The Modernization of Kentucky's Civil Commitment Statute, KRS 202A

A patient-health focused approach that improves public safety

Judge Stephanie Pearce Burke

Kentucky's civil commitment law, primarily codified in Chapter 202A of the Kentucky Revised Statutes (KRS 202A), originated from the nationwide transformation of mental health law during the mid-20th century. The statute's development demonstrated a transition away from policies of institutionalization that prioritized segregation of individuals with mental illness and developmental disabilities into overcrowded state-run facilities. This approach relied on containment rather than treatment and the isolation of individuals from the public at the lowest possible cost.

Some efforts towards deinstitutionalization began in the mid-1950's after the development of the first antipsychotic drug, Thorazine; however, federal efforts to move people into community-based care formally began with President John F. Kennedy's signing of the Community Mental Health Act in 1963. Substantial reform was implemented only after public outcry over human rights violations, and the system moved toward more constitutional protections and due process.

Before the current civil commitment statute was enacted, Kentucky addressed involuntary hospitalization through earlier "lunacy" or "insanity" laws dating to the late 19th and early 20th centuries. These statutes primarily emphasized custodial confinement over treatment and offered minimal procedural protections.

In the 1960s and 1970s, deinstitutionalization, advances in psychiatric medicine and evolving constitutional due process jurisprudence transformed mental health law throughout the United States. Landmark cases such as *O'Connor v. Donaldson* (1975), *Addington v. Texas* (1979) and *Lessard v. Schmidt* (1972) significantly shaped the development of Kentucky's present-day civil commitment framework.

Kentucky established its current involuntary commitment structure in the 1970s through KRS Chapter 202A. This statute modernized state law by prioritizing judicial oversight, procedural safeguards, dangerousness criteria and the principle of using the least restrictive alternative for treatment.

> *The 2026 amendments to KRS 202A constitute the most significant reforms to Kentucky's involuntary commitment system in nearly half a century.*

The most significant advancement was the adoption of the "dangerousness" standard. Under the current version of KRS 202A, commitment requires the court to find that an individual has a mental illness, poses a danger or threat of danger to self or others, can benefit from treatment and that hospitalization is the least restrictive alternative mode of treatment presently available. This standard remained unchanged for more than 50 years until the Kentucky General Assembly made sweeping amendments to the statute during the 2026 legislative session. These amendments will take effect on October 1, 2026.

2026 Modernization of KRS 202A

House Bill 485 was sponsored by Representatives Jason Nemes, Kim Moser and Lisa Willner. It was the product of months of collaboration among legislators, the Kentucky District Judges Association, the Kentucky County Attorneys Association, the Kentucky Commonwealth's Attorneys Association, mental health practitioners and many mental health advocacy groups, including the Kentucky Mental Health Coalition. The bill passed the House 95-0 and was ultimately attached to Senate Bill 122 in the final days of the 2026 session. SB122 then passed the Senate 37-0, and the law was enacted by the Governor's signature on April 10, 2026.

The 2026 amendments to KRS 202A constitute the most significant reforms to Kentucky's involuntary commitment system in nearly half a century. These revisions update procedures, clarify legal standards and are intended to enhance coordination among courts, hospitals, law enforcement and mental health providers to more aptly benefit the patient and protect the public.

Under previous legal frameworks, individuals could experience severe psychosis, disorganization, inability to care for themselves or escalating psychiatric decline without meeting the threshold for intervention, as they had not yet posed an "immediate threat" of physical harm.

A key change in the legislation expands the definition of dangerousness to include "psychiatric deterioration." This revision acknowledges that serious mental illness often worsens progressively rather than solely through sudden acts of violence or suicidality.

For years, mental health experts have called for revising Kentucky's "dangerous" criteria, noting that mental health practitioners lacked the legal authority to help individuals with a documented history of serious mental illness who were experiencing clinical decline until they reached the most severe possible condition.

The revised statute recognizes that "psychiatric deterioration" itself may pose substantial risks. Individuals experiencing severe psychiatric decline may stop eating or sleeping, be unable to secure shelter or medical care, lose contact with reality or engage in dangerous, self-destructive behavior.

The reform also reflects growing recognition of anosognosia, the neurological inability of some individuals with serious mental illness to recognize their condition. By enabling earlier intervention, the revised statute aims to reduce recurrent crises, incarceration,

(Continued on next page)

(Continued from previous page)

homelessness and medical deterioration. It allows the courts to order appropriate treatment and conditions sooner. In other states where "psychiatric deterioration" has been included in the dangerousness criteria, this has led to better patient outcomes, including greater long-term stability and fewer rehospitalizations.

The overarching goal of reducing relapse is grounded in the clinical need to protect the patient's baseline brain and mental health. It is well established that cycles of relapse and remission can compromise brain integrity and make subsequent episodes more severe or harder to treat. The ability to stabilize and preserve baseline neurological and psychological health as early as possible should be emphasized in mental health policy, and the amendments to KRS202A finally provide mental health practitioners and the courts with this important option.

The revised statute also defines "benefit from treatment," which was previously undefined. As defined in the statute, "benefit from treatment" means the desired outcomes of treatment in a psychiatric hospital for an individual with a mental illness, including but not limited to:

- Symptom management and increased stability;
- A lessening of irrational thoughts and behaviors;
- Reduced risk of harm; or
- Acquisition of skills for self-care and for interacting and living in the community.

This definition enables patients to access medical assistance before they reach a severe psychiatric crisis or self-neglect. It eliminates the need for families to wait until a loved one becomes actively violent or suicidal to seek help. Early psychiatric stabilization can prevent secondary physical harm, such as malnutrition or exposure. Furthermore, early intervention helps patients preserve vital social supports, including housing, employment and family relationships.

Procedural Safeguards and Judicial Flexibility

In addition to definitional changes, the 2026 reforms introduce procedural mechanisms that enable courts to impose conditions, safeguards and structured interventions at various stages of the proceedings.

Historically, commitment systems often required courts to adopt an "all-or-nothing" approach, either ordering hospitalization or releasing the individual with minimal or no intermediate protections.

The revised statute provides courts with more nuanced tools, including:

- Structured outpatient treatment or court-ordered assisted outpatient treatment (AOT)
- Medication compliance monitoring
- Coordination with community mental health providers
- Supervised discharge planning; and
- Increased judicial oversight

These reforms benefit patients by promoting earlier, less restrictive interventions while preserving constitutional protections and treatment autonomy whenever feasible.

The increased procedural flexibility also enhances continuity of care by reducing fragmentation across emergency detention, hospitalization, judicial hearings and community follow-up.

From a public safety perspective, the reforms acknowledge that untreated psychiatric deterioration often precedes emergency encounters, victimization, criminal justice involvement and behavioral crises. Earlier intervention and structured oversight may reduce the need for law enforcement responses or incarceration.

The 2026 reforms reflect a contemporary understanding that effective behavioral health interventions are most successful when they are timely, individualized, coordinated and proportional to the patient's current clinical needs. As shown in other states that have adopted similar legislation, the expected outcomes should include reduced relapse and rehospitalization, fewer arrests and incarcerations, improved clinical outcomes for patients, increased public safety and significant cost savings.

The modernization of KRS 202A is a commonsense reform that protects our most vulnerable citizens, supports the families who care for them and safeguards the public safety of our communities.

Judge Stephanie Pearce Burke presides over Division 14 of Jefferson District Court. ■