first degree shall apply only to persons whose crime was committed after July 15, 2002.

➔Section 20. KRS 625.050 is amended to read as follows:

(1) A petition for involuntary termination of parental rights shall be entitled "In the interest of ..., a child."

(2) The petition shall be filed in the Circuit Court for any of the following counties:

(a) The county in which either parent resides or may be found;

(b) The county in which juvenile court actions, if any, concerning the child have commenced; or

(c) The county in which the child involved resides or is present.

(3) Proceedings for involuntary termination of parental rights may be initiated upon petition by the cabinet, any child-placing agency licensed by the cabinet, any county or Commonwealth's attorney or parent.

(4) The petition for involuntary termination of parental rights shall be verified and contain the following:

(a) Name and mailing address of each petitioner;

(b) Name, sex, date of birth and place of residence of the child;

(c) Name and address of the living parents of the child;

(d) Name, date of death and cause of death, if known, of any deceased parent;

(e) Name and address of the putative father, if known by the petitioner, of the child if not the same person as the legal father;

(f) Name and address of the person, cabinet or agency having custody of the child;

(g) Name and identity of the person, cabinet or authorized agency to whom custody is sought to be transferred;

(h) Statement that the person, cabinet or agency to whom custody is to be given has facilities available and is willing to receive the custody of the child;

(i) All pertinent information concerning termination or disclaimers of parenthood or voluntary consent to termination;

(j) Information as to the legal status of the child and the court so adjudicating; and

(k) A concise statement of the factual basis for the termination of parental rights.

(5) No petition may be filed under this section prior to five (5) days after the birth of the child.

(6) No petition may be filed to terminate the parental rights of a woman solely because of her use of a nonprescribed controlled substance during pregnancy if she enrolls in and maintains substantial compliance with both a substance abuse treatment or recovery program and a regimen of prenatal care as recommended by her health care practitioner throughout the remaining term of her pregnancy. Upon certified completion of the treatment or recovery program, or six (6) months after giving birth during which time substantial compliance with a substance abuse treatment or recovery program has occurred, whichever is earlier, any records maintained by a court or by the cabinet relating to a positive test for a nonprescribed controlled substance shall be sealed by the court and may not be used in any future criminal prosecution or future petition to terminate the woman's parental rights.

➔Section 21. The Cabinet for Health and Family Services is encouraged to:

(1) Study the advantages and disadvantages of:

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

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

(c) Establishing a mechanism to direct heroin and other opioid-addicted postpartum women into treatment facilities instead of the judicial system unless the patient is already incarcerated;

(2) Study the feasibility of and, if warranted, establish a physician-led committee composed of diverse regional, state, and national experts to assist in the development of evidence-based medical management standards to treat the disease of addiction in the Commonwealth and assist in developing overdose prevention and reaction protocols;

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

(4) Collaborate with all medical schools and medical-related post-graduate training programs in Kentucky, including nursing schools, to include a minimum of ten hours of coursework on the disease of addiction for all medical professionals providing direct patient care, including but not limited to physicians, registered nurse practitioners, registered nurses, and physical therapists;

(5) Work with the licensing boards for medical and allied health professionals in

Kentucky to increase continuing education units, at least to two units every two years, that focus on the disease of addiction; and

(6) Make any recommendations for legislation to the Interim Joint Committee on Health and Welfare by November 30, 2015.

➔Section 22. The Department of Criminal Justice Training shall offer voluntary regionalized in-service training on the topic of heroin for law enforcement officers employed by agencies that utilize Department of Criminal Justice Training basic training for their recruits, including instructional material on the detection and interdiction of heroin trafficking, the dynamics of heroin abuse, and available treatment options for addicts. There shall be at least one course offered in each area development district by December 31, 2015, with the courses being designed to qualify as in-service training under KRS 15.404.

➔Section 23. The Legislative Research Commission is requested to appoint a Senate Bill 192 Implementation Oversight Committee consisting of three senators and three representatives to monitor the implementation of this Act during the 2015 legislative interim.

➔Section 24. The following shall be necessary government expenses up to $10,000,000 in fiscal year 2015-2016 and shall be paid from the General Fund Surplus Account, KRS 48.700, or the Budget Reserve Trust Fund Account, KRS 48.705:

(1) Substance abuse treatment as outlined in Section 3(5)(b)1. and 2. of this Act;

(2) Supplemental grant funding to community mental health centers as outlined in Section 3(5)(b)3. of this Act;

(3) Funding to address neonatal abstinence syndrome as outlined in Section 3(5)(b)4. of this Act;

(4) Supplemental funding for traditional KY-ASAP substance abuse programming as outlined in Section 3(5)(b)5. of this Act;

(5) Purchase of an FDA-approved extended-release treatment as outlined in

Section 3(5)(b)6. of this Act;

(6) Supplemental funding to the Social Worker Program as outlined in Section 3(5)(b)7. of this Act; and

(7) Funding for the Prosecutors Advisory Council to enhance the use of rocket docket prosecutions in controlled substance cases as outlined in Section 3(5)(b)8. of this Act.

The secretary of the Justice and Public Safety Cabinet shall have the authority to determine the distribution of the aforementioned funds. If the secretary provides funding for the Department for Public Advocacy under this section, he or she shall enter into a Memorandum of Agreement with the Prosecutors Advisory Council to receive equal funding to that distributed to the Department for Public Advocacy.

➔Section 25. Whereas the illegal substances addressed in this Act pose a clear and present danger to the health and safety of Kentucky's citizens and no just cause exists for delay, an emergency is declared to exist, and this Act takes effect upon its passage and approval by the Governor or upon its otherwise becoming a law.