OLR Bill Analysis

sHB 7157 (as amended by House "A")

AN ACT CONCERNING VARIOUS REVISIONS TO THE PUBLIC HEALTH STATUTES.

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Requires SDE, within available appropriations, to create a pilot program in priority school districts on mental and behavioral health awareness and treatment using an online tool

SUMMARY

This bill makes various changes to public health-related statutes as described in the section-by-section analysis below.

*House Amendment "A" replaces the original bill (File 628) and adds the provisions on (1) technical revisions to public health statutes, (2) Infant Mortality Review Program data sharing, (3) the pediatric hospice working group, (4) Connecticut Liver Health Day, (5) the statewide health information exchange, (6) a sewage disposal working group and related regulations, and (7) a priority school district mental health pilot program. It also (1) limits the fee waiver for a minor's OCME investigation records to parents and adult siblings; (2) makes the ethics and jurisprudence continuing education requirement for physical therapists every two years; (3) adds additional entities that may board-certify an APRN as a psychiatric behavioral health provider; and (4) specifies that short-form death certificates may only be requested for deaths that occurred on or after January 1, 2021.

EFFECTIVE DATE: October 1, 2025, unless otherwise noted below.

§ 1 — FEES FOR OCME INVESTIGATION RECORDS

Prohibits OCME from charging a parent or adult sibling of a deceased minor for copies of the minor's investigation record

By law, the Office of the Chief Medical Examiner (OCME) must investigate deaths that (1) involve certain conditions, such as violence or suspicious circumstances, or (2) are sudden or unexpected and not caused by an easily recognizable disease. The office must keep complete records of these investigations (including autopsy and toxicology reports and a copy of the death certificate).

The bill prohibits OCME from charging a fee to a parent or adult sibling of a deceased minor for copies of the minor's records.

Generally, existing law limits public access to copies of these records unless the person has a legitimate interest in them, or the decedent was under state custody at the time of death. The Commission on Medicolegal Investigations, which oversees OCME, sets conditions on accessing the records and related fees.

EFFECTIVE DATE: July 1, 2025

§ 2 — EMS ADMINISTRATION OF EPINEPHRINE

Allows EMS personnel to administer epinephrine using any device approved by the federal Food and Drug Administration, including nasal spray

The bill allows emergency medical services (EMS) personnel (paramedics, emergency medical responders, and emergency medical technicians) to administer epinephrine by any device approved by the federal Food and Drug Administration (including nasal spray), instead of only by auto injectors or prefilled vials or syringes as under current law.

Under existing law and the bill, EMS personnel must (1) be trained on administering the medication in line with national standards the Department of Public Health (DPH) commissioner recognizes and (2) administer the medication under the written protocol or standing order of a physician serving as an EMS medical director. Ambulances must be equipped with epinephrine devices.

EFFECTIVE DATE: July 1, 2025

§ 3 — PHYSICAL THERAPIST CONTINUING EDUCATION

Starting January 1, 2026, requires licensed physical therapists to complete education or training on ethics and jurisprudence as part of their existing continuing education requirement

Starting January 1, 2026, the bill requires licensed physical therapists to complete at least two hours of training or education on ethics and jurisprudence as part of their existing continuing education requirements. The requirement applies only (1) during the first license renewal period for which continuing education is required (i.e. the second license renewal) and (2) at least once every two years after that.

By law, physical therapists must complete at least 20 hours of continuing education during each registration period (i.e. the 12-month period for which a license has been renewed). This continuing education must include at least two hours of training and education on (1) screening for post-traumatic stress disorder, suicide risk, depression, and grief and (2) suicide prevention training. This requirement applies

(1) during the second license renewal and (2) at least once every six years after that.

EFFECTIVE DATE: July 1, 2025

§ 4 — REQUIRING PATIENTS TO KEEP PAYMENT METHODS ON FILE

Prohibits health systems and health care providers from requiring patients to provide electronic payment methods on file as a prerequisite to providing them services and makes a violation of this prohibition an unfair trade practice

The bill prohibits health systems and health care providers from requiring patients to provide electronic payment methods (e.g., bank account information, credit cards, or debit cards) to keep on file as a prerequisite to (1) seeing patients for an office visit or (2) providing them services.

It makes a violation of this prohibition an unfair trade practice under the Connecticut Unfair Trade Practices Act (CUTPA).

Under the bill, the prohibition does not (1) affect a patient's obligation to pay for health care services or (2) prevent patients from voluntarily giving health care providers their electronic payment methods or other payment-related information to keep on file.

Background — CUTPA

The law prohibits businesses from engaging in unfair and deceptive acts or practices. CUTPA allows the consumer protection commissioner to issue regulations defining what constitutes an unfair trade practice, investigate complaints, issue cease and desist orders, order restitution in cases involving less than $10,000, enter into consent agreements, ask the attorney general to seek injunctive relief, and accept voluntary statements of compliance. It also allows individuals to sue. Courts may issue restraining orders; award actual and punitive damages, costs, and reasonable attorney's fees; and impose civil penalties of up to $5,000 for willful violations and $25,000 for violation of a restraining order.

§§ 5-17 & 52 — PSYCHOLOGIST PATIENT CONFIDENTIALITY PROTECTIONS

Updates patient confidentiality requirements for psychologists by repealing current statutory provisions and instead subjecting them to existing requirements for psychiatric behavioral health providers; makes related minor, conforming, and technical changes to several related statutes

The bill updates statutory requirements for psychologists on confidentiality of patient communications and records to align with those of other behavioral health providers. It does so by repealing current law's requirements for psychologists and instead subjecting them to similar patient confidentiality requirements that already apply to psychiatrists and advanced practice registered nurses (APRNs) certified as behavioral health providers ("psychiatric behavioral health providers").

The bill also makes related minor, conforming, and technical changes, including updating statutory definitions to reflect the addition of psychologists and those they diagnose and treat (hereafter "patients") to these provisions (e.g., adding a psychologist's office to the definition of "mental health facility"). It also specifies that APRNs may be board-certified as psychiatric mental health providers by the American Academy of Nurse Practitioners or other certifying bodies, instead of only the American Nurses Credentialing Center as under current law.

Disclosure of Patient Communications and Records

Under current law and the bill, a psychologist is generally prohibited from disclosing communications and related records concerning a patient's diagnosis and treatment without the consent of the patient or his or her authorized representative. The patient or representative may withdraw their consent in writing at any time.

However, as is already the case for psychiatric behavioral health providers, the bill permits disclosure without consent in the following situations:

1. to other people and mental health facilities (e.g., a hospital, clinic, or psychologist's office) engaged in diagnosing or treating the patient, if the disclosure is necessary for diagnosis or treatment and the patient is informed of the disclosure;

2. when the psychologist determines that there is a substantial risk of imminent physical injury by the patient, or disclosure is necessary to place the patient in a mental health facility;

3. to individuals and agencies that collect fees for services the psychologist provides (e.g., billing services) or contract with the psychologist (e.g., the Department of Mental Health and Addiction Services (DMHAS)), except that the disclosure must be limited to only information needed to process or substantiate the fee or claim (e.g., patient contact information, the fees, and the dates and duration of the services);

4. the disclosure is related to a psychological examination ordered by a court or made as part of a probate court conservatorship proceeding, if (a) the patient is a party to the proceeding; (b) his or her competence is questioned because of mental illness; or (c) it is in appropriate pretrial proceedings, so long as the patient is informed that the patient's communication is not confidential and disclosure is limited to issues involving the patient's mental condition;

5. the disclosure is in connection with a civil proceeding in which the patient introduces his or her mental condition as part of his or her claim or defense (or their beneficiary does) and the court determines it is in the interest of justice;

6. to (a) DPH in connection with a health care facility's inspection or investigation and (b) DMHAS for an inquiry, records examination, or investigation of a serious injury or unexpected death of certain people receiving services at a DMHAS-operated or -funded facility or program; and

7. to immediate family members or legal representatives of a victim of a homicide committed by a patient found not guilty due to mental disease or defect, if they request the communication or record within six years of the verdict and it is used only for a related civil action.

Likewise, the bill grants access to psychologists' patient communications and records for the following purposes:

1. to researchers, if the researcher's plan is approved by the mental health facility's director or designee, the information is not removed from the facility (except for certain de-identified data), and patient-identifiable information is generally not disclosed, and

2. to DMHAS, for patients under the department's care, for administrative, research, or planning purposes, so long as the data is de-identified and a patient's identity can only be accessed by the DMHAS commissioner.

Labeling Confidential Records

The bill extends to psychologists the current requirement for psychiatric behavioral health providers that any patient communications and records they disclose include a statement specifying (1) that the information is confidential and cannot be further disclosed without written consent required by law and (2) who and for what purpose consent was given for the disclosure, including any applicable laws authorizing it. (If the disclosure is made orally, the psychologist must inform the recipient of the above information.)

EFFECTIVE DATE: October 1, 2025, except the provision on patients' consent to disclosure is effective July 1, 2025 (§ 6).

§ 18 — DPH CIVIL PENALTIES

Increases the maximum civil penalty that DPH may impose against individual health care providers from $10,000 to $25,000

The bill increases, from $10,000 to $25,000, the maximum civil penalty that DPH or its licensing boards or commissions may impose, under existing procedures, against individual health care providers. (PA 24-68 lowered this maximum penalty from $25,000 to $10,000.)

EFFECTIVE DATE: July 1, 2025

§ 19 — DPH WORKPLACE VIOLENCE REPORTS

Extends, from January 1 to February 1, the date by which health care employers must annually report to DPH on workplace violence incidents

The bill extends, from January 1 to February 1, the date by which health care employers must annually report to DPH workplace violence incidents. Existing law requires certain health care employers to report to the department on the number of workplace violence incidents that occurred in the prior year on the employer's premises and the specific area or department where they occurred.

The reporting requirement applies to DPH-licensed institutions (e.g., hospitals or nursing homes) with at least 50 full-or part-time employees. It also includes (1) mental health and substance use disorder treatment facilities, (2) Department of Developmental Services-licensed residential facilities for people with intellectual disability, and (3) community health centers.

§ 20 — OXYGEN-RELATED PATIENT CARE

Authorizes MRI and radiologic technicians to perform certain oxygen-related patient care activities in hospitals just as existing law allows for designated licensed health care providers and certified ultrasound, nuclear medicine, and polysomnographic technologists

The bill authorizes magnetic resonance imaging (MRI) and radiologic technicians to perform the following oxygen-related patient care activities in hospitals: (1) connecting or disconnecting oxygen supply; (2) transporting a portable oxygen source; (3) connecting, disconnecting, or adjusting the mask, tubes, and other patient oxygen delivery apparatus; and (4) adjusting the oxygen rate or flow consistent with a medical order. Existing law already allows designated licensed health care providers and certified ultrasound, nuclear medicine, and polysomnographic technologists to do these things.

As under existing law, this authorization does not apply to any type of (1) ventilator, (2) continuous positive airway pressure or bi-level positive airway pressure unit, or (3) other noninvasive positive pressure ventilation.

Under existing law and the bill, MRI and radiologic technicians may perform these activities only to the extent allowed by hospitals' policies and procedures, including applicable bylaws, rules, and regulations.

The hospital must document that each technologist is properly trained, either through (1) his or her professional education or (2) training provided by the hospital. It must also require each technologist to complete annual competency testing.

EFFECTIVE DATE: July 1, 2025

§ 21 — HOSPITAL NURSE STAFFING PLAN COMPLIANCE REPORTS

Changes the dates by which hospitals must biannually report to DPH on their compliance in the past six months with at least 80% of nurse staffing assignments in their nurse staff plans

Existing law requires each hospital to report biannually to DPH whether it has complied in the past six months with at least 80% of nurse staffing assignments in its nurse staffing plan.

The bill requires hospitals to report by each (1) January 15 for the most recent six-month period ending January 1 and (2) July 15 for the most recent six-month period ending July 1. Current law requires hospitals to report by each October 1 and April 1.

§ 22 — DCF OUTPATIENT PSYCHIATRIC CLINICS

Specifies that DPH-licensed hospitals are not required to also obtain DCF licensure to provide inpatient or outpatient mental health services as part of DCF's outpatient psychiatric clinic program

Existing law requires the Department of Children and Families (DCF) to administer an outpatient psychiatric clinic program that provides behavioral health services to children and adolescents under age 18 with psychiatric conditions, and their families. Under the program, DCF licenses community-based psychiatric clinics and designates a subset of them as child guidance clinics that receive DCF grants to help maintain or expand them.

The bill specifies that DPH-licensed hospitals are not required to also obtain DCF licensure to participate in the program and (1) provide inpatient or outpatient mental health services to patients of any age and (2) receive any related DCF grants.

EFFECTIVE DATE: Upon passage

§ 23 — SHORT FORM DEATH CERTIFICATES

Requires DPH, by January 1, 2026, to establish a process for someone to request a short-form death certificate that does not include the decedent's cause of death

The bill requires the DPH commissioner, by January 1, 2026, to establish a process for someone to request a short-form death certificate for a death that occurred on or after January 1, 2021. The short-form death certificate must exclude the medical certification part of the death certificate that identifies the decedent's cause of death. Under current law, the state only offers long-form death certificates that must include information on the cause of death (CGS § 7-62b).

Under the bill, requestors may give the short-form death certificate to people or institutions (e.g., banks and financial institutions, mortgage lenders, and the motor vehicles department) that do not need to know the decedent's cause of death.

Existing law generally allows anyone age 18 or older to purchase a certified copy of a death record (CGS § 7-51a).

EFFECTIVE DATE: Upon passage

§§ 24-42 — TECHNICAL REVISIONS

Makes technical changes in various public health and related statutes

The bill makes technical changes in various public health and related statutes.

Background — Related Bill

HB 6980 (File 94), favorably reported by the Public Health Committee, contains substantially similar provisions.

§§ 43 & 44 — INFANT MORTALITY REVIEW PROGRAM DATA SHARING

Allows DPH to disclose Infant Mortality Review Program data to the Child Advocate and, in turn, allows the Child Advocate to disclose to DPH information on infant deaths necessary for each to perform their statutory duties; deems this shared information and data confidential and not subject to further disclosure

The bill allows the DPH commissioner to disclose information and data from the Infant Mortality Review Program (see *Background – Infant Mortality Review Program*) to the Child Advocate, if the commissioner

deems it necessary for the Child Advocate to perform her statutory duties.

In turn, the bill allows the Child Advocate to share information with the DPH commissioner about infant deaths (i.e. those occurring between birth and one year of age) if the Child Advocate determines it is necessary for the purpose of the Infant Mortality Review Program.

Under the bill, any data disclosed for these purposes (1) is confidential and not subject to further disclosure, (2) is not admissible as evidence in a court or agency proceeding, and (3) must be used solely for medical or scientific research purposes (CGS § 19a-25).

Background — Infant Mortality Review Program

A 2023 law established an Infant Mortality Review Program within DPH to review medical records and other relevant data on infant deaths. This review is conducted by an Infant Mortality Review Committee and must include information from birth and death records and medical records from health care providers and facilities to make recommendations on reducing health care disparities and identify gaps in, or problems with, health care or service delivery to reduce infant deaths.

By law, pharmacies and health care providers and facilities must give DPH, upon request, access to all medical or other records, including prenatal records, associated with infant death cases under the program's review.

Background — Related Bill

sHB 7049 (File 121), favorably reported by the Public Health Committee, contains the same provisions.

§ 45 — PEDIATRIC HOSPICE WORKING GROUP

Requires the pediatric hospice services working group to make recommendations to establish a (1) Children's Health, Advocacy, Management, and Palliative Care program and (2) Pediatric Palliative and Hospice Care Center of Excellence pilot program; requires the working group chairpersons to report the recommendations to the Public Health Committee by March 1, 2026

The bill adds to the required duties of the working group (established

under 2024 legislation) on pediatric hospice services within the state.

Currently, the working group is responsible for (1) reviewing existing pediatric hospice services in Connecticut, (2) making recommendations for appropriate levels of these services, and (3) evaluating pediatric hospice care payment and funding options. (The group submitted its report on these matters this March.)

The bill specifies that these current duties applied through March 1, 2025. From then through June 30, 2026, the bill requires the working group to also make recommendations to establish (1) a Children's Health, Advocacy, Management, and Palliative Care program and (2) within that program, a Pediatric Palliative and Hospice Care Center of Excellence pilot program, as described in the group's March 2025 report. The recommendations must include the following:

1. appropriations needed to establish the programs;

2. requirements for operating the pilot program, including staff and facility requirements;

3. education and curriculum requirements for nurses participating in the pilot program or providing pediatric palliative or hospice care services; and

4. any licensing or certification requirements needed to operate the pilot program or expand pediatric palliative or hospice care services in Connecticut.

Within 30 days after the bill's passage, the working group's chairpersons must schedule a meeting to start working on the additional responsibilities described above.

Under the bill, the chairpersons must report on the working group's recommendations to the Public Health Committee by March 1, 2026.

EFFECTIVE DATE: Upon passage

Background — Related Bill

sSB 1540 (File 827), favorably reported by the Appropriations Committee, contains the same provisions.

§ 46 — CONNECTICUT LIVER HEALTH DAY

Designates each April 19 as Connecticut Liver Health Day to raise awareness of liver health issues

The bill requires the governor to proclaim each April 19 as Connecticut Liver Health Day to raise awareness of liver health issues, including metabolic dysfunction-associated steatotic liver disease (MASLD) and metabolic dysfunction-associated steatohepatitis (MASH). Under the bill, suitable activities may be held at the State Capitol and elsewhere as the governor designates.

EFFECTIVE DATE: Upon passage

Background — MASLD and MASH

MASLD is a condition in which fat builds up in the liver (among people with low alcohol use). MASH is the advanced stage of MASLD. In some cases, MASH can lead to cirrhosis (advanced scarring), which can progress to liver failure.

MASH was formerly called nonalcoholic steatohepatitis (NASH). MASLD was formerly called nonalcoholic fatty liver disease (NAFLD).

Background — Related Bill

sSB 1537 (File 826), favorably reported by the Appropriations Committee, contains the same provision.

§§ 47 & 48 — STATEWIDE HEALTH INFORMATION EXCHANGE

Requires OHS to study the exclusion of certain patient health information from the exchange; exempts certain providers from having to connect with the exchange; sets patient notification requirements in the case of a data breach, ransomware, or hacking; and prohibits disclosure of protected health information in response to a subpoena, with limited exceptions

The bill makes various changes affecting the Statewide Health Information Exchange ("Connie"). Principally, it:

1. requires the Office of Health Strategy (OHS) commissioner to study the exclusion of certain patient health information from the

exchange;

2. exempts health care providers who do not actively practice in Connecticut from existing law's requirement to connect with the exchange;

3. requires the exchange, when experiencing a data breach, ransomware, or hacking, to notify affected patients and perform any necessary mitigation on behalf of affected health care providers; and

4. prohibits the exchange (and its vendor) from disclosing protected health information in response to a subpoena unless the disclosure fully complies with applicable federal and state laws on releasing medical records.

EFFECTIVE DATE: October 1, 2025, except the study provision takes effect upon passage.

Study Requirements

The bill requires the OHS commissioner to study the exclusion of certain patient health information from the Statewide Health Information Exchange. Specifically, the study must evaluate the following:

1. options allowing a patient a granular choice in selecting which specific types of their health information and medical records to share with the exchange (e.g., the ability to exclude certain information and records associated with a particular health care provider);

2. the operational and financial implications of implementing these options; and

3. an option that allows health care providers to participate in the exchange using only a business associate agreement entered into under HIPAA (i.e. a contract between a HIPAA-covered entity and a business associate that specifies how protected health

information will be handled).

Under the bill, the study must also (1) examine current procedures allowing patients to opt out of the exchange and determine whether to enhance or improve these procedures by enhancing their transparency and simplifying them and (2) summarize, using publicly available resources, the state's health data sharing landscape and related protections as well as the benefits of provider access to patient health information.

The bill requires the commissioner to report the study results by September 30, 2026, to the Public Health Committee.

Provider Exemptions From Connecting to the Exchange

By May 3, 2023, existing law generally required all licensed health care providers with an electronic health record system capable of connecting to and participating in the statewide health exchange to apply to begin the process to do so. (Hospitals and clinical laboratories were required to apply by May 3, 2022.) By this same 2023 deadline, providers without such a system were required to be capable of sending and receiving secure messages in line with specified federal standards.

Generally, health care providers, no later than 18 months after OHS implements policies and procedures related to exchange participation, must be connected to and actively participating in the exchange. (OHS has not yet implemented these policies and procedures.)

The bill exempts health care providers who do not actively practice in Connecticut from the requirement to connect with the exchange. Existing law already exempts providers if they (1) have no patient medical records or (2) are individuals and exclusively practice as employees of a covered entity under HIPAA, and the covered entity is legally responsible for decisions on the safeguarding, release, or exchange of health information and medical records.

Under current law, participating in the exchange means actively sharing medical records with the exchange under applicable law, including HIPAA and federal regulations on the confidentiality of

substance use disorder patient records. The bill instead requires providers to actively share "designated record sets" for this purpose, as defined under HIPAA regulations. Generally, these record sets include medical, billing, payment, claims, health plan enrollment, case management, and other records used wholly or partially by or for a HIPAA-covered entity (e.g., health care provider or health plan) to make decisions about individuals.

Notification of Data Breaches

If the exchange experiences a data breach, ransomware, or hacking, the bill requires it to notify affected patients and perform any necessary mitigation on behalf of affected health care providers.

Existing law specifies that health care providers are not liable for any private or public claim related directly to a data breach, ransomware, or hacking experienced by the exchange. But they are liable for any failure to comply with applicable state and federal data privacy and security laws and regulations in sharing information with and connecting to the exchange. The law specifically exempts providers from the requirement to share information with or connect to the exchange if doing so would violate any other law.

Background — Related Bill

sSB 1331 (File 577), favorably reported by the Public Health Committee, requires the OHS commissioner to study whether (1) to exclude from the exchange patient health information and medical records related to sensitive medical procedures and (2) new patient participation procedures (i.e. opt-in or opt-out) are needed.

§§ 49 & 50 — WORKING GROUP ON SEWAGE DISPOSAL AND RELATED REGULATIONS

Establishes a working group to assess and make recommendations on (1) sewage disposal regulation and (2) balancing housing development costs with protecting public health and the environment; requires the DEEP commissioner to post notice of her intent to amend certain sewerage-related regulations on the eRegulations system by July 1, 2026, and consider the working group's recommendations when adopting the regulations

The bill establishes a working group to assess and make recommendations on (1) regulatory requirements for sewage disposal,

including nitrogen discharge limits and their impact on housing development, public health, and the environment, and (2) balancing the costs of housing development and a risk-based approach to protecting public health and the environment.

Under the bill, the working group chairperson must report on the group's assessment and recommendations by February 1, 2026, to the DPH commissioner and the Environment, Housing, and Public Health committees.

Additionally, PA 23-207 transferred regulatory authority from the Department of Energy and Environmental Protection (DEEP) to DPH over small community sewerage systems and household and small commercial subsurface sewage disposal systems with daily capacities of up to 10,000 gallons. Under current law, DEEP must amend its regulations by July 1, 2025, to effectuate the transfer. The bill instead requires the DEEP commissioner to post notice of her intent to amend these regulations on the eRegulations system by July 1, 2026, and only after the working group has convened. Before amending the regulations, she must consider the working group's recommendations.

EFFECTIVE DATE: Upon passage

Working Group Membership and Leadership

At a minimum, the working group may include the following state officials: (1) the DEEP, DPH, and housing commissioners or their designees and (2) the Public Health Committee chairpersons and ranking members. The committee chairpersons and ranking members may also appoint the following members to the working group:

1. a representative of an in-state residential construction trade association;

2. one representative each of in-state associations representing municipal planners, septic system installers, and professional engineers;

3. one representative each of a local or district health department

that (a) includes an area with a coastal boundary, (b) includes an area upland of municipally regulated inland wetlands or inland watercourses, and (c) has no land in a coastal boundary or an upland review area;

4. one expert each in coastal environmental science, wetland soil science, and environmental justice; and

5. one residential building developer each with experience in developing an area (a) with coastal land and (b) no coastal boundary.

The bill requires the Public Health Committee chairpersons and ranking members to select the working group's chairperson from among its members. The chairperson must schedule and hold the working group's first meeting by June 30, 2025.

Under the bill, the Public Health Committee's administrative staff serves in this capacity for the working group.

Background — Related Bill

sHB 7247 (File 708), favorably reported by the Public Health Committee, contains similar provisions on a working group on sewage disposal and related regulations.

§ 51 — PRIORITY SCHOOL DISTRICT MENTAL HEALTH PILOT PROGRAM

Requires SDE, within available appropriations, to create a pilot program in priority school districts on mental and behavioral health awareness and treatment using an online tool

The bill requires the state Department of Education (SDE), within available appropriations, to create a pilot program to allow at least 100,000 students in priority school districts (see *Background – Priority School Districts*) to use an electronic mental and behavioral health awareness and treatment tool (through a website, mobile application, or other online service). SDE must create the program by January 1, 2026, and select the tool to be used in the program.

EFFECTIVE DATE: Upon passage

Program Components

Under the bill, the pilot program's chosen electronic tool must provide mental and behavioral health education resources to promote awareness and understanding of these issues. It also must include peer-to-peer support services, screened by a moderator to encourage social connection and mutual support among students.

The chosen tool must also include private online sessions with state-licensed mental or behavioral health care providers experienced in delivering services in both rural and urban school districts. These sessions must comply with the state's laws on (1) telehealth and (2) parental consent and notification regarding a minor's outpatient mental health treatment (see *Background — Outpatient Mental Health Treatment for Minors*).

Program Objectives and Reporting

Under the bill, during the program's first year, its objectives are to (1) build partnerships between priority school districts and community organizations providing mental and behavioral health care services and (2) launch a digital marketing campaign to raise awareness and engagement among students about these issues.

During the program's second year, its objectives are to (1) refer students to mental and behavioral health care providers, as needed, and (2) enhance students' engagement with mental and behavioral health tools, including coping strategies and clinician support.

By January 1, 2026, and again by January 1, 2027, the bill requires the SDE commissioner to report to the Public Health and Education committees on the program's success in achieving these objectives.

Background — Priority School Districts

Priority school districts are districts (1) whose students receive low standardized test scores, (2) that have high levels of poverty, or (3) in the eight towns with the largest populations in the state. There are 16 priority school districts in the 2024-25 school year.

Background — Outpatient Mental Health Treatment for Minors

By law, parental consent or notification is not required for a minor to request and receive outpatient mental health treatment (not including prescribing legend drugs) under certain circumstances. Among other things, the provider must determine that (1) the treatment is clinically indicated, (2) requiring parental consent or notification would cause the minor to reject the treatment, and (3) the minor is mature enough to participate in the treatment productively. Under the law, a provider may notify a parent or guardian of this treatment without the minor's consent or notification if the (1) provider determines that notification or disclosure is necessary for the minor's well-being, (2) treatment is solely for mental health and not for a substance use disorder, and (3) minor is given an opportunity to object to the notification or disclosure.

COMMITTEE ACTION

Public Health Committee

Joint Favorable Substitute
Yea 32 Nay 0 (03/21/2025)