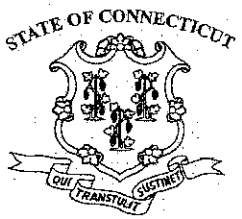

Substitute Senate Bill No. 972

Public Act No. 13-178

AN ACT CONCERNING THE MENTAL, EMOTIONAL AND BEHAVIORAL HEALTH OF YOUTHS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective July 1, 2013*) (a) (1) The Commissioner of Children and Families, in consultation with representatives of the children and families served by the department, providers of mental, emotional or behavioral health services for children and families, advocates, and others interested in the well-being of children and families in this state, shall develop a comprehensive implementation plan, across agency and policy areas, for meeting the mental, emotional and behavioral health needs of all children in the state, and preventing or reducing the long-term negative impact of mental, emotional and behavioral health issues on children. In developing the implementation plan, the department shall include, at a minimum, the following strategies to prevent or reduce the long-term negative impact of mental, emotional and behavioral health issues on children:

(A) Employing prevention-focused techniques, with an emphasis on early identification and intervention;

(B) Ensuring access to developmentally-appropriate services;

(C) Offering comprehensive care within a continuum of services;

(D) Engaging communities, families and youths in the planning, delivery and evaluation of mental, emotional and behavioral health care services;

(E) Being sensitive to diversity by reflecting awareness of race, culture, religion, language and ability;

(F) Establishing results-based accountability measures to track progress towards the goals and objectives outlined in this section and sections 2 to 7, inclusive, of this act;

(G) Applying data-informed quality assurance strategies to address mental, emotional and behavioral health issues in children;

(H) Improving the integration of school and community-based mental health services; and

(I) Enhancing early interventions, consumer input and public information and accountability by (i) in collaboration with the Department of Public Health, increasing family and youth engagement in medical homes; (ii) in collaboration with the Department of Social Services, increasing awareness of the 2-1-1 Infoline program; and (iii) in collaboration with each program that addresses the mental, emotional or behavioral health of children within the state, insofar as they receive public funds from the state, increasing the collection of data on the results of each program, including information on issues related to response times for treatment, provider availability and access to treatment options.

(2) Not later than April 15, 2014, the commissioner shall submit and present a status report on the progress of the implementation plan, in accordance with section 11-4a of the general statutes, to the Governor and the joint standing committees of the General Assembly having cognizance of matters relating to children and appropriations.

(3) On or before October 1, 2014, the commissioner shall submit and present the implementation plan, in accordance with section 11-4a of the general statutes, to the Governor and the joint standing committees of the General Assembly having cognizance of matters relating to children and appropriations.

(4) On or before October 1, 2015, and biennially thereafter through and including 2019, the department shall submit and present progress reports on the status of implementation, and any data-driven recommendations to alter or augment the implementation in accordance with section 11-4a of the general statutes, to the Governor and the joint standing committees of the General Assembly having cognizance of matters relating to children and appropriations.

(b) Emergency mobile psychiatric service providers shall collaborate with community-based mental health care agencies, school-based health centers and the contracting authority for each local or regional board of education throughout the state, utilizing a variety of methods, including, but not limited to, memoranda of understanding, policy and protocols regarding referrals and outreach and liaison between the respective entities. These methods shall be designed to (1) improve coordination and communication in order to enable such entities to promptly identify and refer children with mental, emotional or behavioral health issues to the appropriate treatment program, and (2) plan for any appropriate follow-up with the child and family.

(c) Local law enforcement agencies and local and regional boards of education that employ or engage school resource officers shall, provided federal funds are available, train school resource officers in nationally-recognized best practices to prevent students with mental health issues from being victimized or disproportionately referred to the juvenile justice system as a result of their mental health issues.

(d) The Department of Children and Families, in collaboration with

agencies that provide training for mental health care providers in urban, suburban and rural areas, shall provide phased-in, ongoing training for mental health care providers in evidence-based and trauma-informed interventions and practices.

Sec. 2. (NEW) (*Effective October 1, 2013*) The Office of Early Childhood, as established in section 1 of substitute house bill 6359 of the current session, in collaboration with the Department of Children and Families, shall provide, to the extent that private, federal or philanthropic funding is available, professional development training to pediatricians and child care providers to help prevent and identify mental, emotional and behavioral health issues in children by utilizing the Infant and Early Childhood Mental Health Competencies, or a similar model, with a focus on maternal depression and its impact on child development.

Sec. 3. (NEW) (*Effective July 1, 2013*) The birth-to-three program, established under section 17a-248b of the general statutes and administered by the Department of Developmental Services, shall provide mental health services to any child eligible for early intervention services pursuant to Part C of the Individuals with Disabilities Education Act, 20 USC 1431 et seq., as amended from time to time. Any child not eligible for services under said act shall be referred by the program to a licensed mental health care provider for evaluation and treatment, as needed.

Sec. 4. (NEW) (*Effective July 1, 2013*) The state shall seek existing public or private reimbursement for (1) mental, emotional and behavioral health care services delivered in the home and in elementary and secondary schools, and (2) mental, emotional and behavioral health care services offered through the Department of Social Services pursuant to the federal Early and Periodic Screening, Diagnosis and Treatment Program under 42 USC 1396d.

Sec. 5. (NEW) (*Effective October 1, 2013*) Not later than December 1, 2014, the Office of Early Childhood, through the Early Childhood Education Cabinet, shall provide recommendations for implementing the coordination of home visitation programs within the early childhood system that offer a continuum of services to vulnerable families with young children, including prevention, early intervention and intensive intervention, to the joint standing committees of the General Assembly having cognizance of matters relating to appropriations, human services, education and children. Vulnerable families with young children may include, but are not limited to, those facing poverty, trauma, violence, special health care needs, mental, emotional or behavioral health care needs, substance abuse challenges and teen parenthood. The recommendations shall address, at a minimum:

(1) A common referral process for families requesting home visitation programs;

(2) A core set of competencies and required training for all home visitation program staff;

(3) A core set of standards and outcomes for all programs, including requirements for a monitoring framework;

(4) Coordinated training for home visitation and early care providers, to the extent that training is currently provided, on cultural competency, mental health awareness and issues such as child trauma, poverty, literacy and language acquisition;

(5) Development of common outcomes;

(6) Shared reporting of outcomes, including information on any existing gaps in services, disaggregated by agency and program, which shall be reported annually, pursuant to section 11-4a of the general statutes, to the joint standing committees of the General Assembly

having cognizance of matters relating to appropriations, human services and children;

(7) Home-based treatment options for parents of young children who are suffering from severe depression; and

(8) Intensive intervention services for children experiencing mental, emotional or behavioral health issues, including, but not limited to, relationship-focused intervention services for young children.

Sec. 6. (NEW) (*Effective October 1, 2013*) (a) The Office of Early Childhood, as established in section 1 of substitute house bill 6359 of the current session, in collaboration with the Departments of Children and Families, Education and Public Health, to the extent that private funding is available, shall design and implement a public information and education campaign on children's mental, emotional and behavioral health issues. Such campaign shall provide:

(1) Information on access to support and intervention programs providing mental, emotional and behavioral health care services to children;

(2) A list of emotional landmarks and the typical ages at which such landmarks are attained;

(3) Information on the importance of a relationship with and connection to an adult in the early years of childhood;

(4) Strategies that parents and families can employ to improve their child's mental, emotional and behavioral health, including executive functioning and self-regulation;

(5) Information to parents regarding methods to address and cope with mental, emotional and behavioral health stressors at various ages of a child's development and at various stages of a parent's work and

family life;

(6) Information on existing public and private reimbursement for services rendered; and

(7) Strategies to address the stigma associated with mental illness.

(b) Not later than October 1, 2014, and annually thereafter, to the extent that private funding is available under subsection (a) of this section, the Office of Early Childhood shall report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to children and public health on the status of the public information and education campaign implemented pursuant to subsection (a) of this section.

Sec. 7. (NEW) (*Effective October 1, 2013*) (a) The Judicial Branch, in collaboration with the Departments of Children and Families and Correction, may seek public or private funding to perform a study (1) disaggregated by race, to determine whether children and young adults whose primary need is mental health intervention are placed into the juvenile justice or correctional systems rather than receiving treatment for their mental health issues; (2) to determine the consequences that result from inappropriate referrals to the juvenile justice or correctional systems, including the impact of such consequences on the mental, emotional and behavioral health of children and young adults and the cost to the state; (3) to determine the programs that would reduce inappropriate referrals; and (4) to make recommendations to ensure proper treatment is available for children suffering from mental, emotional or behavioral health issues.

(b) Upon completion of the study conducted pursuant to subsection (a) of this section, the Judicial Branch shall report, in accordance with the provisions of section 11-4a of the general statutes, to the joint

standing committees of the General Assembly having cognizance of matters relating to appropriations, children and the judiciary on the results of such study.

Sec. 8. (*Effective July 1, 2013*) (a) There is established a Children's Mental Health Task Force to study the effects of nutrition, genetics, complementary and alternative treatments and psychotropic drugs on the mental, emotional and behavioral health of children within the state. Members of the task force shall serve without compensation but shall, within the limits of available funds, be reimbursed for expenses necessarily incurred in the performance of their duties. The task force shall: (1) Study the effects of nutrition, genetics, complementary and alternative treatments and psychotropic drugs on the mental, emotional and behavioral health of children; (2) gather and maintain current information regarding said effects; and (3) advise the General Assembly and Governor concerning the coordination and administration of state programs that may address the impact of said effects on the mental, emotional and behavioral health of children using a results-based accountability framework.

(b) The task force shall consist of the chairpersons and ranking members of the joint standing committee of the General Assembly having cognizance of matters relating to children, and ten members appointed as follows:

(1) A psychologist licensed under chapter 383 of the general statutes, appointed by the president pro tempore of the Senate;

(2) A child psychiatrist licensed to practice medicine in this state, appointed by the speaker of the House of Representatives;

(3) A licensed and board-certified physician specializing in genetics, appointed by the majority leader of the Senate;

(4) A public health expert in children's health issues, appointed by

the minority leader of the Senate;

(5) An educator with expertise providing school-based mental health services in collaboration with community-based mental health service providers, appointed by the minority leader of the House of Representatives;

(6) A pediatrician licensed to practice medicine in the state, appointed by the Senate chairperson of the joint standing committee of the General Assembly having cognizance of matters relating to children;

(7) A complementary and alternative medicine or integrative therapy expert specializing in the treatment of physical, mental, emotional and behavioral health issues in children, appointed by the House chairperson of the joint standing committee of the General Assembly having cognizance of matters relating to children;

(8) A dietitian-nutritionist licensed under chapter 384b of the general statutes, appointed by the Senate ranking member of the joint standing committee of the General Assembly having cognizance of matters relating to children;

(9) A psychotropic pharmacologist, appointed by the House ranking member of the joint standing committee of the General Assembly having cognizance of matters relating to children; and

(10) A pharmacologist, appointed by the Governor.

(c) All appointments to the task force shall be made not later than thirty days after the effective date of this section. Any vacancy shall be filled by the appointing authority.

(d) The chairpersons of the joint standing committee of the General Assembly having cognizance of matters relating to children shall serve

as the chairpersons of the task force. Such chairpersons shall schedule the first meeting of the task force, which shall be held not later than sixty days after the effective date of this section.

(e) The administrative staff of the joint standing committee of the General Assembly having cognizance of matters relating to children shall serve as administrative staff of the task force.

(f) Not later than September 30, 2014, the task force shall submit a report on its findings and recommendations to the Commissioner of Children and Families and the joint standing committee of the General Assembly having cognizance of matters relating to children, in accordance with the provisions of section 11-4a of the general statutes. The task force shall terminate on the date that it submits such report or September 30, 2014, whichever is later.

Approved June 24, 2013

PA 13-178—sSB 972

Children Committee

Human Services Committee

Public Health Committee

AN ACT CONCERNING THE MENTAL, EMOTIONAL AND BEHAVIORAL HEALTH OF YOUTHS

SUMMARY: This act requires the Department of Children and Families (DCF) and the Office of Early Childhood (OEC), in consultation and collaboration with various individuals and agencies, to take several steps to address Connecticut children's mental, emotional, and behavioral health needs. It requires DCF to develop a comprehensive plan to (1) meet these needs and (2) prevent or reduce the long-term negative impact of mental, emotional, and behavioral health issues on children. It requires OEC to (1) provide recommendations to several legislative committees on coordinating home visitation programs that offer services to vulnerable families with young children and (2) design and implement a public information and education campaign on children's mental, emotional, and behavioral health issues.

The act requires training for school resource officers, mental health care providers, pediatricians, and child care providers. It also requires the (1) state to seek existing public and private reimbursement for mental, emotional, and behavioral health services and (2) Birth-to-Three program to provide mental health services to children eligible for early intervention services under federal law.

The act also (1) allows the Judicial Branch to seek funding to perform a study to determine whether children and young adults who primarily need mental health interventions are placed in the juvenile justice or corrections systems instead of receiving appropriate treatment and (2) establishes a 14-member task force to study the effects of nutrition, genetics, complementary and alternative treatments, and psychotropic drugs on children's mental, emotional, and behavioral health.

EFFECTIVE DATE: July 1, 2013, except the Judicial Branch and OEC provisions are effective on October 1, 2013.

§ 1 — DCF IMPLEMENTATION PLAN AND TRAINING REQUIREMENTS

Implementation Plan

The act requires DCF to develop a comprehensive implementation plan across agency and policy areas for meeting the mental, emotional, and behavioral needs of all children in the state and preventing or reducing the long-term negative impact of mental, emotional, and behavioral health issues on children. DCF must develop the plan in consultation with (1) representatives of children and families the department serves; (2) providers of mental, emotional, or behavioral health services for children and families; (3) advocates; and (4) others interested in the well-being of children and families in the state.

Plan Requirements. The plan must include strategies to prevent or reduce the long-term negative impact of mental, emotional, and behavioral health issues on children by:

1. employing prevention-focused techniques that emphasize early identification and intervention;

2. ensuring access to developmentally appropriate services;

3. offering comprehensive care within a service continuum;

4. engaging communities, families, and youth in mental, emotional, and behavioral health care services planning, delivery, and evaluation;

5. reflecting race, culture, religion, language, and ability awareness;

6. establishing results-based accountability (RBA) measures to track progress towards the act's goals and objectives;

7. applying data-informed quality assurance strategies to address children's mental, emotional, and behavioral health issues; and

8. improving school and community-based mental health services integration.

The plan must also include strategies to enhance early interventions, consumer input, and public information and accountability by increasing:

1. family and youth engagement in medical homes, in collaboration with the Department of Public Health (DPH) (see BACKGROUND);

2. awareness of the 2-1-1 Infoline (a single telephone source for information about community services, referrals to human services programs, and crisis intervention), in collaboration with the Department of Social Services (DSS); and

3. in collaboration with each program that addresses the mental, emotional, or behavioral health of children and receives state public funds, data collection on each program's results, including information on issues related to treatment response times, provider availability, and access to treatment options.

Reporting Requirements. The act requires the DCF commissioner to submit to the governor and Children's and Appropriations committees (1) a report on the implementation plan's progress by April 15, 2014 and (2) the implementation plan by October 1, 2014.

It requires DCF, starting by October 1, 2015 and biennially through 2019, to submit to the governor and Children's and Appropriations committees progress reports on the status of implementation and any data-driven recommendations to alter or augment implementation.

Mental Health Care Provider Training

The act requires DCF, in collaboration with agencies that provide training for mental health care providers in urban, suburban, and rural areas, to provide phased-in, ongoing training for mental health care providers in evidence-based and trauma-informed interventions and practices.

§ 1 — SCHOOL BOARD REQUIREMENTS

Collaboration Between Health Care Providers and School Boards

The act requires emergency mobile psychiatric service providers to collaborate with community-based

mental health care agencies, school-based health care centers, and the contracting authority for each local or regional board of education in the state to, at a minimum, (1) improve coordination and communication in order to promptly identify and refer children with mental, emotional, or behavioral health issues to the appropriate treatment program and (2) plan for any appropriate follow-up with the child and family. This may be done through memoranda of understanding, policy and protocols regarding referrals and outreach, liaison between the respective entities, or other methods.

School Resource Officer (SRO) Training

The act requires local law enforcement agencies and local and regional school boards that employ or engage SROs, provided federal funds are available, to train SROs in nationally recognized best practices to prevent students with mental health issues from being victimized or disproportionately referred to the juvenile justice system because of their mental health issues.

§§ 2, 5, & 6 — OEC

Pediatrician and Child Care Provider Training

The act requires OEC to collaborate with DCF to provide, to the extent that private, federal, or philanthropic funding is available, professional development training to pediatricians and child care providers to help prevent and identify mental, emotional, and behavioral health issues in children by using the Infant and Early Childhood Mental Health Competencies, or a similar model, with a focus on maternal depression and its impact on child development.

(This provision refers to OEC as created by SB 6359, which did not pass during the 2013 legislative session. OEC was instead created on June 24, 2013 by Executive Order No. 35. OEC's powers under the order are essentially the same as they would have been under the bill.)

Home Visitation Programs

The act requires OEC, by December 1, 2014 and through the Early Childhood Education Cabinet, to provide recommendations to the Appropriations, Children's, Education, and Human Services committees for implementing the coordination of home visitation programs that offer a services continuum to vulnerable families with young children, including prevention, early intervention, and intensive intervention within the early childhood system. (Apparently this refers to the system of early care and education and child development that the new OEC will administer.) Such families include those facing poverty, trauma; violence; special health care needs; mental, emotional or behavioral health care needs; substance abuse challenges; and teen parenthood. The recommendations must address, at a minimum:

1. a common referral process for families requesting home visitation programs;

2. a core set of (a) competencies and required training for all home visitors and (b) standards and outcomes for all programs, including requirements for a monitoring framework;

3. coordinated training for home visitation and early care providers, to the extent that training is currently provided, on cultural competency; mental health awareness; and issues such as child trauma, poverty, literacy, and language acquisition;

4. development of common outcomes;

5. shared annual outcome reporting to the Appropriations, Children's, and Human Services committees, including information on existing gaps in services, disaggregated (broken down) by agency and program;

6. home-based treatment options for parents of young children suffering from severe depression; and

7. intensive intervention services for children experiencing mental, emotional, or behavioral health issues, including relationship-focused intervention services for young children.

Public Information and Education Campaign

The act requires OEC, to the extent that private funding is available and in collaboration with DCF, DPH, and the Department of Education, to design and implement a public information and education campaign on children's mental, emotional, and behavioral health issues. The campaign must provide:

1. information on (a) access to support and intervention programs providing mental, emotional, and behavioral health care services to children, (b) the importance of a relationship with and connection to an adult in the early childhood years, and (c) existing public and private reimbursement for services rendered;

2. a list of emotional landmarks and the typical ages at which they are attained;

3. strategies that (a) parents and families can use to improve their child's mental, emotional, and behavioral health, including executive functioning and self-regulation and (b) address mental illness stigma; and

4. information to parents on methods to address and cope with mental, emotional, and behavioral health issues at various stages of a (a) child's development and (b) parent's work and family life.

The act requires OEC, by October 1, 2014 and to the extent private funding is available, to begin reporting annually to the Children's and Public Health committees on the status of the public information and education campaign. (In this provision, as above, the act refers to OEC as created by SB 6359. OEC was instead created by Executive Order No. 35.)

§ 3 — BIRTH-TO-THREE PROGRAM

The Birth-to-Three program administered by the Department of Developmental Services provides early intervention services as defined by federal regulation to children eligible under Part C of the Individuals with Disabilities Education Act (IDEA) (20 USC § 1431 et seq.) (see BACKGROUND). The act requires the program to provide mental health services to any child eligible for early intervention services under that provision. The program must refer any child not eligible for services to a licensed mental health care provider for evaluation and treatment, as needed.

§ 4 — MENTAL, EMOTIONAL, OR BEHAVIORAL HEALTH SERVICES REIMBURSEMENT

The act requires the state to seek existing public and private reimbursement for mental, emotional, and behavioral health services (1) delivered in the home and elementary and secondary schools or (2) offered through DSS under the federal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. It does not specify what agent of the state must seek the reimbursement.

§ 7 — JUVENILE JUSTICE AND CORRECTIONS REFERRALS

The act allows the Judicial Branch, in collaboration with DCF and the Department of Correction, to seek public and private funding to perform a study:

1. disaggregated by race, to determine whether children and young adults whose primary need is mental health intervention are placed into the juvenile justice or corrections systems instead of receiving treatment;

2. to determine (a) the consequences of inappropriate referrals to the juvenile justice or correctional systems, including the impact on children and young adults' mental, emotional, and behavioral health and the cost to the state and (b) programs that would reduce inappropriate referrals; and

3. to make recommendations to ensure proper treatment is available for children suffering from mental, emotional, or behavioral health issues.

The act requires the Judicial Branch, upon completing the study, to report the results to the Appropriations, Children's, and Judiciary committees. (The act does not specify a timeframe for the study's completion.)

§ 8 — CHILDREN'S MENTAL HEALTH TASK FORCE

The act establishes the Children's Mental Health Task Force to:

1. study the effects of nutrition, genetics, complementary and alternative treatments, and psychotropic drugs on children's mental, emotional, and behavioral health;

2. gather and maintain current information on those effects; and

3. advise the governor and General Assembly on how to coordinate and administer state programs to address the impact of those effects on children's mental, emotional, and behavioral health using an RBA framework.

The task force members must serve without compensation but must, within the limits of available funds, be reimbursed for necessary expenses incurred performing their duties. The members must include the Children's Committee chairpersons and ranking members and the following:

1. a state-licensed (a) psychologist appointed by the Senate president pro tempore, (b) child psychiatrist appointed by the House speaker, (c) pediatrician appointed by the Children's Committee Senate chairperson, and (d) dietitian-nutritionist appointed by the Children's Committee Senate ranking member;

2. a licensed and board-certified physician specializing in genetics, appointed by the Senate majority leader;

3. a public health expert in children's health issues, appointed by the Senate minority leader;

4. an educator with expertise providing school-based mental health services in collaboration with community-based mental health service providers, appointed by the House minority leader;

5. a complementary and alternative medicine or integrative therapy expert specializing in the treatment of physical, mental, emotional, and behavioral health issues in children, appointed by the Children's Committee House chairperson (PA 13-234, § 121, instead requires the House majority leader to make this appointment);

6. a psychotropic pharmacologist, appointed by the Children's Committee House ranking member; and

7. a pharmacologist appointed by the governor.

All task force appointments must be made by July 31, 2013. The appointing authority must fill any vacancy. The Children's Committee chairpersons must chair the task force and schedule the first meeting by August 30, 2013, and the committee's administrative staff serve as the task force's administrative staff.

The act requires the task force to report its findings and recommendations to the DCF commissioner and Children's Committee by September 30, 2014. It terminates on the date it submits the report or September 30, 2014, whichever is later.

BACKGROUND

Medical Homes

Medical homes, as defined by federal law, are for people eligible for Medicaid services who have (1) two chronic conditions, (2) one chronic condition with a risk of developing a second, or (3) a serious and persistent mental health or substance abuse condition. Medical home care includes:

1. comprehensive case management;

2. care coordination and health promotion;

3. comprehensive transitional care, including appropriate follow up, from inpatient to other settings;

4. patient and family support;

5. referral to community and social support services, if relevant; and

6. the use of health information technology to link services.

IDEA – Part C

Part C of IDEA (20 USC § 1431 et seq.) provides federal grants to states for early intervention services for infants and toddlers up to age three with disabilities and their families. Part C provides general eligibility guidelines and leaves it to each state to define eligible developmental delays.

Under Connecticut regulations, a child age three or younger has a developmental delay that makes him or her eligible for early intervention services if his or her score on an appropriate norm-referenced standardized diagnostic instrument is (1) two standard deviations below the mean in one area of development or (2) one and one-half standard deviations below the mean in at least two areas of development (Conn. Agencies Reg. , § 17a-248-1).

Under the federal regulations, early intervention services include family training, counseling, home visits, and psychological and social work services (39 CFR § 303. 12).

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