INTERIM JOINT COMMITTEE ON HEALTH, WELFARE, AND FAMILY SERVICES

Minutes of the 4th Meeting of the 2019 Interim

August 19, 2019

Call to Order and Roll Call

The 4th meeting of the Interim Joint Committee on Health, Welfare, and Family Services was held on Monday, August 19, 2019, at 1:00 PM, in Room 154 of the Capitol Annex. Senator Ralph Alvarado, Chair, called the meeting to order, and the secretary called the roll.

Present were:

Members: Senator Ralph Alvarado, Co-Chair; Representative Kimberly Poore Moser, Co-Chair; Senators Julie Raque Adams, Tom Buford, Danny Carroll, Julian M. Carroll, Denise Harper Angel, Alice Forgy Kerr, Morgan McGarvey, Stephen Meredith, and Max Wise; Representatives Danny Bentley, Adam Bowling, George Brown Jr., Tom Burch, Deanna Frazier, Robert Goforth, Scott Lewis, Mary Lou Marzian, Melinda Gibbons Prunty, Steve Riley, Steve Sheldon, Nancy Tate, Russell Webber, and Lisa Willner.

Guests: Representative Rob Rothenburger House District 58; Jim Duke, Owner, Com-Care, Inc.; Carol Steckel, Commissioner, Department for Medicaid Services, Cabinet for Health and Family Services; Wendy Morris, Commissioner, Stephanie Craycraft, Executive Advisor, Dee Werline, Executive Advisor, Department for Behavioral Health, Developmental and Intellectual Disabilities, Cabinet for Health and Family Services; Jim Musser, Executive Director, Office of Legislative and Regulatory Affairs, Cabinet for Health and Family Services; Betsy Johnson, President, Executive Director, Bruce Linder, Executive Vice President, Kentucky Association of Health Care Facilities, Kentucky Center for Assisted Living; Sheila Schuster, PhD, Licensed Clinical Psychologist, Executive Director, Kentucky Mental Health Coalition; Amanda Parker, Senior Director, Ayaan Hirsi Ali Foundation; Jenny, Local Survivor and Advocate for Anti-Female Genital Mutilation; Dale McCreary, Director, Franklin-Simpson County Ambulance Service; Nathan Goldman, Kentucky Board of Nursing; Elizabeth Caywood, Deputy Commissioner, Douglas Beard, Division Director, Jessica Hinkle, Human Services Program Branch Manager, Brian Isaacs, Human Services Program Compliance Analyst, Department for Community Based Services, Cabinet for Health and Family Services; Judy Taylor, Director, Government Affairs, Kentucky Ambulance Providers Association; Phill Gunning, Executive Director, Shannon Baker, Director of Development and Communications, Valerie Mudd, Consumer Programs Coordinator, Lexington National Alliance on Mental Illness (NAMI); Christy Shuffett, M.Ed., Executive Director, New

Beginnings, Bluegrass, Inc.; John Wood, Kentucky Board of Emergency Medical Services; Heidi Schissler, Legal Director, Kentucky Protection and Advocacy Division; Natalie Cunningham, Outreach Director, Kentucky Center for Economic Policy; Shellie A. May, Executive Director, Jonathan Borden, Procedures Development Specialist II, Office for Children with Special Health Care Needs, Cabinet for Health and Family Services; Jaclyn McGranahan, Field Organizer for Reproductive Rights, American Civil Liberties Union (ACLU); and Kathy Hager, President, Kentucky Nurses Association.

LRC Staff: DeeAnn Wenk, CSA, Ben Payne, Chris Joffrion, Dana Simmons, Sean Meloney, Becky Lancaster, and Hillary McGoodwin.

Consideration of Referred Administrative Regulations

The following administrative regulations were on the agenda for consideration: **201 KAR 002:010 Regular -** Schools approved by the board; **201 KAR 002:090 Regular -** Reference material and prescription equipment; **201 KAR 002:100 Regular -** Security and control of drugs and prescriptions; **201 KAR 002:116 Regular** - Substitution of drugs, biologics and biosimilar products; **201 KAR 002:225 Regular** - Special limited pharmacy permit - Medical gas; **201 KAR 002:240 Regular** - Special limited pharmacy permit – Charitable; **201 KAR 002:270 Regular** – Expungement; **201 KAR 002:340 Regular** - Special limited pharmacy permit - Clinical practice; **201 KAR 006:030 Regular** - Temporary permits; **201 KAR 006:040 Regular** - Renewal, reinstatement, and reactivation of license; **201 KAR 013:040 Regular** – Licensing; **201 KAR 013:050** Regular – Apprentices; **201 KAR 013:055 Regular** - Continuing education requirements; **201 KAR 013:060 Regular** - Military service; reciprocity; endorsement; **201 KAR 020:370 Regular** - Applications for licensure; **201 KAR 020:506 Regular** - Nurse licensure compact; **201 KAR 025:090 Regular** - Prescribing and dispensing controlled substances; **202 KAR 007:560 Regular** - Ground vehicle staff; **902 KAR 004:030 Regular** - Newborn screening program; **902 KAR 004:035 Regular** - Cost reimbursement for specialized food products; **902 KAR 009:010 Regular** - Environmental health; **902 KAR 045:120 Regular** - Inspection and permit fees for recreational vehicle communities, youth camps, and private water supplies; **908 KAR 001:341 Regular** - Repeal of 908 KAR 1:340; **908 KAR 001:370 Regular** - Licensing procedures, fees, and general requirements for nonhospital-based alcohol and other drug treatment entities; **908 KAR 001:372 Regular** - Licensure of residential alcohol and other drug treatment entities, **908 KAR 001:374 Regular** - Licensure of nonhospital-based outpatient alcohol and other drug treatment entities; **921 KAR 001:380 Regular** - Child Support Enforcement Program application and intergovernmental process; and **922 KAR 001:510 Regular** - Authorization for disclosure of protection and permanency records. A motion to accept the administrative regulations was made by Representative Marzian, seconded by Senator Raque Adams, and accepted by voice vote.

Legislative Hearing on the FFY 2020-2021 Community Services Block Grant

Laura Begin, Legislative Liaison, Douglas Beard, Division Director, and Jessica Hinkle, Human Services Program Branch Manager, Department for Community Based Services (DCBS), Cabinet for Health and Family Services (CHFS), were present to answer questions. Mr. Beard stated that the Community Services Block Grant (CSBG) issued by the Department of Health and Human Services (HHS) and provides services to all 120 counties in Kentucky through 23 community action agencies. It is up to the individual county agencies to decide how to use the grant funding. Some counties use the grant money for a meals-on-wheels type of program, the local Head Start program, or to offer financial literacy courses.

In response to questions from Representative Burch, Mr. Beard stated that each agency must present a plan to CHFS. CHFS submits a collective plan to HHS for approval. There is annual monitoring for all of the 23 community action agencies which looks at the program outcomes.

A motion to accept the block grant was made by Senator Buford, seconded by Representative Frazier, and accepted by voice vote.

Legislative Hearing on the FFY 2020 Social Services Block Grant

Laura Begin, Legislative Liaison, Department for Community Based Services (DCBS) and Rachel Ratliff, Legislative Liaison, Division of Protection and Permanency, Cabinet for Health and Family Services, were present to answer questions. The block grant can be found at https://apps.legislature.ky.gov/CommitteeDocuments/7/ . Ms. Begin stated that the Social Services Block Grant (SSBG) began in 1981. The SSBG provides federal funding to DCBS through the Department of Juvenile Justice. The funding is used for adult and child domestic violence protective services and other services to stabilize households through in-home living supports. The SSBG also provides funding for juvenile services to help prevent future involvement with juvenile or criminal justice systems. A motion to accept the block grant was made by Senator Buford, seconded by Representative Moser, and accepted by voice vote.

Legislative Hearing on Executive Order 2019-466 Relating to Reorganization of the Cabinet for Health and Family Services

Jim Musser, Executive Director, Office of Legislative and Regulatory Affairs, Cabinet for Health and Family Services, stated that the executive order was created in response to 2019 Regular Session Senate Bill 167 (SB 167) that required reorganization of the Office of Administration and Technology Services (OATS). SB 167 abolished OATS and two new offices were created, the Office of Administration Services and the Office of Application Technology Services. Within the Office of Administration Services, the Division of General Accounting, the Division of Facilities Management, and the Division of Procurement Services and Grant Oversight, were created. Within the Offices of Application Technology Services, the Division of Strategic Services, the Division of Social

Support Systems, the Division of Eligibility Systems, and the Division of Medicaid Systems were created. A motion to accept the executive order was made by Senator Buford, seconded by Representative Tate, and accepted by voice vote.

Items Received for Review

Senator Alvarado stated that the half-year block grant status reports for the Child Care and Development Fund (CCDF), Community Services Block Grant (CSBG), Social Services Block Grant (SSBG), Temporary Assistance for Needy Families (TANF), and Low Income Home Energy Assistance Program (LIHEAP) block grants are available for review.

Discussion on 2020 Regular Session Prefiled Bill Request 83

Representative Rothenburger stated that the 2020 Regular Session Prefiled Bill Request 83 (BR 83) is an act relating to ground ambulance service providers and making an appropriation therefor. As Emergency Medical Services (EMS) struggle, there is a need to develop more revenue streams for the ambulance services. BR 83 authorizes the EMS to access a fund to allow more money to be federally matched by Medicaid. Jim Duke, owner, Com-Care Inc., stated that the Kentucky Ambulance Providers Association (KAPA) includes 130 ambulance services in Kentucky and is supportive of BR 83. KAPA works to enhance the Medicaid reimbursements. The EMS in Missouri and Tennessee have passed similar legislation with success in finding ways to have more money matched by federal funds.

In response to questions and comments from Senator Julian Carroll, Mr. Duke stated that the cost of providing a Medicare emergency transport in Kentucky varies from $350 to $800 for each transport. The average reimbursement from Medicaid to transport a patient is $125. The federal funds matching program would double that reimbursement and bring the total closer to the lower end of the Medicare cost. BR 83 should help many emergency service providers that have high numbers of Medicaid transports to be close to the cost of providing care to patients. 911 Ambulance services do not get a choice of caring for a patient. EMS must take care of the patient regardless if the patient has insurance or not. The regulatory agency is the Kentucky Board of EMS that is under the Kentucky Community College System.

In response to questions and comments from Senator Buford, Mr. Duke stated that the Medicaid reimbursement for a transport is an average $125. Medicare reimburses approximately $450 for a transport. BR 83 will help EMS providers receive more money for each transport. The maximum assessment rate according to The Centers for Medicare and Medicaid Services (CMS) is six percent of a provider's gross revenue for emergency calls. KAPA is encouraging an across the board increase with Medicaid. Carol Steckel, Commissioner, Department for Medicaid Services (DMS), Cabinet for Health and Family Services, stated that a job of Medicaid is to work with the providers that are offering up the state share of money to be federally matched. She stated that going by each county or city

to see how it is individually taxed and funded would be extremely complicated. DMS is working with EMS providers to get the maximum dollar amount while following federal rules and regulations.

In response to questions and comments from Representative Riley, Mr. Duke stated that KAPA has spoken at all the regional association meetings and sent email surveys to providers. When KAPA's membership supports legislation, KAPA trusts that the members have the support of their governing body whether it is a judge-executive, board of directors, or hospital administrator. The majority of Kentucky counties are in support of BR 83. Representative Rothenburger stated that he has met with the Kentucky Association of Counties (KACO) but the association has not stated whether it is in favor of BR 83. Previously KACO has been supportive of any legislation that helps to increase revenue to local governments.

In response to questions and comments from Senator Meredith, Mr. Duke stated that the annual assessment is based on the total number of emergency transport services. Each ambulance service will pay a percentage. He confirmed that $200,000 will go to CHFS for administration and DMS will manage the balance of the money received from the matching federal funds. For every dollar that is accumulated, the federal government will match with two dollars and the money will come back to the providers in the form of a higher reimbursement rate for transporting patients. The higher reimbursement rate would be a flat rate increase for all. It is not guaranteed that each ambulance service will receive the total amount of the fees it has paid. Commissioner Steckel stated that DMS will need to do a full methodological study on how to get the providers' reimbursement close to a full return of the taxes paid. DMS is not a tax collector and will need to work on what department will collects the taxes.

In response to a question from Senator Danny Carroll, Mr. Duke stated that BR 83 only relates to ground transport providers not air flight service providers.

Deferred Administrative Regulation

The following deferred administrative regulation was on the agenda for consideration: **911 KAR 001:010 Regular** - application to clinical programs. A motion to accept the amendment on the deferred administrative regulation was made by Senator Buford, seconded by Senator Raque Adams, and accepted by voice vote. A motion to accept the amended administrative regulation was made by Senator Raque Adams, seconded by Representative Moser, and accepted by voice vote.

Personal Care Homes, Individuals with Serious Mental Illness, and Homelessness

Wendy Morris, Commissioner, Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID), Cabinet for Health and Family Services, stated that serious mental illness is defined through diagnosis, duration, and disability. Examples of serious mental illness include major depression, bipolar disorder, post-traumatic stress

disorder (PTSD), and schizophrenia. The housing options for people that have a serious mental illness are independent housing, living with family or a friend, supported housing, three-person homes, and institutions such as hospitals, nursing homes, personal care homes, or boarding homes. The key services necessary to help people live in the community are assertive community treatment (ACT), targeted case management, and supported employment. Vouchers from Kentucky Housing Corporation (KHC) and DCBS supplemental funding financially assist people in maintaining housing. The reasons people cannot access housing include lack of available and affordable housing, stigma associated with serious mental illness, lack of personal resources, criminal history, and personal choice.

There are also limiting factors such as the Olmstead Decision and the Second Amended Settlement Agreement (SASA). The SASA required CHFS to contract with the technical assistance collaborative, a national organization that has looked specifically at housing for people with serious mental illness in Kentucky and will provide recommendations to CHFS. Personal care homes could become a more integral part of the continuum of care. There would need to be regulatory changes in regards to personal care homes to assure alignment with the Olmstead decision. An enhanced reimbursement rate would be necessary to support any regulatory changes. Workforce capacity continues to be a limiting factor. The serious mental illness (SMI) waiver is under consideration as part of the Kentucky Medicaid 1915(c) Home and Community Based Services (HCBS) waiver redesign and must be approved by CMS. An increase in the general fund allocation would allow flexible funding for innovative and community-specific interventions.

The Community Mental Health Centers (CMHC) of Kentucky serve all 120 counties. CMHC are the only provider type that serves people with serious mental illness in Kentucky. DBHDID contracts with CMHC for services that include crisis services, diversion, SASA deliverables, re-entry, and homeless outreach. The expansion of Kentucky Medicaid's service array has not assured access because of managed care organizations (MCOs) approvals, low reimbursement rates, and continued workforce capacity. Prevention and early intervention are critical to patients with a serious mental illness. Fifty percent of those who develop mental health disorders show symptoms by age 14 and 75 percent of mental health conditions develop by age 24. DBHDID has the following early intervention initiatives; Early Detection and Intervention of First Episode Psychosis, Kentucky Suicide Awareness and Prevention, Transition-Age Youth Launching Realized Dreams (TAYLRD), Kentucky AWARE (Advancing Awareness and Resiliency in Education), and the Kentucky Opioid Response Effort (KORE).

In response to questions and comments from Senator Danny Carroll, Commissioner Morris stated that DBHDID general funds do not fund personal care homes. DBHDID does not have enough funds to use to match for federal money. Commissioner Steckel stated that personal care homes are a part of the 1915(c) HCBS waivers and that may be a benefit to those with a serious mental illness. She stated that adding a benefit like assisted living

services as a Medicaid benefit means DMS would have to offer the benefit to all Medicaid beneficiaries unless the benefit is added as a SMI waiver. Commissioner Morris stated that the settlement agreement between CHFS and the Kentucky Protection and Advocacy Division (KYPA) obligate DBHDID to spend $7 million a year.

In response to questions and comments from Senator Julian Carroll, Commissioner Morris that DBHDID does not have funds in the budget to match for additional federal funds. If a SMI waiver was submitted, it would be for three-person homes and family home providers and not for congregate living settings. The DBHDID has general fund money to support approximately 12 three-person homes and if the money went towards a federal match, DBHDID could triple the number of people in three-person homes. The DBHDID is spending approximately $5 million for 12 personal care homes.

In response to questions and comments from Senator Meredith, Stephanie Craycraft, Executive Advisor, Department for Behavioral Health, Developmental and Intellectual Disabilities, Cabinet for Health and Family Services, stated that 2019 Regular Session Senate Bill 1 is helping to put more mental health services into schools. The Transition Age Youth Launching Realized Dreams (TAYLRD) program has expanded beyond the grant funding. The TAYLRD program helps teens to access services such as job counseling and assistance in finding housing. There is a Facebook page available for all 14 community health centers to contribute content and for the public to view. NAMI also has programs for youth and families.

In response to questions and comments from Representative Frazier, Commissioner Steckel stated that there are certain places of service that DMS would not fund such as assisted living facilities.

In response to questions and comments from Senator Alvarado, Ms. Craycraft stated that through the KHC subsidy that DBHDID provides there are approximately 200 people on the vouchers. There are 36 people in three-person homes. There are 1,290 recipients in the DCBS community integration supplement program. Commissioner Morris stated that DCBS spends roughly $7 million in addition to the $7 million that DBHDID spends for the community integration supplement program. She stated that DBHDID must review any new programs or ideas for housing. Mental health screening of junior high age children is a good idea because symptoms are often missed because the symptoms may look like normal behavior for the age group.

Heidi Schissler, Legal Director, Kentucky Protection and Advocacy Division, stated that KYPA is an independent state agency that promotes the rights of individuals with disabilities. KYPA receives seven federal grants that are the majority of the funding for the division. KYPA is required by United States Congress to use the funding to do various things for individuals that have disabilities that include investigating abuse and neglect, monitoring any place where a person with a disability lives or receives services, advocating

for systemic change, monitoring legislation and regulations, and representing individuals and classes. KYPA gathered information on personal care homes and defined them as free-standing homes that are not a part of an assisted living facility or a nursing facility. KYPA reported in March 2012 that 85 percent of people living in personal care homes had a serious mental illness, 48 percent had guardians, and 39 percent had lived in the personal care home for more than five years. KYPA determined that personal care homes are institutions.

Ms. Schissler stated that the Olmstead Decision and SASA have changed many of the services that are available to individuals who are living or are at risk of living in a personal care home. Many individuals that are receiving services through the settlement agreements are homeless. Kentucky needs to increase the service level that is available to anyone whether they are living or are at risk of living in a personal care homes or coming out of a psychiatric hospital. The people that choose to live in personal care homes can continue to do so but must be given the choice of still receiving services and being successful in the community. The 1915(c) waivers are home and community based waivers so an individual could not use 1915(c) money to provide services in a personal care home because it is considered an institution. The state prisons and jails are the largest mental health providers in Kentucky.

Betsy Johnson, President, Executive Director, Kentucky Association of Health Care Facilities (KAHCF), Kentucky Center for Assisted Living (KCAL), stated that DCBS distributes a rate letter that states the allowable amount for personal care homes. There are gaps in services for the elderly and people with a serious mental illness in the continuum of care in Kentucky. Personal care homes receive $40.47 a day to care for an individual with a serious mental illness. The people living in a three-person home receive $380.00 a day and could have the same serious mental illness diagnosis as someone living in a personal care home. Personal care homes are licensed and regulated by the Office of the Inspector General. Personal care homes require a certificate of need, have set-up costs, provide 24 hour supervision, and oversight of medical care. The medical care provided includes medication services, administration, residential care, personal care, three meals and three snacks a day, activity services, and basic instruction with Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL), for $40.47 a day.

Ms. Johnson stated that if Kentucky does not change its rates then freestanding personal care homes will close due to increased costs of operations. If personal care homes close there would be an increase in the number of individuals in the state jails, hospitals, and emergency rooms along with an increased risk of drug addiction and homelessness. The Kentucky legislature should take steps to increase reimbursement and let personal care homes be a part of the solution. The last rate increase for personal care homes was in 2006. An increase in reimbursement would allow the care, medication, food, and services to continue for those with a serious mental illness. Personal care homes are the most cost efficient level of care.

In response to questions and comments from Representative Goforth, Ms. Johnson stated that the individuals living in a three-person home are receiving care management and services by DBHDID. The only difference in the individuals being served is that one chose a three-person home and one chose a personal care home but the providers are paid differently. The services are more enhanced for those that decided to move to a three-person home. Bruce Linder, Executive Vice President, Kentucky Association of Health Care Facilities, Kentucky Center for Assisted Living, stated that the personal care home buildings vary but could be a converted hospital wing, former hospital, or former hotel. The personal care home could have one to four people in a room based on the size of the room. The personal care homes are licensed under the Office of the Inspector General and follow those regulations. Ms. Johnson stated there are no specifications as to what the building needs to look like to be a personal care home.

In response to questions and comments from Senator Harper Angel, Ms. Johnson stated that it is an individual's choice to live in a personal care home as opposed to a three-person home with a higher rate of care and that choice is supported by the Olmstead Decision. The personal care home and congregate living is familiar and comfortable for some individuals with serious mental illness. Congregate living helps those individuals from becoming isolated. The individuals are aware and given the choice, per the Olmstead Decision, where to live. The personal care home worker is mandated to inform the individual that they have right to live elsewhere.

In response to questions and comments from Senator Julian Carroll, Commissioner Morris stated that there are only 12 three-person homes. Three-person homes came about when the state owned and operated personal care homes were closed. The three-person home is a pilot program to see if the level of care would work for the serious mental health population. If so, DBHDID would then advocate for a SMI waiver. The three-person homes should not be compared to the personal care homes but to the Supports for Community Living (SCL) waiver supports. DBHDID would need to work with DMS to have an accurate allocation to request a federal match. Individuals do not have the option to go the three-person homes, they were only available to people living in a state owned personal care home. Ms. Johnson stated that under the settlement agreement individuals are given the option to live in an apartment.

Commissioner Morris stated that DBHDID does not have the funding available to continue the three-person home program. The only way to provide funding for three-person homes would be to request an SMI waiver. She stated that obtaining a SMI waiver is a complicated process. DBHDID does have a lot of data and can work with Medicaid on a SMI waiver. Personal care homes are an important part of the continuum of care. Commissioner Morris does not want to see the personal care homes go away. The math of a rate increase would be based on the DBHDID contracts for personal care homes. Theoretically, the money used for three-person homes could be used for a match except

that money is used for maintenance of block grant dollars. Ms. Johnson stated that KAHCF has had conversations with CHFS regarding the continuum of care but the providers have been dealing with the same funding amount for 17 years without a rate increase. The personal care homes are reaching a crisis status that could affect 3,200 Kentuckians who depend on that level of care.

In response to questions from Representative Sheldon, Ms. Johnson stated there are approximately 50 personal care homes located throughout the state with various owners. The owners have taken risks financially and otherwise to get a license and be regulated by the state. The personal care home owners should be supported to provide the continuum of care. The rate in 2016 was increased by $2.00 totaling $40.47 per day.

In response to questions from Representative Gibbons Prunty, Ms. Johnson stated KAHCF was not part of the settlement agreements. KAHCF and KCAL were not invited to give its perspective regarding the settlement agreements.

Youth and Mental Health Issues

Sheila Schuster, PhD, Licensed Clinical Psychologist, Executive Director, Kentucky Mental Health Coalition, stated that there are approximately 130,000 children enrolled in Kentucky schools with mental illness. She stated that one in every six children age two to eight have a mental, behavioral, or developmental disorder. Six percent of Kentucky's youth age 12 to 17 have depression. Eleven percent of the youth in Kentucky have anxiety. A 2017 survey showed that 29 percent of Kentucky high school students show symptoms of depression. Of the youth age 12 to 17 who had a major depressive episode in the past year, fewer than half received treatment for depression. A 2017 survey of Kentucky high school students in grades 9 through 12 revealed that 15 percent reported that they had seriously considered suicide during the 12 months before the survey. Eight percent of those students surveyed stated they had attempted suicide in the previous 12 months before the survey. Last school year in Jefferson County, there was a death of a 10 year old by suicide.

Senator Seum has addressed the issue with legislation requiring school personnel, as well as mental health professionals, to have specific training in suicide identification and prevention. Fifty percent of lifetime mental health conditions develop by age 14. She stated that 37 percent of youth age 14 and over with a mental health issue drop out of school. At the college level, 51 percent of United States college students report feeling hopeless in the last 12 months. There has been a 40 percent increase in college counseling center utilization while enrollment only increased 5 percent. The Adverse Childhood Experiences (ACES) study speaks to the trauma that all people have experienced in one form or another. Many children in Kentucky relate that they have experienced divorce, death, or separation of the family. Kentucky has a high rate of one or both parents being incarcerated. Kentucky has poor mental health resources. The community mental health centers are charged by statute to make available in every county, access to mental health

programs, substance use disorder assistance, and services for developmental and intellectual disabilities. Kentucky is ranked 45 in per person mental health funding.

Early diagnosis and access to appropriate services can make a huge difference. Kentucky has a shortage of child psychiatrists and psychiatric mental health nurse practitioners. Stigma is still a barrier to be reviewed. The number of children in Kentucky that are victims of abuse and neglect and the impact of that on their mental health is a barrier. There are many school children that are homeless or are changing schools almost weekly in Kentucky. Kentucky needs to review the consent to be treated issue. However, there has been more focus, discussion, and awareness on mental health and substance use disorders in the last four years.

Anti-Female Genital Mutilation Legislation

Amanda Parker, Senior Director, Ayaan Hirsi Ali (AHA) Foundation, stated that the AHA Foundation believes in liberty for all women and girls. The AHA Foundation works to end honor violence, forced marriage, child marriage, and female genital mutilation in the United States. The AHA Foundation was founded by Ayaan Hirsi Ali, who is a survivor of female genital mutilation and forced marriage. Female genital mutilation is a form of child abuse that is used to control the sexuality of women and girls. The practice predates all major religions and is not required by any major religion but has been adopted by some patriarchal sects and religious organizations. There are four types of female genital mutilation or cutting. The World Health Organization defines female genital mutilation or cutting as "all procedures that involve partial or total removal of external female genitalia, or other injury to female genital organs for non-medical reasons." There are no health benefits to female genital mutilation but there are lifelong health and psychological consequences associated with the practice. The World Health Organization makes is clear that female genital mutilation should not be performed in any of its forms not even by a healthcare provider.

Globally, 200 million women and girls have under gone female genital mutilation. The Centers for Disease Control and Prevention estimate that in the United States there are 513,000 women and girls who are at risk of or have under gone the practice. In Kentucky, the Population Reference Bureau estimate that 1,845 women and girls are at risk for or have undergone female genital mutilation. There are 35 states with laws against female genital mutilation. Senator Raque Adams is drafting a bill that would make female genital mutilation a crime, make it illegal to take a girl across state lines for the practice, and it would provide education and outreach to communities and professionals who are likely to encounter cases of female genital mutilation.

Jenny, local survivor and advocate for anti-female genital mutilation, stated that the numbers of women and girls who are at risk of or have under gone the practice does not include her, her daughters, or sisters because they are white, American, and part of a Christian faith. The practice of female genital mutilation is still a silent issue that women

and girls do not talk about freely. Jenny was five when she underwent female genital mutilation and it will affect her for the rest of her life. Female genital mutilation affects women physically, emotionally, and spiritually. She has suffered from depression, PTSD with flashbacks and nightmares, had all of her five children by cesarean section (C-section), and struggles with pain on a daily basis. She stated that she previously did not know that this practice was not normal because no one talked about the practice. She hopes that the new law will reach other women who may not know that this is not a safe or legal practice. The proposed law will help bring more education about female genital mutilation to women and health providers. She has gone to therapy about her experience and had to educate her therapist about the practice of female genital mutilation.

In response to questions and comments from Senator Alvarado, Ms. Parker stated that she does not know of any physicians that are performing female genital mutilation in Kentucky at this time. She stated that families that are performing female genital mutilation on their daughters are not doing it to be hurtful but believe they are doing what is best for their children. In many communities the practice is done for a girl to be marriageable and to secure her and her family's future. Over 98 percent of women in Somalia, 74 percent of women in Ethiopia, and 90 percent of women in Egypt undergo female genital mutilation.

In response to questions and comments from Senator Kerr, Jenny stated that she does not say what denomination of Christian faith that she was aligned with that practices female genital mutilation.

In response to a question from Representative Bentley, Senator Raque Adams stated that in her proposed bill the reporting of female genital mutilation will be going to vital statistics and would be public information.

Adjournment

There being no further business, the meeting was adjourned at 3:19 PM.