Final Report of the Task Force to Study the Comprehensive Needs of Children in the State

December 2021

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Charge to the Task Force to Study the Comprehensive Needs of Children in the State

The Connecticut General Assembly (2021), through Public Act 21-46, "established a task force to study the comprehensive needs of children in the state and the extent to which such needs are being met by educators, community members and local and state agencies" (p. 40). The resulting Task Force was charged by the CGA to:

> (1) identify the needs of children using the following tenets of the whole child initiative developed by the Association for Supervision and Curriculum Development: (A) Each student enters school healthy and learns about and practices a healthy lifestyle, (B) each student learns in an environment that is physically and emotionally safe for students and adults, (C) each student is actively engaged in learning and is connected to the school and broader community, (D) each student has access to personalized learning and is supported by qualified, caring adults, and (E) each student is challenged academically and prepared for success in college or further study and for employment and participation in a global environment; (2) recommend new programs or changes to existing programs operated by educators or local or state agencies to better address the needs of children in the state; (3) recognize any exceptional efforts to meet the comprehensive needs of children by educators, community members or local or state agencies; (4) identify and advocate for resources, including, but not limited to, funds, required to meet the needs of children in the state; (5) identify redundancies in existing services or programs for children and advocate for the elimination of such redundancies; and (6) assess all publicly available data concerning the comprehensive needs of children identified pursuant to subdivision (1) of this subsection and collect, or make recommendations to the state to collect, any data that is not being collected by educators, community members or local or state agencies. (p. 40)

The pages that follow identify the individuals who comprised the Task Force, as well as the organizations or agencies that they represent. They articulate the process that the Task Force followed throughout the Fall of 2021 to study the comprehensive needs of children in the state, and to determine recommendations for how those needs ought to be met going forward. They describe the five tenets of the Whole Child Framework, the lens through which the Task Force both studied the comprehensive needs of children in the state and identified recommendations for

how those needs should be met more effectively and systematically in the future. They enumerate, by tenet of the Whole Child Framework, the thirty-one (31) recommendations being made by the Task Force.

Membership of the Task Force to Study the Comprehensive Needs of Children in the State

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Process followed by the Task Force to Study the Comprehensive Needs of Children in the State

The Task Force met virtually on four Mondays: October 18, November 8, November 22, and December 6. Prior to the first meeting, the co-chairs created a shared electronic folder in which to store documents compiled by Task Force members to support the needs of children in Connecticut.

At the first meeting in October, Task Force members introduced themselves, the charge of the Task Force was discussed, the five tenets of the Whole Child Framework (healthy, safe, engaged, supported, and challenged) were reviewed, and the process to identify the priorities of the members was discussed. Task Force members agreed to add surveys, reports, or studies that supported the tenets to the shared folder.

The five tenets of the Whole Child were discussed in detail during the two November meetings: healthy and safe on November 8; and the three remaining tenets, engaged, supported, and challenged, on November 22. Before and between meetings, members also added notes and ideas regarding needs and recommendations on a shared document. Each suggestion was reviewed at the meeting and any additional ideas added to a master document.

Recommendations with supporting documents were shared with all Task Force members in advance of the December 6 meeting at which each recommendation was reviewed. The meeting ended with each member present voicing a vote in favor of presenting the thirty (30) substantive recommendations in this final report.

The Whole Child Framework

During a recent interview, Jason Reynolds – the National Ambassador for Young People's Literature – asked the question, "Who deserves our intention more than children?"

Convinced that no one is more deserving of our intention than our young people, we on the Task Force to Study the Comprehensive Needs of Children in the State urge Connecticut's elected and appointed leaders to gauge each policy measure that they consider according to the degree to which it comports with the Whole Child framework – that is, with a view to how well it would serve to keep children healthy, safe, engaged, supported, and/or challenged.

Source: ASCD Whole Child Network (2020)

ASCD – formerly, the Association for Curriculum Development and Supervision – enumerated these five tenets a decade and one-half ago, when it first set forth the Whole Child Framework. Based on research in child development, these tenets articulate that each and every child deserves to be – and, therefore, that society must ensure that each child is – healthy, safe, engaged, supported, and challenged. As Slade and Griffith (2013) explain, "This framework does not seek to divorce itself from academic development but it does seek to expand what constitutes academic development in the 21st century and aims to refocus attention on all attributes required for educational and societal success" (p. 21).

We ask that everyone in the state – residents and officials, alike – take a long view of matters of public policy, recognizing both that the consequences (positive and negative) of decisions made in the short term will last well into the future, and that the effects of choices that individual families and communities make for themselves are invariably (if unintentionally) felt by others – with the most negative effects too often being felt by families and communities least able to withstand them.

Despite having among the highest per capita income and the highest per capita wealth of any state in the nation, Connecticut is also distinguished as having among the greatest gaps in both household income and household wealth – and, by extension, in health outcomes, access to healthcare, and academic achievement.

In its most recent *Kids Count Profile*, the Annie E. Casey Foundation (2021) reported that – even before the onset of the COVID-19 pandemic – 14% of children in Connecticut were living in poverty, and that 27% of children in our state had parents who did not have secure employment.

In their publication *ALICE in Connecticut: A Financial Hardship Study*, the Connecticut United Ways (2020) report data on households in the state that can be assigned the ALICE designation, indicating that they are Asset Limited, Income Constrained [and] Employed. The authors explain, "ALICE households earn too much to qualify as 'poor' but are still unable to make ends meet" (p. 5). In short, ALICE households do not earn enough income to cover the costs of housing, child care, food, transportation, health care, and other necessities.

In 2018, well before the onset of the COVID-19 pandemic, 11% of Connecticut households were below the federal poverty level. That same year, 27% of households in

Connecticut qualified as ALICE – a 40% increase in such households from 2007 until that date (Connecticut United Ways, 2020).

That same publication – whose findings, it bears repeating, pre-date the onset of COVID-19 – makes plain that the state's income and wealth disparities are not proportionately distributed across all racial and ethnic groups. As of 2018, 38% of all households in Connecticut fell below the ALICE threshold, but 57% of Black households in the state – and 63% of Hispanic households – fell below that threshold. Put differently, while Black households represent 10% of all households in the state, they represent 15% of Connecticut's ALICE households. Despite representing only 13% of Connecticut's total households, Hispanic households represent 22% of the state's ALICE households (Connecticut United Ways, 2020).

"Social reproduction" DeLuca and Clampet-Lundquist (2016) remind us, "is not inevitable."

> Policies that offer low-income families affordable housing in opportunity-rich neighborhoods, provide youth with a range of programs in schools and other settings so they can pursue their interests, and give low-income young adults affordable post-secondary education with concrete avenues to stable jobs can help launch youth out of poverty as they move into adulthood. To not act on these policies is at best an expensive folly; at worst, it is intentional neglect. (p. 16)

The inequities that characterize our state are by no means inevitable. Connecticut has historically possessed the material resources to address them. What we have for too long lacked is the political will to do so.

Findings and Recommendations of the Task Force

Connecticut should take to heart and act upon what Frederick Douglass articulated one hundred sixty-five years ago: "It is easier to build strong children than to repair broken men."

The thirty-one recommendations below are designed to build strong children in Connecticut by ensuring that all youngsters in the state are *healthy* (recommendations H.1 through H.15), *safe* (recommendations Sa.1 through Sa.4), *engaged* (recommendations E.1 through E.6), *supported* (recommendations Su.1 and Su.2), and *challenged* (recommendations C.1 through C.3).

Abraham Maslow (1943) identified individuals' physiological needs as pre-potent to all of their other needs (i.e., their needs for safety, belongingness and love, esteem, and self-actualization). Similarly, when enumerating the five component tenets of the Whole Child framework, ASCD identified the need for children to be healthy as foundational to their being safe, engaged, supported, and challenged.

As the Department of Public Health (2021) explains in its compelling report *Healthy Connecticut 2025 – State Health Improvement Plan*, four elements are critical to ensuring that individuals and communities are healthy: Access to Health Care, Economic Stability, Healthy Food and Housing, and Community Strength and Resilience. These 'Social Drivers of Health' - the conditions in which people live, attend school, and work - "disproportionately impact vulnerable or disadvantaged populations, such as children and young people; people with disabilities; seniors; veterans; immigrants regardless of status; People of Color; current and recently incarcerated people; the poor; the homeless and those experiencing housing insecurity; people with Substance Use Disorders; and Lesbian, Gay, Bisexual, Pansexual, Transgender, Genderqueer, Queer, Intersex, Agender, Asexual and other Queer-identifying (LGBTQIA+) people" (p. 20).

Because health disparities - which are preventable differences “in health status, risk factors, and/or health outcomes among subgroups of the population”(DPH, 2021, p. 20) - often stem from the social, economic, and/or environmental disadvantages that people experience, all four Social Drivers of Health are reflected in the Task Force’s recommendations.

As is made plain below, many of the recommendations being offered by the Task Force to Study the Comprehensive Needs of Children in the State have also been - or are being - made by other agencies and organizations in Connecticut.

Healthy: ***Each student enters school healthy and learns about and practices a healthy lifestyle.***

H.1. Increase children's access to preventative care to promote their medical, dental, and social-emotional health.

The Task Force endorses the Department of Social Services' (2021) *State Action Plan for Fiscal Year 2022*, which, among other things, calls for increases in:

- the number of children who receive well-child exams annually;
- the number of children who receive dental visits annually; and
- the number of DPH funded School Based Health Center sites that conduct Adverse Childhood Experiences (ACEs) screenings, and make necessary referrals.

Likewise, this recommendation reflects the Task Force's appreciation of the efforts of the task force that had been established under Public Act 21-35 to examine strategies to expand access to school-based health centers (SBHCs) or expand SBHC sites.

H.2. Make health care costs – including the costs of behavioral and mental health care – affordable for families.

As the U.S. Department of Education (2021a) explains, "Nearly one in five children in the United States live in poverty, and youth from lower income households are less likely to access health care…and more likely to experience significant mental health systems" (p. 10).

The Task Force endorses the Connecticut Department of Public Health's (2021) *Healthy Connecticut 2025 - State Health Improvement Plan*, which, among other things, calls for a decrease in the number of Connecticut residents who are at risk of spending more than 10% of their net income on health care services and coverage.

H.3. Increase availability of settings (telehealth, out-patient, and in-patient) for mental health preventive care, treatment, and crisis intervention for individuals of all ages.

This recommendation reflects the Connecticut Department of Public Health's (2021) priorities - expressed in *Healthy Connecticut 2025 - State Health Improvement Plan* - that there be an increase in "the number of traditional and alternative (community- and technology-based) places people can access health care" (p. 45), and that there be an increase in "the availability and diversity of primary care providers, community partners, and care management services" (p. 46).

Additionally, this recommendation echoes that of the Centers for Disease Control and Prevention (2019), which advocates interventions to lessen the immediate and long-term harms to youngsters of Adverse Childhood Experiences (ACEs). Among the interventions that the CDC recommends are: enhanced primary care, victim-centered services, treatment to lessen the harms of ACEs, treatment to prevent problem behavior and future involvement in violence, and family-centered treatment for substance use disorders.

This recommendation likewise reflects the aim, expressed in the *Connecticut Children's Behavioral Health Plan - 2021 Annual Report*, that the state invest in collaborative activities that will allow for the provision of services and supports needed by children.

The Sandy Hook Advisory Commission explained in 2015:

Many of our students and their families live under persistent and pervasive stress that interferes with learning and complicates the educational process. There are many potential resources such as school based health centers that should provide a locus of preventive care, including screenings and referrals for developmental and behavioral difficulties, exposure to toxic stress, and other risk factors, as well as treatment offerings that can address crisis, grief and other stressors.

H.4. Expand access to treatment services for addiction for individuals of all ages.

This recommendation reflects the Department of Social Services' (2021) goal, articulated in its *State Action Plan for FY 2022,* of reducing the number of adolescents who report using substances.

Moreover, this recommendation reinforces the CDC's (2019) promotion of family-centered treatment for substance use disorders as one mechanism by which to mitigate the impacts of Adverse Childhood Experiences.

H.5. Enhance – and provide sufficient resources, including personnel and training for – schools' efforts to promote students' social and emotional health; to teach social-emotional and relationship skills; and to implement disciplinary policies and practices that are educative and restorative.

The Task Force agrees with the CDC's (2019) expression of the importance of teaching young people to "handle stress, manage emotions, and tackle everyday challenges."

The Sandy Hook Advisory Commission identified in 2015:

> For many children schools offer the only real possibility of accessing services, so districts should increase the availability of school guidance counselors, social workers, psychologists, and other school health and behavioral health professionals during and after school as well as potentially on Saturdays.

The Task Force likewise endorses Connecticut Voices for Children's (2021) recommendation that the Connecticut General Assembly:

> Increase funding for behavioral health support staff in schools including counselors, psychologists, and social workers. Behavioral health support staff spend years in higher education learning to support positive school environments, connect with and support families, and identify when children are struggling and intervene before crises emerge. (p. 16)

Darling-Hammond and Podolsky (2019) report that policymakers in nations with histories of high academic achievement provide resources necessary for "ongoing time and support for professional learning and collaboration" (p. 29). Persistently inequitable school funding in Connecticut inhibits these kinds of supports from being available in schools and districts that serve communities with the greatest concentrations of need.

"Because Connecticut does not fund school districts based on the complete learning needs of the students they serve," the School + State Finance Project (2020) explains, "districts serving the highest-need students often do not receive funding that reflects the needs of their student population, making it difficult for those districts to provide their students with educational opportunities equal to those of their non-need peers" (p. 18).

H.6. Address payment/reimbursement issues for pay-for-service in the school setting. (Statutory language allowing five sessions before parental notification prevents those sessions from being eligible for reimbursement.)

Waive elements of the comprehensive psychosocial assessment or timeline for completion: Create a core set of necessary psychosocial elements to be completed that are consistent with health care more broadly. Extend the time for clinicians to document all of the psychosocial elements (often close to 20 separate elements) over a series of sessions and as relevant to the individual's care.

Extend deadlines for service or treatment plan: Most states require that a service plan is in place within three-to seven days of the first appointment. Allow a clinical program to create a service plan within 30 days to support more attention on the individual's needs and clinical relief up front with a plan tailored to patient specific goals.

Consider eliminating the requirement that the treatment plan be a separate document: Update treatment plans as part of the clinical documentation in each session, as is done in primary health care. Standard medical care integrates the treatment plan into the body of the visit note allowing the plan to be reviewed and updated at each visit.

Long-term, states need to advocate with federal agencies such as the Centers for Medicare and Medicaid Services (CMS) to allow a more streamlined and responsive service planning that is updated at each visit rather than maintaining the requirement that behavioral health treatment plans be developed as a separate document that is updated every 90 – 120 days.

Heinrich, Camacho, Henderson, Hernández, and Joshi (2021) explain of administrative burdens:

> They not only appear to impede children's and families' access to public benefits and social service support that affect their healthy development and well-being, but they also place additional strain on the capacity of public and private nonprofit organizations that serve as the health and social safety net for those in most need, particularly in communities with more limited resources and social service infrastructure. (p. 29)

The Task Force underscores the following recommendations made by the Sandy Hook Advisory Commission in 2015:

- To promote healthy child development and foster robust communities, our systems of care must attend to the factors affecting family welfare. Current funding structures must thus be revamped. The Commission recommends support for models of integrated care driven by family needs in which all providers focus on family strength, address their risk factors, and accept the family as a partner in treatment.
- Inadequate reimbursement rates combined with high utilization rates at many outpatient behavioral health clinics have made this model of care financially unsustainable. In addition, overall Medicaid rates for adult inpatient care have not increased in at least eight years. Recent increases in rates for inpatient child and adolescent care have been coupled with decreases in other Medicaid reimbursement rates to the same hospitals. The Commission recommends that higher reimbursement rates in both outpatient and inpatient settings, which better reflect the costs of care, be a core component of a redesigned behavioral health care system.
- Connecticut has significant problems with system fragmentation resulting from diverse payment systems and a lack of coordination or consistency among state agencies. A fragmented system yields unequal access to effective treatment, discontinuities of care for those

receiving service, and unsustainable financial burdens for individuals, families and communities.

H.7. Increase the number of individuals seeking to become mental health and behavioral health providers, and retain those professionals already in the field, by:

- **increasing the rates paid for services;**
- **providing tuition reimbursement to those entering or already serving in these roles; and**
- **providing reimbursement for the costs of licensure and renewal.**

This recommendation echoes that articulated in the 2021 Annual Report of the Connecticut Children' Behavioral Health Plan:

> Take immediate steps to retain existing skilled behavioral health professionals and expand the pool of qualified clinicians from all disciplines. Suggested actions include:
> a) Adjust grant funding levels and reimbursement rates to support competitive compensation packages.
> b) Eliminate regulatory requirements that create barriers to entry not necessary to maintain clinical integrity.

Explaining, "Inadequate reimbursement rates have…impacted the behavioral health workforce which remains insufficient to meet the needs of many Connecticut residents," the Sandy Hook Advisory Commission (2015) recommended, "in addition to addressing reimbursement rates, Connecticut identify and take measures to increase the behavioral health workforce. These might include educational incentives such as loan forgiveness programs."

In some states, individuals are allowed to sit for their initial Social Work license exam during their last semester of matriculation, rather than waiting until after they have graduated to take the exam. This allows them, if they successfully pass their exam, to have their Social Work license issued upon graduation - i.e., several months earlier than if they had been required already to have graduated.

H.8. Attend to the wellness of educators and other personnel who serve children and adolescents – both in school and out.

Recommending that "Wellness for Each and Every Child, Student, Educator, and Provider" be prioritized, the U.S. Department of Education (2021) explains:

> Educator wellness is associated with child and student wellness…Educators who provide emotional support and establish positive relationships influence children's and students' health, overall wellness, and life satisfaction (Steward & Suldo, 2011). Wellness is multidimensional and may include medical, emotional, environmental, occupational, physical, intellectual, spiritual, and financial components…Educators' wellness is an important component to ensuring a healthy school climate, and educator wellness programs are associated with greater workplace satisfaction and lower rates of absenteeism…Promoting staff wellness benefits staff, children, and students. (p. 20)

H.9. Increase awareness of nutrition programs offered through the Connecticut Department of Agriculture and the Connecticut Department of Public Health, including but not limited to, the Farmer's Market Nutrition Program.

The task force is very appreciative of the ongoing and evolving partnerships between Connecticut's Departments of Agriculture and of Public Health in the area of nutrition. In an effort to support increased utilization of the nutrition programs offered through state agencies, the task force recommends additional support for outreach and awareness of these programs.

In *Healthy Connecticut 2025 - State Health Improvement Plan*, the Department of Public Health (2021) identified as one of its priority areas "Healthy Food and Housing." DPH explains:

> Many of our health outcomes are influenced by what, how much, and how often we eat. Yet for many, making the healthy food choice is not the easy choice. For some CT residents, healthy and affordable foods are not as readily available in their communities as are places that prepare or sell processed pre-packaged foods that are more likely to be high in salt, sugars, and fats. Children within these communities are especially vulnerable since they are subject to the food choices made by their parents…[H]ealthy food access, which is influenced by the affordability and availability of food and household income is an important factor that impacts population health both immediately and with lasting effects. (p. 55)

To meet this priority, DPH (2021) recommends that Connecticut:

- "Increase the utilization of available housing and food programs by eligible residents…" (p. 57), and
- "Increase the number of access points where people can obtain affordable, healthy, and nutritious food…" (p. 57).

H.10. Increase the number of employers across sectors that offer equitable and sustainable employment opportunities for all levels and demographics.

In making this recommendation, the Task Force repeats verbatim one of the aims put forth by the Department of Public Health.

Edelman (2012) urges that policymakers not "forget the underlying issues of jobs and income and the closely connected and still-important issues of race and gender" (p. 141). He continues:

> The poverty-related activities that can be conducted within schools and by using schools as a base are worthwhile, but people should not confuse them with the policies that are necessary to reduce poverty meaningfully. Quality education is a core strategy in fighting poverty, but unless we fight poverty on all fronts, the schools will not succeed in helping all children have the chance to achieve their full potential. (p. 141)

H.11. Increase funding to expand parents' and caregivers' access to the Connecticut Department of Labor's various job-training and workforce development programs.

The Task Force underscores the Department of Public Health's (2021) aims that Connecticut:

- Increase the amount of capital investment in communities and local businesses to support workforce development, community development, and entrepreneurship... (p. 51)

- Increase the number of employers who invest in employment retention and wellness programs/policies that support the continuity of their work... (p. 51)
- Increase the number of opportunities for children, young adults, adults, and retirees/older adults for equitable, affordable education on career development and personal finance… (p. 52)

H.12. Create a Connecticut Child Tax Credit

The Task Force bases this recommendation on recommendations from both the Centers for Disease Control and Prevention and Connecticut Voices for Children.

In its publication *Preventing Adverse Experiences (ACEs): Leveraging the Best Available Evidence*, the CDC (2019) reports, "The evidence tells us that ACEs can be prevented by…strengthening household financial security" (p. 11). It continues by explaining that Child Tax Credits "help increase income for working families while offsetting the costs of childcare," and that they "have also been shown to reduce child behavioral problems (e.g. physical aggression, anxiety, and hyperactivity) - factors that are linked to later perpetration of violence toward peers and intimate partners" (p. 11).

Connecticut Voices for Children (2021) advocates a Connecticut Child Tax Credit, explaining that such a measure "would provide financial support for working and middle-class families, make Connecticut's tax system fairer, and make Connecticut more competitive" (p. 5).

H.13. Expand access to affordable, high-quality child care and preschool; and ensure that the professionals who staff those programs are paid at competitive rates that reflect their levels of education and training, and the responsibility that they hold.

This recommendation echoes the suggestion made by the Hunt/Kean Leadership Fellows (2021) that the early childhood workforce - those women and men who care for and teach our communities' youngest members - be supported to become credentialed, to provide high quality care and education, and to be compensated in accordance with the importance of their work.

This recommendation likewise echoes the Centers for Disease Control and Prevention's (2019) priority of "Ensuring a strong start for children and paving the way for them to reach their full potential" through such measures as "early childhood home visitation," "high-quality child care," and "preschool enrichment with family engagement" (p. 9).

Connecticut Voices for Children (2021) explains that, during the COVID-19 pandemic, "Lack of available and affordable child care forced many people to choose between working and keeping their children safe and learning" (p. 16).

H.14. Address homelessness among adolescents – particularly those who identify as LGBTQIA+.

In *Healthy Connecticut 2025 - State Health Improvement Plan*, the Department of Public Health (2021) identified as one of its aims to "[d]ecrease the number of persons experiencing or at risk of homelessness and increase opportunities to obtain affordable and sustainable housing…" (p. 58).

The Task Force appreciates the Department of Housing's ongoing efforts in this area, and it urges the Connecticut General Assembly to make more funding available to support those efforts as well as those of local agencies and organizations that work to support homeless and housing insecure adolescents - particularly those who identify as LGBTQIA+.

The Task Force likewise appreciates the work of the Statewide Minor Homelessness Task Force, co-chaired by the Center for Children's Advocacy and the Connecticut Youth Services Association, which includes the Department of Housing, Department of Children and Families, Connecticut State Department of Education, and other youth-serving organizations and advocates. That panel has been reviewing the limited available data regarding this population, existing resources, and working with the National Coalition for Juvenile Justice, the Court Support Services Division of the Judicial Branch, and other organizations and agencies on a Collaboration for Change pilot project in the greater Stamford region that is establishing a coordinated system - including multi-sector case conferencing - that assists unaccompanied youth experiencing homelessness. Two additional pilots are being launched, which will help inform the work necessary to address unaccompanied minor homelessness across the state.

H.15. Establish a reimbursement mechanism (e.g. under Medicaid) for Occupational Therapy/Executive Function supports, and ensure that such services are made more broadly available to children in all settings.

Executive functioning skills are needed for children and adults to "focus on multiple streams of information at the same time, monitor errors, make decisions in light of available information, revise plans as necessary, and resist the urge to let frustration lead to hasty actions" (Center on the Developing Child, 2011, p. 1). The skills are coordinated in the brain through the development of working memory, mental flexibility, and self-control. In children exposed to "toxic stress" the skill development in the brain is delayed (p. 7). Occupational therapy can develop executive functioning skills by focusing on daily real-life situations.

The Task Force understands that Medicaid, operated by the Department of Social Services in Connecticut, reimburses for health-care services as stated in the Department's publication entitled *Medicaid School Based Child Health Program* (2017). In addition, although occupational therapy services are included in those services that are reimbursable, services exclusively to develop executive functioning skills are not included as reimbursable. Children who need occupational therapy support to develop executive function skills for life and learning should have the opportunity to receive these services and be included among those that are reimbursable.

SAFE: ***Each student learns in an environment that is physically and emotionally safe for students and adults.***

Sa.1. Increase families' access to safe, affordable housing by:

- **increasing the stock of affordable housing;**
- **increasing housing subsidies, so that families are not required to spend more than 30% of their income on housing.**

In *Healthy Connecticut 2025 - State Health Improvement Plan*, the Department of Public Health (2021) identified as one of its priority areas "Healthy Food and Housing." DPH explains:

> Households are considered cost burdened when they spend more than 30% of their gross income on housing. In 2017, an estimated 27% of owners and 48% of renters in Connecticut were cost-burdened. When families have to spend a large part of their income on housing, they may not have enough money to pay for things like healthy food or health care. This is linked to increased stress, mental health problems, and an increased risk of disease. (p. 56)

To meet this priority, DPH (2021) recommends that Connecticut:

- "Adopt and begin to implement a Connecticut property maintenance code that includes a statewide definition for safe and quality housing…" (p. 58), and
- "Increase the percentage of owner-occupied housing in CT…" (p. 59).

The Task Force appreciates the Connecticut Department of Housing's (2020) ongoing "Work to Ensure That All of the State's Residents Live in a Suitable Living Environment":

> A suitable living environment includes improving the safety and livability of neighborhoods; increasing access to quality public and private facilities and services; reducing the isolation of income groups within a community or geographical area through the spatial de-concentration of housing opportunities for persons of lower income and the revitalization of deteriorating or deteriorated neighborhoods; restoring and preserving properties of special historic, architectural, or aesthetic value; and conservation of energy resources and consideration of potential impacts of climate change on existing and future development. (p. 3)

Sa.2. Enact zoning reform to ensure that safe, affordable housing is available in <u>all</u> communities.

The Department of Public Health (2021) explains:

> Low-income families may be more likely to live in poor-quality housing that can damage health. Housing quality refers to the physical condition of a person's home as well as the quality of the social and physical environment in which the home is located…[T]he quality of a home's neighborhood is shaped in part by how well individual homes are maintained; living in a poor quality home and widespread residential deterioration in a neighborhood can both negatively affect mental health. (p. 55)

The Task Force appreciates the work of Connecticut's Commission on Human Rights and Opportunities in addressing issues housing discrimination, in improving access to affordable housing, and in advocating for zoning reform.

The Task Force echoes Connecticut Voices for Children's (2021) recommendations that the Connecticut General Assembly "continue efforts toward residential zoning reform and the development of more affordable housing in future legislative sessions" (p. 11); and that the CGA ask "Connecticut towns to plan and zone for their fair share of the state's affordable housing needs" (p. 12).

DeLuca & Clampet-Lundquist (2016) explain, "Policies that offer low-income families affordable housing in opportunity-rich neighborhoods, provide youth with a range of programs in schools and other settings so they can pursue their interests, and give low-income young adults affordable post-secondary education with concrete avenues to stable jobs can help launch youth out of poverty as they move into adulthood" (p. 16).

Sa.3. Increase children's and adolescents' access to mentoring programs and after-school programs.

In its publication *Preventing Adverse Childhood Experiences (ACEs): Leveraging the Best Available Evidence*, the Centers for Disease Control and Prevention (2019) recommends "Connecting youth to caring adults and activities" through such approaches as "mentoring programs" and "after-school programs" (p. 9).

Sa.4. Increase Access to Public Transportation.

As was memorably said to one of the Task Force co-chairs 27 years ago by a young mother who had just explained the time required and logistical challenges associated with getting her small children to their early morning medical appointments and herself to the mid-afternoon meeting at which the conversation occurred, "Being poor is a full-time job." Not having sufficient financial resources to own a vehicle of her own, and living in a region of the state where public transportation was limited, added significantly to the burdens and stresses of this mother and her family.

Connecticut's Judicial Branch provides cards and vouchers that families whose children are involved with the courts may use for transportation. Regrettably, these enormously valuable supports cease when these children and adolescents exit the system.

Investments in expanding public transportation in Connecticut, and in increasing access to that expanded system, will go a long way to reducing stresses on children and families with low incomes. Moreover, given what is now all-too-clear about climate change and its impact on public health (particularly for children and families with low incomes), expanded public transportation will serve to reduce carbon emissions by decreasing people's reliance upon personal vehicles.

This recommendation underscores the Department of Public Health's (2021) priority that Connecticut "Increase the number of policies and systems that address environmental and social justice, health disparities, and community safety as a result of meaningful community engagement…" (p. 64).

ENGAGED: ***Each student is actively engaged in learning and connected to the school and broader community.***

E.1. Fully fund the Education Cost Sharing formula passed by the CGA in October 2017 in advance of the projected FY 2028 date.

"Because Connecticut does not fund school districts based on the complete learning needs of the students they serve," the School + State Finance Project (2020) explains, "districts serving the highest-need students often do not receive funding that reflects the needs of their student population, making it difficult for those districts to provide their students with educational opportunities equal to those of their non-need peers" (p. 18).

As the National Commission on Social, Emotional, and Academic Development (2018) explains,

> Balanced and equitable preK-12 learning systems require balanced and equitable distribution of resources, which should include a diverse and stable cadre of effective educators, reasonable class sizes, appropriate ratios of counselors and other support staff to students, and access to health and mental health services. Federal, state and local leaders should account for the differing needs of students by supporting weighted school funding formulas that provide more resources for students with greater needs… (p. 36)

The necessity for schools and districts serving greater numbers of students with significant needs to receive funding commensurate with those numbers and needs has been underscored by the challenges posed by the COVID-19 pandemic.

E.2. Increase the number of individuals seeking to become educators (teachers, school counselors, school psychologists, school nurses, speech/language pathologists, social workers, occupational therapists, etc.), and retain those professionals already in the field, by:

- **increasing the salaries for these roles;**
- **subsidize the costs of tests and fees that individuals incur in the process of preparing to become educators;**
- **providing tuition reimbursement to those entering or already serving in these roles; and**
- **providing reimbursement for the costs of certification and renewal.**

The U.S. Department of Education (2021) explains that - after over a year and one-half of operating during the COVID-19 pandemic, "many school districts, straining under logistical challenges and uncertain budgets, have pointed to staffing shortages as an ongoing challenge in supporting students who are struggling" (p. 4). The Department goes on to report, "According to the National Association of Elementary School Principals, nearly 70% of school principals who participated in a survey conducted in early 2021 said they could not meet their students' mental health needs with the staff they had" (p. 4).

The task force agrees with the National Commission on Social, Emotional and Academic Development (2018), which writes:

> In order to attract a highly qualified and diverse educator workforce, state leaders can leverage opportunities and partnerships to expand and strengthen the recruitment mechanisms for future educators. Along with expanded recruitment, there should be a complementary focus on retention connected to ongoing professional support and growth. (p. 29).

Darling-Hammond and Podolsky (2019) report that policymakers in nations with histories of high academic achievement provide resources necessary to ensure

- Teacher compensation competitive with other college-educated professions and
- High-quality preparation available at little or no cost to entering teachers. (p. 29)

E.3. Enhance families' knowledgeable, confident engagement in their children's and adolescents' social, emotional, and academic development.

In its publication *Preventing Adverse Childhood Experiences (ACEs): Leveraging the Best Available Evidence*, the Centers for Disease Control and Prevention (2019) recommends, "Teaching skills to help parents and youth handle stress, manage emotions, and tackle everyday challenges" (p. 9).

The Judicial Branch's Department of Probation oversees an invaluable family engagement initiative. This initiative should continue, and it should be replicated by other agencies, so that families of youth who are no longer involved with the court system may continue to benefit, and the families of youth who have never had such involvement may likewise learn to knowledgeably, confidently engage in their children's and adolescents' social, emotional, and academic development.

E.4. Significantly reduce the number of mandates for schools – especially those serving students with the greatest need, who therefore most require genuinely engaging, culturally responsive instructional practices. While accountability is inarguably necessary, many of the current mechanisms for ensuring it have served to narrow the curriculum, stifle innovation, and render school less engaging for students and educators.

"Administrative burdens," Heinrich, Camacho, Henderson, Hernández, and Joshi (2021) explain, "may have far-reaching individual and systemic consequences – they generate substantial negative externalities…"

> They not only appear to impede children's and families' access to public benefits and social service support that affect their healthy development and well-being, but they also place additional strain on the capacity of public and private nonprofit organizations that serve as the health and social safety net for those in most need, particularly in communities with more limited resources and social service infrastructure. (p. 29)

Moreover, the sociologist Donald T. Campbell (1979) famously explained, "The more any quantitative social indicator is used for social decision-making, the more subject it will be to corruption pressures and the more apt it will be to distort and corrupt the social processes it is intended to monitor…" (p. 84).

Nowhere, perhaps, has Campbell's Law been more evident than in education policy. With good intentions of ensuring equitable outcomes for youngsters from traditionally under-resourced and under-served backgrounds, policymakers have for decades employed stagnant or decreasing scores as justification, not to address underlying societal inequities, but to impose still more prescriptions on the educators who serve these youngsters.

> The consequence of holding everyone accountable to low level tests in reading and math, without building any of the supporting structures, climate, or culture that would enable those results, is that schools serving disadvantaged students **narrowed the curriculum** and focused disproportionately on **test prep**, whereas more advantaged public schools and private schools had flexibility to continue offering a **richer and more holistic educational approach**.
> (Mehta, 2019 - emphasis in the original)

Education scholar Andy Hargreaves (2015) writes,

> Some of America's leading educational academics…repeatedly remind us that most of the variance in student achievement is explained by factors outside the school and beyond the ambit of educational policy and strategy. Poverty, poor infant care, lack of statutory maternity or paternity support, environmental toxins, neighborhood violence, financial insecurity and resulting instability among the working poor – these are the kinds of factors that are the greatest predictors of student underachievement in the United States. (p. 276)

Ironically, the very report that catalyzed the education reforms that have served to exacerbate societal inequities identified this issue nearly four decades ago. In *A Nation at Risk: The Imperative for Educational Reform*, the National Commission on Excellence in Education (1983) explained,

> That we have compromised [the] commitment [to schools and colleges of high quality] is, upon reflection, hardly surprising, given the multitude of often conflicting demands we have placed on our Nation's schools and colleges. They are routinely called on to provide solutions to personal, social, and political problems that the home and other institutions either will not or cannot resolve. We must understand that these demands on our schools and colleges often exact an educational cost as well as a financial one. (p. 1)

"If the goal in the long run is not simply to hold schools accountable but to enable them to consistently produce at higher levels of practice," Harvard's Jal Mehta (2013) explains, "the United States will need to move away from its recurring emphasis on scientific methods of control from above and embrace the more professional path characteristic of top-performing nations" (p. 13). The Task Force believes that there is no better place for this movement to begin than Connecticut.

The U.S. Department of Education (2021) recommends the following action steps:
Action Steps:

- Eliminate ineffective or redundant efforts such as non-instructional administrative duties and non-critical meetings so educators can direct their attention and energy toward better and sustained implementation of high-quality practices for all children or students, especially those with high risk. (p. 20)
- Establish a realistic workload, child or student to teacher ratio, and a manageable approach to teaching an aligned and integrated curriculum for academics and social-emotional, and behavioral health instruction. Feeling competent is part of wellness. When educators feel like they have the skills, resources, and supports to do their job well, they feel less stressed and are able to better meet the needs of their children, students and families… (p. 20)
- Integrate wellness into professional development approaches by providing adequate planning time for staff that includes opportunities for collaboration, training, peer coaching, and supportive performance feedback. (p. 21)
- Prioritize collaborative planning time for delivery of instruction…[P]rovide collaborative opportunities to engage in group learning focused on a common issue and grade level/core/department team meetings to create small systems of support for staff…" (p. 21)

E.5. Enhance the instructional and therapeutic capacity of all staff in schools through funding for ongoing, job-embedded professional development, and for additional full-day professional development opportunities beyond the scheduled academic year.

The National Commission on Social, Emotional, and Academic Development (2018) explains:

> The understanding that learning is social, emotional, and cognitive should be applied to both adults' and students' learning experiences. However, today's educators typically receive limited pre-service or

> in-service training on how to promote the development of these skills or how to construct learning environments that promote their development or practice. To ensure young people gain the broad set of skills necessary for success requires comprehensively training and developing the educators who support them. (p. 28)

Darling-Hammond and Podolsky (2019) report that policymakers in academically high-achieving nations provide "readily available support from trained mentors for beginning teachers" and "ongoing time and support for professional learning and collaboration" (p. 29). School leaders in Connecticut's public schools endeavor to provide these supports to their faculty and staff members, but persistently inequitable funding inhibits this in the schools and districts that serve communities with the greatest concentrations of need.

The Task Force endorses Connecticut Voices for Children's (2021) recommendation that the Connecticut General Assembly:

> Increase funding for behavioral health support staff in schools including counselors, psychologists, and social workers. Behavioral health support staff spend years in higher education learning to support positive school environments, connect with and support families, and identify when children are struggling and intervene before crises emerge. (p. 16)

Citing the long-term impacts of what has already been a protracted COVID-19 pandemic, the U.S. Department of Education (2021) explains:

> There is a critical need for **all staff** in schools (e.g., administrators, educators, school nurses, community health workers, family advocates, family resource developers, school liaisons, teacher aides, teacher assistants, student aides, class aides, behavior coaches, behavior interventionists, behavior aides) to be trained to fully support schools' Tier 1 (promotion prevention) and Tier 2 (early intervention) programming…[S]chools and programs are and will be contending with significantly elevated child and student social, emotional, and behavioral concerns as well as addressing the lost instructional time associated with the pandemic. (p. 31 - emphasis in the original)

The U.S. Department of Education (2021) goes on to recommend that we:

- Modify or extend pre- and in-service professional development to include mental health training. Ensure that teacher preservice programs include mental health training. Offer blended professional development for teachers and other service providers so evidence-based practices can be implemented effectively and with high fidelity… (p. 32); and
- Implement coaching models to further strengthen teachers' mental health knowledge and capacity…" (p. 32)

E.6. Increase access to hands-on job-training programs, leadership development opportunities, and civic engagement opportunities for children and adolescents, especially those from families with limited means.

Connecticut's Judicial Branch and the Connecticut Department of Children and Families both provide these kinds of opportunities to children and adolescents who are involved with their respective systems. These programs should continue, and they should be expanded and extended so that youth who are no longer involved with these systems may continue to access them, and so that youth who have had no such involvement may benefit from them.

This recommendation reinforces that made by the Department of Public Health (2021) in its publication *Healthy Connecticut 2025 - State Health Improvement Plan*:

> Increase the number of opportunities for children, young adults, adults, and retirees/older adults for equitable, affordable education on career development and personal finance… (p. 52)

The Commission on Human Rights and Opportunities has a robust internship program available to high school students, college students, and students in law or graduate programs. These students have the opportunity to engage in a variety of civil rights issues including the planning of a summer symposium and the mediation of discrimination complaints. Funding for financial stipends for students would allow CHRO to expand the program, particularly to those students who may not be able to afford to work an unpaid internship.

SUPPORTED: ***Each student has access to personalized learning and is supported by qualified, caring adults.***

Su.1. Increase the diversity of professionals in both the mental/behavioral health and education fields. (Tuition reimbursement in both areas, coupled with strategic, long-term recruiting beginning in high school, will contribute to achieving this goal.)

This recommendation echoes the aim articulated in the 2021 Annual Report for the Connecticut Children's Behavioral Health Plan to "develop new partnerships and strategies to increase behavioral health workforce diversity to be more reflective of the children and families seeking services."

The Department of Public Health (2021) asserts, "Access to health care impacts one's overall physical, social, and mental health status and quality of life. It is important to recognize that comfort and trust in a health care provider may mean finding a provider who is not only culturally humble but who looks like the patients he or she serves" (p. 43).

The same can be said of the educators by whom students and families are supported, which is why the ongoing work of Connecticut's Commission on Human Rights and Opportunities and the Connecticut State Department of Education to increase minority teacher recruitment and retention are so crucial.

Citing the fact that "Connecticut has the fifth highest [racial and ethnic] education disparity in the United States, and the highest of the six New England states," Troyer (2019) suggests, "One possible explanation for the disparity is a lack of representation. Until 2018, 23 school districts didn't have a single person of color on staff" (p. 63).

Su.2. Provide greater supports – in school and out – for children and adolescents who have been disengaged in or disconnected from school due to social-emotional concerns, academic delays, suspensions/expulsions.

The Task Force recommends that greater resources be invested in supporting children and adolescents who are disengaged in or disconnected from school. These additional resources could be allocated to state and local agencies, as well as to not-for-profit organizations that train and employ Youth Development Professionals who facilitate children's and adolescents' access to school and the requisite supports.

"**Disengaged youth** are enrolled in school, but show at least one of three signs of not being effectvively connected to their education" – that is, they miss approximately 25 or more days of school per year; they have two or more suspensions or expulsions; and/or they have failed two or more courses per year (Parthenon - EY Education Practices, 2016, p. 8 – emphasis added).

"**Disconnected youth** have not received a high school diploma or equivalent and are not enrolled in high school despite being 21 or younger" (Parthenon - EY Education Practices, 2016, p. 21 – emphasis added).

"Finding ways to keep young people engaged in high school, and to re-engage young people who are disconnected, is an urgent need not just for the public education system, but also for the whole state" (Parthenon - EY Education Practices, 2016, p. 16).

Public Health - "Disconnected youth in Connecticut aged 18-24 are more than twice as likely to experience health challenges as peers their age, and 33% more likely to be struggling with substance abuse" (Parthenon - EY Education Practices, 2016, p. 15).

Racial Equity - “Disengaged and disconnected youth are more than twice as likely to be black or Hispanic versus all other students in the state, and nearly three times as likely to be boys of color” (Parthenon - EY Education Practices, 2016, p. 15).

Economic Development - “Disconnected youth in Connecticut aged 18-24 have a 34% unemployment rate, 2.5 times the rate of all other young people in the state” (Parthenon - EY Education Practices, 2016, p. 15).

School to Prison Pipeline - “Disconnected youth in Connecticut aged 18-24 are five times more likely to be incarcerated than their peers who completed high school, at an annual cost of more than $50,000 per inmate” (Parthenon - EY Education Practices, 2016, p. 15).

Fiscal Sustainability - “On average, Connecticut spends almost four times more on health care, corrections and welfare programs or a high school dropout than for other citizens” (Parthenon - EY Education Practices, 2016, p. 15).

“Once a student disconnects from high school in Connecticut, the odds that he or she effectively re-engages and earns a diploma are low. Of all students who dropped out of a Connecticut high school between 2012 and 2014:

- Only 12% ever re-enrolled in any public high school (including alternative schools).
- Only 1% ever attained a high school diploma.
- Only 9% achieved a GED or credit diploma through the adult education system.

(Parthenon - EY Education Practices, 2016, p. 17)

“These findings pose a dual challenge: the need for more high-quality supports for the 14,000 disconnected youth in Connecticut today that are at risk of falling into a cycle of poverty, absent help to get back on track; and the need for creative thinking and deeper investment in new strategies, collaborations and program approaches to more effectively engage students while they are enrolled in school. The incentive is clear to focus on preventing disengaged youth from becoming disconnected in the first place” (p. 17).

“Helping disengaged and disconnected youth connect to success would spark a virtuous cycle for both these young people and the state as a whole: stronger schools, higher employment, fewer individuals becoming involved with incarceration or addiction, healthier and more prosperous communities, and more rapid and sustainable economic growth…” (Parthenon - EY Education Practices, 2016, p. 5).

CHALLENGED: ***Each student is challenged academically and prepared for success in college or further study and for employment and participation in a global environment.***

C.1. Offer all children the ability to attend preschool free-of-charge beginning at age 3.

The Task Force recognizes that children's earliest years are critical to their cognitive, behavioral, social, and emotional development. High-quality early childhood educational opportunities serve to mitigate against Adverse Childhood Experiences (CDC, 2019, p. 15), and are crucial to youngsters' future academic, social, and vocational success.

Furthermore, the Task Force understands that gaps in preschool access exist between children whose parents have higher income and educational attainment and those whose parents have lower income and less educational attainment. This differential access to, and utilization of, early childhood programs exacerbates existing inequalities in childhood development and eventual academic and economic outcomes (Council of Economic Advisers, 2014).

Moreover, the Task Force appreciates that investments in early childhood programs have been shown to yield financial dividends, not only for participating children themselves (in the form of higher eventual earnings) but also for the economy as a whole (Council of Economic Advisers, 2014; Liebtag, 2018).

C.2. Expand CSCU's PACT (Pledge to Advance Connecticut) program to cover:

- **students already enrolled in community colleges;**
- **students who need to enroll part-time, due to family or work obligations.**

The PACT program is laudable. Regrettably, though, it ignores the fact that many students who begin their higher education experiences in community colleges, rather than in four-year colleges or universities, do so because of limited resources and/or the need to balance their studies with work, child care, and/or other family obligations by enrolling part-time rather than full-time. Expanding eligibility for the PACT program to students who are already enrolled in community colleges, as well as to students who need to enroll on a part-time basis, will better serve the needs of a great many students and families in Connecticut, and will better reflect the historic mission of the state's community colleges.

C.3. Return Connecticut's funding for state colleges and universities to pre-recession levels in order to increase access for young people whose families have limited means.

Adjusted for inflation, Connecticut's funding for public higher education remains 21% below what it had been before the onset of the Great Recession (Mitchell, Leachman, & Saenz, 2019).

The failure of the state government to adequately fund higher education negatively impacts students, both by adding to their out-of-pocket costs and by compromising the quality of their learning experiences. Still worse, they exacerbate existing inequality, by making higher education less accessible to low-income students and students of color (Mitchell, Leachman, & Saenz, 2019).

31. Extend the authorization of the Task Force to Study the Comprehensive Needs of Children in the State by one year (i.e., until January 1, 2023).

In order that we may propose, and testify in support of, legislation to advance our various other recommendations, the Task Force to Study the Comprehensive Needs of Children in the State recommends that our authorization be extended by one calendar year (i.e., until January 1, 2023).

References

Annie E. Casey Foundation. *2021 Kids Count Data Book: State Trends in Child Well-Being*. Author: Baltimore, MD.

ASCD Whole Child Network (2020). *The Learning Compact Renewed: Whole Child for the Whole World.* Author: Alexandria, VA.

Center on the Developing Child, Harvard University (2011). *Building the Brain's "Air Traffic Control" System: How Early Experiences Shape the Development of Executive Function: Working Paper 11.* Author: Cambridge, MA.

Connecticut Children's Behavioral Health Plan Implementation Advisory Board (2021). *Connecticut Children's Behavioral Health Plan: 2021 Annual Report.* Author: Hartford, CT.

Connecticut Department of Housing (2020). *State of Connecticut 2020-24 Consolidated Plan for Housing and Community Development*. Author: Hartford CT.

Connecticut Department of Public Health (2021). *Healthy Connecticut 2025: State Healthy Improvement Plan.* Author: Hartford, CT.

Connecticut Department of Social Services (2017). *Medicaid School Based Child Health Program: User Guide.* Author: Hartford, CT.

Connecticut United Ways (2020). *ALICE in Connecticut: A Financial Hardship Study*.

Connecticut Voices for Children (2021). *2021 Legislative Session Review: Legislative Brief June 2021 by Connecticut Voices for Children Staff*. Author: New Haven, CT.

Council of Economic Advisers (2014). *The Economics of Early Childhood Investments.* Author: Washington, DC.

Darling-Hammond, L. & Podolsky, A. (2019). Breaking the cycle of teacher shortages: What kind of policies can make a difference? *Education Policy Analysis Archives, 27*(34).

DeLuca, S. & Clampet-Lundquist, S. (2016). *The Cycle of Poverty Is Not Inevitable: Lessons from Baltimore's Resilient Youth.* Washington, DC: The Century Foundation.

Edelman, P. (2012). *So Rich, So Poor: Why It's So Hard to End Poverty in America*. New Press: New York.

Hargreaves, A. (2015). The iniquity of inequity: And some international clues about ways to address it. (In Blankstein, A.M. & Noguera, P., eds.) *Excellence through Equity: Five*

principles of courageous leadership to guide achievement for every student. ASCD: Alexandria, VA.

Hunt / Kean Leadership Fellows. (2021). *Childhood Education: Issue Brief 2021.* The Hunt Institute: Cary, NC.

Kantor, H. & Lowe, R. (2013). Educationalizing the welfare state and privatizing education: The evolution of social policy since the new deal. In Carter, P.L. & Welner, K.G. (Eds.) *Closing the Opportunity Gap: What America Must Do to Give Every Child an Even Chance* (pp. 25-39). Oxford University Press: Oxford, UK.

Liebtag, E. (2018). Early childhood: What we know, and what's possible. *Getting Smart*, January 30, 2018. Retrieved from: https://www.gettingsmart.com/2018/01/30/early-learning-what-we-know-and-where-we-are-headed/

Mapp, S. & Gabel, S.G. (2019). It is easier to build strong children than to repair broken men. *Journal of Human Rights and Social Work, 4*, 145-146.

Maslow, A. H. (1943). A theory of human motivation. *Psychological Review*, *50*(4), 370–396.

Mehta, J. (2013). The penetration of technocratic logic into the educational field: Rationalizing schooling from the progressives to the present. *Teachers College Record, 115*(5), 1-36.

Mehta, J. (2019). Why equity has been a conservative force in American education – and how that could change. *Education Week's Blogs,* February 14, 2019.

Mitchell, M., Leachman, M., and Saenz, M. (2019). *State higher education funding cuts have pushed costs to students, worsened inequality.* Center for Budget and Policy Priorities: Washington, DC.

National Commission on Excellence in Education (1983). *A Nation at Risk: The Imperative for Educational Reform, A Report to the Nation and the Secretary of Education.* United States Department of Education: Washington, DC

National Commission on Social, Emotional, and Academic Development (2018). *A Policy Agenda in Support of How Learning Happens.* Aspen Institute: Washington, DC.

Parthenon-EY Education Practice (2016). *Untapped Potential: Engaging all Connecticut Youth.* Dalio Foundation: Westport, CT.

Reynolds, J. (2021). *The Late Show with Stephen Colbert (12/3/21).* https://www.youtube.com/watch?v=nNzYE_4DdtA

Sandy Hook Advisory Commission (2015). *Final Report of the Sandy Hook Advisory Commission*. Author: Hartford, CT.

School + State Finance Project (2020). *Mismatch Between Funding & Student Needs in CT: Policy Brief, July 28, 2020.* Retrieved from: www.schoolstatefinance.org

Slade., S., & Griffith, D. (2013). A whole child approach to student success. *KEDI Journal of Educational Policy*, Special Issue (2013), 21-35.

Troyer, M. (2019). States with the worst education disparity. (January 26, 2019.) Retrieved from: https://stacker.com/stories/2398/states-worst-education-disparity

U.S. Department of Education, Office of Civil Rights (2021). *Education in a Pandemic: The Disparate Impacts of COVID-19 on America's Students.* Author: Washington, DC.

U.S. Department of Education, Office of Special Education and Rehabilitative Services (2021a). *Supporting Child and Student Social, Emotional, Behavioral, and Mental Health Needs.* Author: Washington, DC.

Appendices

Consolidated Recommendations

HEALTHY
H.1. Increase children's access to preventative care to promote their medical, dental, and social-emotional health.
H.2. Make health care costs – including the costs of behavioral and mental health care – affordable for families.
H.3. Increase availability of settings (telehealth, out-patient, and in-patient) for mental health preventive care, treatment, and crisis intervention for individuals of all ages.
H.4. Expand access to treatment services for addiction for individuals of all ages.
H.5. Enhance – and provide sufficient resources, including personnel and training for – schools' efforts to promote students' social and emotional health; to teach social-emotional and relationship skills; and to implement disciplinary policies and practices that are educative and restorative.

H.6. Address payment/reimbursement issues for pay-for-service in the school setting. (Statutory language allowing five sessions before parental notification prevents those sessions from being eligible for reimbursement.)

Waive elements of the comprehensive psychosocial assessment or timeline for completion: Create a core set of necessary psychosocial elements to be completed that are consistent with health care more broadly. Extend the time for clinicians to document all of the psychosocial elements (often close to 20 separate elements) over a series of sessions and as relevant to the individual's care.

Extend deadlines for service or treatment plan: Most states require that a service plan is in place within three-to seven days of the first appointment. Allow a clinical program to create a service plan within 30 days to support more attention on the individual's needs and clinical relief up front with a plan tailored to patient specific goals.

Consider eliminating the requirement that the treatment plan be a separate document: Update treatment plans as part of the clinical documentation in each session, as is done in primary health care. Standard medical care integrates the treatment plan into the body of the visit note, allowing the plan to be reviewed and updated at each visit.

Long-term, states need to advocate with federal agencies such as the Centers for Medicare and Medicaid Services (CMS) to allow a more streamlined and responsive service planning that is updated at each visit rather than maintaining the requirement that behavioral health treatment plans be developed as a separate document that is updated every 90 – 120 days.

H.7. Increase the number of individuals seeking to become mental health and behavioral health providers, and retain those professionals already in the field, by:

- increasing the rates paid for services;
- providing tuition reimbursement to those entering or already serving in these roles; and
- providing reimbursement for the costs of licensure and renewal.

H.8. Attend to the wellness of educators and other personnel who serve children and adolescents – both in school and out.

H.9. Increase awareness of nutrition programs offered through the Connecticut Department of Agriculture and the Connecticut Department of Public Health, including but not limited to, the Farmer's Market Nutrition Program.

H.10. Increase the number of employers across sectors that offer equitable and sustainable employment opportunities for all levels and demographics.
H.11. Increase funding to expand parents' and caregivers' access to the Connecticut Department of Labor's various job-training and workforce development programs.
H.12. Create a Connecticut Child Tax Credit
H.13. Expand access to affordable, high-quality child care and preschool; and ensure that the professionals who staff those programs are paid at competitive rates that reflect their levels of education and training, and the responsibility that they hold.
H.14. Address homelessness among adolescents – particularly those who identify as LGBTQIA+.
H.15. Establish a reimbursement mechanism (e.g. under Medicaid) for Occupational Therapy/ Executive Function supports, and ensure that such services are made more broadly available to children in all settings.
SAFE
Sa.1. Increase families' access to safe, affordable housing by: ● increasing the stock of affordable housing; ● increasing housing subsidies, so that families are not required to spend more than 30% of their income on housing.
Sa.2. Enact zoning reform to ensure that safe, affordable housing is available in <u>all</u> communities.
Sa.3. Increase children's and adolescents' access to mentoring programs and after-school programs.
Sa.4. Increase Access to Public Transportation

ENGAGED

E.1. Fully fund the Education Cost Sharing formula passed by the CGA in October 2017 in advance of the projected FY 2028 date.

E.2. Increase the number of individuals seeking to become educators (teachers, school counselors, school psychologists, school nurses, speech/language pathologists, social workers, occupational therapists, etc.), and retain those professionals already in the field, by:

- increasing the salaries for these roles;
- subsidizing the costs of tests and fees that individuals incur in the process of preparing to become educators;
- providing tuition reimbursement to those entering or already serving in these roles; and
- providing reimbursement for the costs of certification and renewal.

E.3. Enhance families' knowledgeable, confident engagement in their children's and adolescents' social, emotional, and academic development.

E.4. Significantly reduce the number of mandates for schools – especially those serving students with the greatest need, who therefore most require genuinely engaging, culturally responsive instructional practices. While accountability is inarguably necessary, many of the current mechanisms for ensuring it have served to narrow the curriculum, stifle innovation, and render school less engaging for students and educators.

E.5. Enhance the instructional and therapeutic capacity of all staff in schools through funding for ongoing, job-embedded professional development, and for additional full-day professional development opportunities beyond the scheduled academic year.

E.6. Increase access to hands-on job-training programs, leadership development opportunities, and civic engagement opportunities for adolescents, especially those from families with limited means.

SUPPORTED
Su.1. Increase the diversity of professionals in both the mental/behavioral health and education fields. (Tuition reimbursement in both areas, coupled with strategic, long-term recruiting beginning in high school, will contribute to achieving this goal.)
Su.2. Provide greater supports – in school and out – for children and adolescents who have been disconnected from school due to social-emotional concerns, academic delays, suspensions/expulsions.
CHALLENGED
C.1. Offer all children the ability to attend preschool free-of-charge beginning at age 3.
C.2. Expand CSCU's PACT (Pledge to Advance Connecticut) program to cover: • students already enrolled in community colleges; • students who need to enroll part-time, due to family or work obligations.
C.3. Return Connecticut's funding for state colleges and universities to pre-recession levels in order to increase access for young people whose families have limited means.
31. Extend the authorization of the Task Force to Study the Comprehensive Needs of Children in the State by one year (i.e., until January 1, 2023).

Substitute Senate Bill No. 2

Public Act No. 21-46

AN ACT CONCERNING SOCIAL EQUITY AND THE HEALTH, SAFETY AND EDUCATION OF CHILDREN.

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

Section 1. (NEW) (*Effective July 1, 2021*) (a) As used in this section, (1) "evidence-based" describes a training program that (A) incorporates methods demonstrated to be effective for the intended population through scientifically based research, including statistically controlled evaluations or randomized trials, (B) can be implemented with a set of procedures to allow successful replication in the state, (C) achieves sustained, desirable outcomes, and (D) when possible, has been determined to be cost-beneficial, and (2) "Question, Persuade and Refer (QPR) Institute Gatekeeper Training" means an educational program designed to teach lay and professional persons who work with youth the warning signs of a suicide crisis and how to respond.

(b) The Youth Suicide Advisory Board, established pursuant to section 17a-52 of the general statutes, and the Office of the Child Advocate, shall jointly administer an evidence-based youth suicide prevention training program in each local health department and district department of health formed pursuant to section 19a-241 of the general statutes. The training program shall provide certification in QPR Institute Gatekeeper Training, utilizing a training model that will enable

participants to provide QPR Institute Gatekeeper Training to other individuals upon completion of the training program. Such training program shall be offered not later than July 1, 2022, and at least once every three years thereafter.

(c) The director of health for each local health department and district department of health shall determine the eligibility criteria for participation in the youth suicide prevention training program. Participants shall be members of the following groups within such district: (1) Employees of such local health department and district department of health, (2) employees of youth service bureaus established pursuant to section 10-19m of the general statutes, (3) school employees, as defined in section 10-222d of the general statutes, (4) employees and volunteers of youth-serving organizations, (5) employees and volunteers of operators of youth athletic activities, as defined in section 21a-432 of the general statutes, (6) employees of municipal social service agencies, (7) members of paid municipal or volunteer fire departments, and (8) members of local police departments. With respect to school employees, such training program may be included as part of an in-service training program provided pursuant to section 10-220a of the general statutes, as amended by this act.

(d) Any individual who has received certification in QPR Institute Gatekeeper Training through the training program administered pursuant to subsection (b) of this section may, during the period in which such certification is valid, provide QPR Institute Gatekeeper Training to any member of a group described in subdivisions (1) to (8), inclusive, of subsection (c) of this section and members of the public.

(e) The Youth Suicide Advisory Board and the Office of the Child Advocate may contract with a nongovernmental entity that provides evidence-based suicide prevention training to carry out the provisions of this section.

Sec. 2. (NEW) (*Effective July 1, 2021*) (a) As used in this section:

(1) "Contact hour" means a minimum of fifty minutes of continuing education and activities; and

(2) "Registration period" means the one-year period for which a license has been renewed in accordance with section 19a-88 of the general statutes and is current and valid.

(b) For registration periods beginning on and after January 1, 2022, a physician assistant licensed pursuant to chapter 370 of the general statutes applying for license renewal shall, during the first renewal period and not less than once every six years thereafter, earn not less than two contact hours of training or education administered by the American Association of Physician Assistants, a hospital or other licensed health care institution or a regionally accredited institution of higher education, on (1) screening for post-traumatic stress disorder, risk of suicide, depression and grief, and (2) suicide prevention training.

(c) Each physician assistant applying for license renewal pursuant to section 19a-88 of the general statutes shall sign a statement attesting that he or she has satisfied the continuing education requirements of subsection (b) of this section on a form prescribed by the Department of Health. Each licensee shall retain records of attendance or certificates of completion that demonstrate compliance with the continuing education requirements of subsection (b) of this section for a minimum of three years following the year in which the continuing education was completed and shall submit such records or certificates to the department for inspection not later than forty-five days after a request by the department for such records or certificates.

Sec. 3. Subsection (a) of section 20-73b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(a) Except as otherwise provided in this section, each physical therapist licensed pursuant to this chapter shall complete a minimum of twenty hours of continuing education during each registration period. For purposes of this section, registration period means the twelve-month period for which a license has been renewed in accordance with section 19a-88 and is current and valid. The continuing education shall be in areas related to the individual's practice, except, on and after January 1, 2022, shall include not less than two hours of training or education on (1) screening for post-traumatic stress disorder, risk of suicide, depression and grief, and (2) suicide prevention training, during the first registration period in which continuing education is required and not less than once every six years thereafter. The requirement described in subdivision (2) of this subsection may be satisfied by the completion of the evidence-based youth suicide prevention training program administered pursuant to section 1 of this act. Qualifying continuing education activities include, but are not limited to, courses offered or approved by the American Physical Therapy Association or any component of the American Physical Therapy Association, a hospital or other licensed health care institution or a regionally accredited institution of higher education.

Sec. 4. Section 20-74h of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

Licenses for occupational therapists and occupational therapy assistants issued under this chapter shall be subject to renewal once every two years and shall expire unless renewed in the manner prescribed by regulation upon the payment of two times the professional services fee payable to the State Treasurer for class B as defined in section 33-182*l*, plus five dollars. The department shall notify any person or entity that fails to comply with the provisions of this section that the person's or entity's license shall become void ninety days after the time for its renewal unless it is so renewed. Any such license

shall become void upon the expiration of such ninety-day period. The commissioner shall establish additional requirements for licensure renewal which provide evidence of continued competency, which, on and after January 1, 2022, shall include not less than two hours of training or education, offered or approved by the Connecticut Occupational Therapy Association, a hospital or other licensed health care institution or a regionally accredited institution of higher education, on (1) screening for post-traumatic stress disorder, risk of suicide, depression and grief, and (2) suicide prevention training during the first renewal period and not less than once every six years thereafter. The requirement described in subdivision (2) of this section may be satisfied by the completion of the evidence-based youth suicide prevention training program administered pursuant to section 1 of this act. The holder of an expired license may apply for and obtain a valid license only upon compliance with all relevant requirements for issuance of a new license. A suspended license is subject to expiration and may be renewed as provided in this section, but such renewal shall not entitle the licensee, while the license remains suspended and until it is reinstated, to engage in the licensed activity, or in any other conduct or activity in violation of the order or judgment by which the license was suspended. If a license revoked on disciplinary grounds is reinstated, the licensee, as a condition of reinstatement, shall pay the renewal fee.

Sec. 5. (NEW) (*Effective July 1, 2021*) (a) As used in this section:

(1) "Contact hour" means a minimum of fifty minutes of continuing education and activities; and

(2) "Registration period" means the one-year period for which a license has been renewed in accordance with section 19a-88 of the general statutes and is current and valid.

(b) For registration periods beginning on and after January 1, 2022, a registered nurse licensed pursuant to chapter 378 of the general statutes

who is actively practicing in this state, and a licensed practical nurse licensed pursuant to chapter 378 of the general statutes who is actively practicing in this state, applying for license renewal shall, during the first renewal period and not less than once every six years thereafter, earn not less than two contact hours of training or education on (1) screening for conditions such as post-traumatic stress disorder, risk of suicide, depression and grief, and (2) suicide prevention training. For purposes of this section, qualifying continuing education activities include, but are not limited to, in-person and online courses offered or approved by the American Nurses Association, Connecticut Hospital Association, Connecticut Nurses Association, Connecticut League for Nursing, a specialty nursing society or an equivalent organization in another jurisdiction, an educational offering sponsored by a hospital or other health care institution or a course offered by a regionally accredited academic institution or a state or local health department.

(c) Each registered nurse and licensed practical nurse applying for license renewal pursuant to section 19a-88 of the general statutes shall sign a statement attesting that he or she has satisfied the continuing education requirements of subsection (b) of this section on a form prescribed by the Department of Public Health. Each licensee shall retain records of attendance or certificates of completion that demonstrate compliance with the continuing education requirements of subsection (b) of this section for a minimum of three years following the year in which the continuing education was completed and shall submit such records or certificates to the department for inspection not later than forty-five days after a request by the department for such records or certificates.

Sec. 6. Subsection (a) of section 20-102ee of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(a) The Commissioner of Public Health shall adopt regulations, in

accordance with the provisions of chapter 54, concerning the regulation of nurse's aides. Such regulations shall require a training program for nurse's aides of not less than one hundred hours. Not less than seventy-five of such hours shall include, but not be limited to, basic nursing skills, personal care skills, care of cognitively impaired residents, recognition of mental health and social service needs, basic restorative services and residents' rights. Not less than twenty-five of such hours shall include, but not be limited to, specialized training in understanding and responding to challenging behaviors related to physical, psychiatric, psychosocial and cognitive disorders. On and after January 1, 2022, not less than two of such hours shall include (1) screening for post-traumatic stress disorder, risk of suicide, depression and grief, and (2) suicide prevention training offered or approved by the American Nurses Association, Connecticut Hospital Association, Connecticut Nurses Association or Connecticut League for Nursing, a specialty nursing society or equivalent organization in another jurisdiction, a hospital or other health care institution, a regionally accredited academic institution, or a state or local health department. The requirement described in subdivision (2) of this section may be satisfied by the completion of the evidence-based youth suicide prevention training program administered pursuant to section 1 of this act.

Sec. 7. Subsection (b) of section 20-185k of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(b) A license issued under this section may be renewed annually. The license shall be renewed in accordance with the provisions of section 19a-88, for a fee of one hundred seventy-five dollars. Each behavior analyst applying for license renewal shall furnish evidence satisfactory to the commissioner of (1) having current certification with the Behavior Analyst Certification Board, and (2) on and after January 1, 2022,

completing not less than two hours of training or education, offered or approved by the Connecticut Association for Behavior Analysis, a hospital or other licensed health care institution or a regionally accredited institution of higher education, on (A) screening for post-traumatic stress disorder, risk of suicide, depression and grief, and (B) suicide prevention training, during the first renewal period and not less than once every six years thereafter. The requirement described in subparagraph (B) of this subdivision may be satisfied by the completion of the evidence-based youth suicide prevention training program administered pursuant to section 1 of this act.

Sec. 8. Subsection (f) of section 20-195ttt of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(f) A certification issued under this section may be renewed every three years. The license shall be renewed in accordance with the provisions of section 19a-88 for a fee of one hundred dollars. Each certified community health worker applying for license renewal shall furnish evidence satisfactory to the commissioner of having completed a minimum of thirty hours of continuing education requirements, including two hours focused on cultural competency, systemic racism or systemic oppression, **[**and**]** two hours focused on social determinants of health and on and after January 1, 2022, two hours of training on (1) screening for post-traumatic stress disorder, risk of suicide, depression and grief, and (2) suicide prevention, provided by the Community Health Worker Advisory Body or training or education providers approved by the Community Health Worker Advisory Body. The requirement described in subdivision (2) of this subsection may be satisfied by the completion of the evidence-based youth suicide prevention training program administered pursuant to section 1 of this act.

Sec. 9. Section 20-206mm of the general statutes is repealed and the

following is substituted in lieu thereof (*Effective July 1, 2021*):

(a) Except as provided in subsections (b) and (c) of this section, an applicant for a license as a paramedic shall submit evidence satisfactory to the Commissioner of Public Health that the applicant has successfully (1) completed a paramedic training program approved by the commissioner, (2) for applicants applying on and after January 1, 2020, completed mental health first aid training as part of a program provided by an instructor certified by the National Council for Behavioral Health, and (3) passed an examination prescribed by the commissioner.

(b) An applicant for licensure by endorsement shall present evidence satisfactory to the commissioner that the applicant (1) is licensed or certified as a paramedic in another state or jurisdiction whose requirements for practicing in such capacity are substantially similar to or higher than those of this state and that the applicant has no pending disciplinary action or unresolved complaint against him or her, or (2) (A) is currently licensed or certified as a paramedic in good standing in any New England state, New York or New Jersey, (B) has completed an initial training program consistent with the National Emergency Medical Services Education Standards, as promulgated by the National Highway Traffic Safety Administration for the paramedic scope of practice model conducted by an organization offering a program that is recognized by the national emergency medical services program accrediting organization, (C) for applicants applying on or after January 1, 2020, has completed mental health first aid training as part of a program provided by an instructor certified by the National Council for Behavioral Health, and (D) has no pending disciplinary action or unresolved complaint against him or her.

(c) Any person who is certified as an emergency medical technician-paramedic by the Department of Public Health on October 1, 1997, shall be deemed a licensed paramedic. Any person so deemed shall renew his license pursuant to section 19a-88 for a fee of one hundred fifty-five

dollars.

(d) On or after January 1, 2020, each person seeking certification as an emergency medical responder, emergency medical technician or advanced emergency medical technician shall apply to the department on forms prescribed by the commissioner. Applicants for certification shall comply with the following requirements: (1) For initial certification, an applicant shall present evidence satisfactory to the commissioner that the applicant (A) has completed an initial training program consistent with the National Emergency Medical Services Education Standards, as promulgated by the National Highway Traffic Safety Administration for the emergency medical responder, emergency medical technician or advanced emergency medical technician curriculum, (B) has passed the examination administered by the national organization for emergency medical certification for an emergency medical responder, emergency medical technician or advanced emergency medical technician as necessary for the type of certification sought by the applicant or an examination approved by the department, and (C) has no pending disciplinary action or unresolved complaints against such applicant, (2) a certificate issued under this subsection shall be renewed once every two years in accordance with the provisions of section 19a-88 upon presentation of evidence satisfactory to the commissioner that the applicant (A) has successfully completed continuing education for an emergency medical responder, emergency medical technician or advanced emergency medical technician as required by the national organization for emergency medical certification or as approved by the department, or (B) presents a current certification as an emergency medical responder, emergency medical technician or advanced emergency medical technician from the national organization for emergency medical certification, or (3) for certification by endorsement from another state, an applicant shall present evidence satisfactory to the commissioner that the applicant (A) is currently certified as an emergency medical responder, emergency

medical technician or advanced emergency medical technician in good standing by a state that maintains certification or licensing requirements that the commissioner determines are equal to or greater than those in this state, or (B) holds a current certification as an emergency medical responder, emergency medical technician or advanced emergency medical technician from the national organization for emergency medical certification.

(e) On or after January 1, 2022, each person seeking renewal of a certification as an emergency medical responder or emergency medical technician under subdivision (2) of subsection (d) of this section, shall present evidence satisfactory to the commissioner that such person has, in the previous six year period, completed (1) the evidence-based youth suicide prevention training program administered pursuant to section 1 of this act, or (2) not less than two hours of training or education, approved by the Commissioner of Public Health, on (A) screening for post-traumatic stress disorder, risk of suicide, depression and grief, and (B) suicide prevention.

[(e)**]** (f) On or after January 1, 2020, each person seeking certification as an emergency medical services instructor shall apply to the department on forms prescribed by the commissioner. Applicants for certification shall comply with the following requirements: (1) For initial certification, an applicant shall present evidence satisfactory to the commissioner that the applicant (A) is currently certified by the department as an emergency medical technician or advanced emergency medical technician or licensed by the department as a paramedic, (B) has completed a program of training as an emergency medical instructor based on current national education standards within the prior two years, (C) has completed twenty-five hours of teaching activity under the supervision of a currently certified emergency medical services instructor, (D) has completed written and practical examinations as prescribed by the commissioner, (E) has no

pending disciplinary action or unresolved complaints against the applicant, and (F) effective on a date prescribed by the commissioner, presents documentation satisfactory to the commissioner that the applicant is currently certified as an emergency medical technician, advanced emergency medical technician or paramedic by the national organization for emergency medical certification, or (2) for renewal certification, an applicant shall present evidence satisfactory to the commissioner that the applicant (A) has successfully completed continuing education and teaching activity as required by the department, which, on and after January 1, 2022, shall include not less than two hours of training or education, approved by the Commissioner of Public Health, on (i) screening for post-traumatic stress disorder, risk of suicide, depression and grief, and (ii) suicide prevention training, during the first renewal period and not less than once every six years thereafter, (B) maintains current certification by the department as an emergency medical technician, advanced emergency medical technician or licensure by the department as a paramedic, and (C) effective on a date as prescribed by the commissioner, presents documentation satisfactory to the commissioner that the applicant is currently certified as an emergency medical technician, advanced emergency medical technician or paramedic by the national organization for emergency medical certification.

[(f)**]** (g) A certified emergency medical responder, emergency medical technician, advanced emergency medical technician or emergency medical services instructor shall document the completion of his or her continuing educational requirements through the continuing education platform Internet web site. A certified emergency medical responder, emergency medical technician, advanced emergency medical technician or emergency medical services instructor who is not engaged in active professional practice in any form during a certification period shall be exempt from the continuing education requirements of this section, provided the emergency medical responder, emergency medical

technician, advanced emergency medical technician or emergency medical services instructor submits to the department, prior to the expiration of the certification period, an application for inactive status on a form prescribed by the department and such other documentation as may be required by the department. The application for inactive status pursuant to this subsection shall contain a statement that the emergency medical responder, emergency medical technician, advanced emergency medical technician or emergency medical services instructor may not engage in professional practice until the continuing education requirements of this section have been met.

[(g)**]** (h) The commissioner may issue a temporary emergency medical technician certificate to an applicant who presents evidence satisfactory to the commissioner that (1) the applicant was certified by the department as an emergency medical technician prior to becoming licensed as a paramedic pursuant to section 20-206*ll*, or (2) the applicant's certification as an emergency medical technician has expired and the applicant's license as a paramedic has become void pursuant to section 19a-88. Such temporary certificate shall be valid for a period not to exceed one year and shall not be renewable.

[(h)**]** (i) An applicant who is issued a temporary emergency medical technician certificate pursuant to subsection **[**(g)**]** (h) of this section may, prior to the expiration of such temporary certificate, apply to the department for: (1) Renewal of such person's paramedic license, giving such person's name in full, such person's residence and business address and such other information as the department requests, provided the application for license renewal is accompanied by evidence satisfactory to the commissioner that the applicant was under the medical oversight of a sponsor hospital, as those terms are defined in section 19a-175, on the date the applicant's paramedic license became void for nonrenewal; or (2) recertification as an emergency medical technician, provided the application for recertification is accompanied by evidence satisfactory

to the commissioner that the applicant completed emergency medical technician refresher training approved by the commissioner not later than one year after issuance of the temporary emergency medical technician certificate. The department shall recertify such person as an emergency medical technician without the examination required for initial certification specified in regulations adopted by the commissioner pursuant to section 20-206oo.

[(i)] (j) Any person certified as an emergency medical responder, emergency medical technician, advanced emergency medical technician or emergency medical services instructor pursuant to this chapter and the regulations adopted pursuant to section 20-206oo whose certification has expired may apply to the Department of Public Health for reinstatement of such certification, provided such person completes the requirements for renewal certification specified in this section. Any certificate issued pursuant to this section shall remain valid for ninety days after the expiration date of such certificate and become void upon the expiration of such ninety-day period.

[(j)] (k) The Commissioner of Public Health shall issue an emergency medical technician certification to an applicant who is a member of the armed forces or the National Guard or a veteran and who (1) presents evidence satisfactory to the commissioner that such applicant holds a current certification as a person entitled to perform similar services under a different designation by the National Registry of Emergency Medical Technicians, or (2) satisfies the regulations promulgated pursuant to subdivision (3) of subsection (a) of section 19a-179. Such applicant shall be exempt from any written or practical examination requirement for certification.

[(k)] (l) For the purposes of this section, "veteran" means any person who was discharged or released under conditions other than dishonorable from active service in the armed forces and "armed forces" has the same meaning as provided in section 27-103.

Sec. 10. Section 19a-14c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(a) For the purposes of this section, "outpatient mental health treatment" means the treatment of mental disorders, emotional problems or maladjustments with the object of (1) removing, modifying or retarding existing symptoms; (2) improving disturbed patterns of behavior; and (3) promoting positive personality growth and development. Treatment shall not include prescribing or otherwise dispensing any medication which is a legend drug as defined in section 20-571.

(b) A psychiatrist licensed pursuant to chapter 370, a psychologist licensed pursuant to chapter 383, an independent social worker certified pursuant to chapter 383b or a marital and family therapist licensed pursuant to chapter 383a may provide outpatient mental health treatment to a minor without the consent or notification of a parent or guardian at the request of the minor if (1) requiring the consent or notification of a parent or guardian would cause the minor to reject such treatment; (2) the provision of such treatment is clinically indicated; (3) the failure to provide such treatment would be seriously detrimental to the minor's well-being; (4) the minor has knowingly and voluntarily sought such treatment; and (5) in the opinion of the provider of treatment, the minor is mature enough to participate in treatment productively. The provider of such treatment shall document the reasons for any determination made to treat a minor without the consent or notification of a parent or guardian and shall include such documentation in the minor's clinical record, along with a written statement signed by the minor stating that (A) **[**he**]** the minor is voluntarily seeking such treatment; (B) **[**he**]** the minor has discussed with the provider the possibility of involving his or her parent or guardian in the decision to pursue such treatment; (C) **[**he**]** the minor has determined it is not in his or her best interest to involve his or her

parent or guardian in such decision; and (D) [he] the minor has been given adequate opportunity to ask the provider questions about the course of his or her treatment.

(c) [After the sixth session of outpatient mental health treatment provided to a minor pursuant to this section, the provider of such treatment shall notify the minor that the consent, notification or involvement of a parent or guardian is required to continue treatment, unless such a requirement would be seriously detrimental to the minor's well-being. If the provider determines such a requirement would be seriously detrimental to the minor's well-being, he shall document such determination in the minor's clinical record, review such determination every sixth session thereafter and document each such review. If the provider determines such a requirement would no longer be seriously detrimental to the minor's well-being, he shall require the consent, notification or involvement of a parent or guardian as a condition of continuing treatment.] (1) Except as otherwise provided in subdivision (2) of this subsection, a minor may request and receive as many outpatient mental health treatment sessions as necessary without the consent or notification of a parent or guardian. No provider shall notify a parent or guardian of treatment provided pursuant to this section or disclose any information concerning such treatment to a parent or guardian without the consent of the minor.

(2) A provider may notify a parent or guardian of treatment provided pursuant to this section or disclose certain information concerning such treatment without the consent of the minor who receives such treatment provided (A) such provider determines such notification or disclosure is necessary for the minor's well-being, (B) the treatment provided to the minor is solely for mental health and not for a substance use disorder, and (C) the minor is provided an opportunity to express any objection to such notification or disclosure. The provider shall document his or her determination concerning such notification or disclosure and any

objections expressed by the minor in the minor's clinical record. A provider may disclose to a minor's parent or guardian the following information concerning such minor's outpatient mental health treatment: (i) Diagnosis; (ii) treatment plan and progress in treatment; (iii) recommended medications, including risks, benefits, side effects, typical efficacy, dose and schedule; (iv) psychoeducation about the minor's mental health; (v) referrals to community resources; (vi) coaching on parenting or behavioral management strategies; and (vii) crisis prevention planning and safety planning. A provider shall release a minor's entire clinical record to another provider upon the request of the minor or such minor's parent or guardian.

(d) A parent or guardian who is not informed of the provision of outpatient mental health treatment for his or her minor child pursuant to this section shall not be liable for the costs of the treatment provided.

Sec. 11. Subsection (a) of section 10-148a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(a) For the school year commencing July 1, **[**2019**]** 2021, and each school year thereafter, each certified employee shall participate in a program of professional development. Each local and regional board of education shall make available, annually, at no cost to its certified employees, a program of professional development that is not fewer than eighteen hours in length, of which a preponderance is in a small group or individual instructional setting. Such program of professional development shall (1) be a comprehensive, sustained and intensive approach to improving teacher and administrator effectiveness in increasing student knowledge achievement, (2) focus on refining and improving various effective teaching methods that are shared between and among educators, (3) foster collective responsibility for improved student performance, (4) be comprised of professional learning that (A) is aligned with rigorous state student academic achievement standards,

(B) is conducted among educators at the school and facilitated by principals, coaches, mentors, distinguished educators, as described in section 10-145s, or other appropriate teachers, (C) occurs frequently on an individual basis or among groups of teachers in a job-embedded process of continuous improvement, and (D) includes a repository of best practices for teaching methods developed by educators within each school that is continuously available to such educators for comment and updating, and (5) include training in culturally responsive pedagogy and practice. Each program of professional development shall include professional development activities in accordance with the provisions of subsection (b) of this section. The principles and practices of social-emotional learning shall be integrated throughout the components of such program of professional development described in subdivisions (1) to (5), inclusive, of this subsection.

Sec. 12. Subsection (b) of section 10-220a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(b) Not later than a date prescribed by the commissioner, each local and regional board of education shall establish a professional development and evaluation committee. Such professional development and evaluation committee shall consist of (1) at least one teacher, as defined in subsection (a) of section 10-144d, selected by the exclusive bargaining representative for certified employees chosen pursuant to section 10-153b, (2) at least one administrator, as defined in subsection (a) of section 10-144e, selected by the exclusive bargaining representative for certified employees chosen pursuant to section 10-153b, and (3) such other school personnel as the board deems appropriate. The duties of such committees shall include, but not be limited to, participation in the development or adoption of a teacher evaluation and support program for the district, pursuant to section 10-151b, and the development, evaluation and annual updating of a

comprehensive local professional development plan for certified employees of the district. Such plan shall: (A) Be directly related to the educational goals prepared by the local or regional board of education pursuant to subsection (b) of section 10-220, as amended by this act, (B) on and after July 1, **[**2011**]** 2021, be developed with full consideration of the priorities and needs related to student social-emotional learning, in accordance with the provisions of section 10-148a, as amended by this act, and student academic outcomes as determined by the State Board of Education, **[**and**]** (C) provide for the ongoing and systematic assessment and improvement of both teacher evaluation and professional development of the professional staff members of each such board, including personnel management and evaluation training or experience for administrators, **[**shall**]** and (D) be related to regular and special student needs and may include provisions concerning career incentives and parent involvement. The State Board of Education shall develop guidelines to assist local and regional boards of education in determining the objectives of the plans and in coordinating staff development activities with student needs and school programs.

Sec. 13. Subsection (b) of section 10-220 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(b) The board of education of each local or regional school district shall, with the participation of parents, students, school administrators, teachers, citizens, local elected officials and any other individuals or groups such board shall deem appropriate, prepare a statement of educational goals for such local or regional school district. The statement of goals shall be consistent with state-wide goals pursuant to subsection (c) of section 10-4 and include goals for the integration of principles and practices of social-emotional learning in the program of professional development for the school district, in accordance with the provisions of section 10-148a, as amended by this act, and career

placement for students who do not pursue an advanced degree immediately after graduation. Each local or regional board of education shall annually establish student objectives for the school year which relate directly to the statement of educational goals prepared pursuant to this subsection and which identify specific expectations for students in terms of skills, knowledge and competence.

Sec. 14. Section 10-221 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(a) As used in this section, "virtual learning" means instruction by means of one or more Internet-based software platforms as part of an in-person or remote learning model.

[(a)**]** (b) Boards of education shall prescribe rules for the management, studies, classification and discipline of the public schools and, subject to the control of the State Board of Education, the textbooks to be used; shall make rules for the control, within their respective jurisdictions, of school library media centers, including Internet access and content, and approve the selection of books and other educational media therefor, and shall approve plans for public school buildings and superintend any high or graded school in the manner specified in this title.

[(b) Not later than July 1, 1985, each**]** (c) Each local and regional board of education shall develop, adopt and implement written policies concerning homework, attendance, promotion and retention. The Department of Education shall make available model policies and guidelines to assist local and regional boards of education in meeting the responsibilities enumerated in this subsection.

[(c)**]** (d) Boards of education may prescribe rules to impose sanctions against pupils who damage or fail to return textbooks, library materials or other educational materials. Said boards may charge pupils for such damaged or lost textbooks, library materials or other educational

materials and may withhold grades, transcripts or report cards until the pupil pays for or returns the textbook, library book or other educational material.

[(d) Not later than July 1, 1991, each**]** (e) Each local and regional board of education shall develop, adopt and implement policies and procedures in conformity with section 10-154a for (1) dealing with the use, sale or possession of alcohol or controlled drugs, as defined in subdivision (8) of section 21a-240, by public school students on school property, including a process for coordination with, and referral of such students to, appropriate agencies, and (2) cooperating with law enforcement officials.

[(e) Not later than July 1, 1990, each**]** (f) Each local and regional board of education shall adopt a written policy and procedures for dealing with youth suicide prevention and youth suicide attempts. Each such board of education may establish a student assistance program to identify risk factors for youth suicide, procedures to intervene with such youths, referral services and training for teachers and other school professionals and students who provide assistance in the program.

[(f) Not later than September 1, 1998, each**]** (g) (1) Each local and regional board of education shall develop, adopt and implement written policies and procedures to encourage parent-teacher communication. These policies and procedures may include monthly newsletters, required regular contact with all parents, flexible parent-teacher conferences, drop-in hours for parents, home visits and the use of technology such as homework hot lines to allow parents to check on their children's assignments and students to **[**get**]** receive assistance if needed. **[**For the school year commencing July 1, 2010, and each school year thereafter, such**]** Such policies and procedures shall require the district to conduct two flexible parent-teacher conferences for each school year.

(2) For the school year commencing July 1, 2021, and each school year thereafter, the policies and procedures described in subdivision (1) of this subsection shall require the district to (A) offer parents the option of attending any parent-teacher conference by telephonic, video or other conferencing platform, (B) conduct one parent-teacher conference, in addition to those required pursuant to subdivision (1) of this subsection, during periods when such district provides virtual learning for more than three consecutive weeks, and one additional parent-teacher conference every six months thereafter for the duration of such period of virtual learning, and (C) request from each student's parent the name and contact information of an emergency contact person who may be contacted if the student's parent cannot be reached to schedule a parent-teacher conference required pursuant to subparagraph (B) of this subdivision.

(3) On and after January 1, 2022, such policies and procedures shall require (A) a teacher conducting a parent-teacher conference required pursuant to subparagraph (B) of subdivision (2) of this subsection to provide a copy of the document developed pursuant to section 15 of this act to the parent prior to the parent-teacher conference, and (B) if a teacher is unable to make contact with a student's parent in order to schedule a parent-teacher conference required pursuant to subparagraph (B) of subdivision (2) of this subsection after making three attempts, such teacher shall report such inability to the school principal, school counselor or other school administrator designated by the local or regional board of education. Such principal, counselor or administrator shall contact any emergency contact person designated by the student's parent pursuant to subparagraph (C) of subdivision (2) of this subsection to ascertain such student and family's health and safety.

Sec. 15. (NEW) (*Effective from passage*) Not later than December 1, 2021, the Department of Education shall develop, and annually update, a document for use by local and regional boards of education that

provides information concerning educational, safety, mental health and food insecurity resources and programs available for students and their families. Such document shall contain, but need not be limited to, (1) providers of such resources and programs, including, but not limited to, the Departments of Education, Children and Families and Mental Health and Addiction Services, the United Way of Connecticut and local food banks, (2) descriptions of the relevant resources and programs offered by each provider, including, but not limited to, any program that provides laptop computers, public Internet access or home Internet service to students, (3) contact information for each provider, resource and program, and (4) relevant Internet web sites. The Department of Education shall annually distribute such document electronically to each local and regional board of education.

Sec. 16. (NEW) (*Effective from passage*) (a) As used in this section, "virtual learning" means instruction by means of one or more Internet-based software platforms as part of an in-person or remote learning model.

(b) Not later than January 1, 2022, the Commissioner of Education shall develop, and update as necessary, standards for virtual learning. The standards shall not be deemed to be regulations, as defined in section 4-166 of the general statutes.

(c) For the school year commencing July 1, 2022, and each school year thereafter, a local or regional board of education may authorize virtual learning to students in grades nine to twelve, inclusive, provided such board (1) provides such instruction in compliance with the standards developed pursuant to subsection (b) of this section, and (2) adopts a policy regarding the requirements for student attendance during virtual learning, which shall (A) be in compliance with the Department of Education's guidance on student attendance during virtual learning, and (B) count the attendance of any student who spends not less than one-half of the school day during such instruction engaged in (i) virtual

classes, (ii) virtual meetings, (iii) activities on time-logged electronic systems, and (iv) the completion and submission of assignments.

Sec. 17. Section 10-16 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

Each school district shall provide in each school year no less than one hundred and eighty days of actual school sessions for grades kindergarten to twelve, inclusive, nine hundred hours of actual school work for full-day kindergarten and grades one to twelve, inclusive, and four hundred and fifty hours of half-day kindergarten, provided school districts shall not count more than seven hours of actual school work in any school day towards the total required for the school year. Virtual learning shall be considered an actual school session for purposes of this section, provided such virtual learning is conducted in compliance with the standards developed pursuant to subsection (b) of section 16 of this act. If weather conditions result in an early dismissal or a delayed opening of school, a school district which maintains separate morning and afternoon half-day kindergarten sessions may provide either a morning or afternoon half-day kindergarten session on such day. As used in this section, "virtual learning" means instruction by means of one or more Internet-based software platforms as part of an in-person or remote learning model.

Sec. 18. Section 10-198b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

[On or before July 1, 2012, the] The State Board of Education shall define "excused absence", [and] "unexcused absence" [, and on or before January 1, 2016, the State Board of Education shall define] and "disciplinary absence" for use by local and regional boards of education for the purposes of carrying out the provisions of section 10-198a, reporting truancy, pursuant to subsection (c) of section 10-220, and calculating the district chronic absenteeism rate and the school chronic

absenteeism rate pursuant to section 10-198c. On or before July 1, 2021, the State Board of Education shall amend the definitions of "excused absence" and "unexcused absence" to exclude a student's engagement in (1) virtual classes, (2) virtual meetings, (3) activities on time-logged electronic systems, and (4) the completion and submission of assignments, if such engagement accounts for not less than one-half of the school day during virtual learning authorized pursuant to section 16 of this act. As used in this section, "virtual learning" means instruction by means of one or more Internet-based software platforms as part of an in-person or remote learning model.

Sec. 19. (NEW) (*Effective July 1, 2021*) (a) As used in this section and section 10-198b of the general statutes, as amended by this act, "mental health wellness day" describes a school day during which a student attends to such student's emotional and psychological well-being in lieu of attending school.

(b) For the school year commencing July 1, 2021, and each school year thereafter, a local or regional board of education shall permit any student enrolled in grades kindergarten to twelve, inclusive, to take two mental health wellness days during the school year, during which day such student shall not be required to attend school. No student shall take mental health wellness days during consecutive school days.

Sec. 20. Section 10-215 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(a) Any local or regional board of education may establish and operate a school lunch program for public school children, may operate lunch services for its employees, may establish and operate a school breakfast program, as provided under federal laws governing said programs, or may establish and operate such other child feeding programs as it deems necessary. Charges for such lunches, breakfasts or other such feeding may be fixed by such boards and shall not exceed the

cost of food, wages and other expenses directly incurred in providing such services. When such services are offered, a board shall provide free lunches, breakfasts or other such feeding to children whose economic needs require such action under the standards promulgated by said federal laws. Such board is authorized to purchase equipment and supplies that are necessary, to employ the necessary personnel, to utilize the services of volunteers and to receive and expend any funds and receive and use any equipment and supplies which may become available to carry out the provisions of this section. Any town board of education may vote to designate any volunteer organization within the town to provide a school lunch program, school breakfast program or other child feeding program in accordance with the provisions of this section.

(b) For the school year commencing July 1, 2021, and each school year thereafter, a local or regional board of education shall include in any policy or procedure for the collection of unpaid charges for school lunches, breakfasts or other such feeding applicable to employees and third-party vendors of such school lunches, breakfasts or such feeding (1) a prohibition on publicly identifying or shaming a child for any such unpaid charges, including, but not limited to, delaying or refusing to serve a meal to such child, designating a specific meal option for such child or otherwise taking any disciplinary action against such child, (2) a declaration of the right for any child to purchase a meal, which meal may exclude any a la carte items or be limited to one meal for any school lunch, breakfast or other such feeding, and (3) a procedure for communicating with the parent or legal guardian of a child for the purpose of collecting such unpaid charges. Such communication shall include, but not be limited to, (A) information regarding local food pantries, (B) applications for the school district's program for free or reduced priced meals and for the supplemental nutrition assistance program administered by the Department of Social Services, and (C) a link to the Internet web site maintained by the town for such school

district listing any community services available to the residents of such town. In the event the unpaid charges for school lunches, breakfasts or other such feeding due from any parent or legal guardian are equal to or more than the cost of thirty meals, the local or regional board of education shall refer such parent or legal guardian to the local homeless education liaison designated by such board, pursuant to Subtitle B of Title VII of the McKinney-Vento Homeless Assistance Act, 42 USC 11431 et seq., as amended from time to time.

(c) A local or regional board of education may accept gifts, donations or grants from any public or private sources for the purpose of paying off any unpaid charges for school lunches, breakfasts or other such feeding.

Sec. 21. Section 17a-10a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(a) The Commissioner of Children and Families shall ensure that a child placed in the care and custody of the commissioner pursuant to an order of temporary custody or an order of commitment is provided visitation with such child's parents and siblings, unless otherwise ordered by the court.

(b) The commissioner shall ensure that such child's visits with his or her parents, or opportunities to communicate with such child's parents and siblings by telephonic, video or other conferencing platform in accordance with the provisions of subsection (a) of this section, shall occur as frequently as reasonably possible, based upon consideration of the best interests of the child, including the age and developmental level of the child, and shall be sufficient in number and duration to ensure continuation of the relationship.

(c) If such child has an existing relationship with a sibling and is separated from such sibling as a result of intervention by the

commissioner including, but not limited to, placement in a foster home or in the home of a relative, the commissioner shall, based upon consideration of the best interests of the child, ensure that such child has access to and visitation rights with such sibling throughout the duration of such placement. In determining the number, frequency and duration of sibling visits, the commissioner shall consider the best interests of each sibling, given each child's age and developmental level and the continuation of the sibling relationship. If the child and his or her sibling both reside within the state and within fifty miles of each other, the commissioner shall, within available appropriations, ensure that such child's visits with his or her sibling occur, on average, not less than once per week, unless the commissioner finds that the frequency of such visitation is not in the best interests of each sibling.

(d) In the event of a pandemic or outbreak of a communicable disease resulting in a declaration of a public health emergency by the Governor pursuant to section 19a-131a, or a declaration of a national emergency by the President of the United States, such child shall be provided opportunities to communicate with such child's parents and siblings by telephonic, video or other conferencing platform in lieu of in-person visitation, for the duration of any such declaration. Not later than January 1, 2022, the commissioner shall develop a policy that requires the temporary cessation of in-person visitation provided pursuant to this section, on a case-by-case basis, in the event that a child or such child's parent or sibling is seriously ill due to a communicable disease, and visitation could result in the contraction of such disease by one or more participants in the visitation. Such policy shall require that such child be provided an opportunity to communicate with such child's parents and siblings by telephonic, video or other conferencing platform in lieu of such visitation. The commissioner shall define "seriously ill" and "communicable disease" for the purposes of carrying out this subsection.

[(d)**]** (e) The commissioner shall include in each child's case record information relating to the factors considered in making visitation determinations pursuant to this section. If the commissioner determines that such visits are not in the best interests of the child, that the occurrence of, on average, not less than one visit per week with his or her sibling is not in the best interests of each sibling, or that the number, frequency or duration of the visits requested by the child's attorney or guardian ad litem is not in the best interests of the child, the commissioner shall include the reasons for such determination in the child's case record.

[(e)**]** (f) On or before October first of each year, the commissioner shall report, in accordance with the provisions of section 11-4a, to the joint standing committee of the General Assembly having cognizance of matters relating to children, data sufficient to demonstrate compliance with subsections (a), (c) and **[**(d)**]** (e) of this section. Such data shall include the total annual number of children in out-of-home placements who have siblings, the total number of child cases with documented sibling visitation and the number of individual siblings involved in each case.

Sec. 22. (NEW) (*Effective July 1, 2021*) Not later than February 1, 2022, the Commissioner of Children and Families shall develop and maintain a software application for use on computers and mobile devices to facilitate (1) the reporting of nonemergent incidents to the Department of Children and Families by mandated reporters, and (2) communication between children in the care and custody of the commissioner and social workers assigned to such children.

Sec. 23. Section 17a-103d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(a) Upon receiving a complaint of abuse or neglect of a child, the Department of Children and Families shall, at the time of any initial

face-to-face contact with the child's parent or guardian on or after October 1, [2011] 2021, provide the parent or guardian with (1) written notice, in plain language, that: [(1)] (A) The parent or guardian is not required to permit the representative of the department to enter the residence of the parent or guardian; [(2)] (B) the parent or guardian is not required to speak with the representative of the department at that time; [(3)] (C) the parent or guardian is entitled to seek the representation of an attorney and to have an attorney present when the parent or guardian is questioned by a representative of the department, including at any meeting conducted to determine whether the parent or guardian's child should be removed from the home; [(4)] (D) any statement made by the parent, guardian or other family member may be used against the parent or guardian in an administrative or court proceeding; [(5)] (E) the representative of the department is not an attorney and cannot provide legal advice to the parent or guardian; [(6)] (F) the parent or guardian is not required to sign any document presented by the representative of the department, including, but not limited to, a release of claims or a service agreement, and is entitled to have an attorney review such document before agreeing to sign the document; and [(7)] (G) a failure of the parent or guardian to communicate with a representative of the department may have serious consequences, which may include the department's filing of a petition for the removal of the child from the home of the parent or guardian, and therefore it is in the parent's or guardian's best interest to either speak with the representative of the department or immediately seek the advice of a qualified attorney; and (2) a list of providers of free and low-cost legal services through which the parent or guardian may obtain legal advice.

(b) The department shall make reasonable efforts to ensure that the notice and list provided to a parent or guardian pursuant to this section [is] are written in a manner that will be understood by the parent or guardian, which reasonable efforts shall include, but not be limited to,

ensuring that the notice [is] and list are written in a language understood by the parent or guardian.

(c) The representative of the department shall request the parent or guardian to sign and date the notice described in subsection (a) of this section as evidence of having received the notice and list. If the parent or guardian refuses to sign and date the notice upon such request, the representative of the department shall specifically indicate on the notice that the parent or guardian was requested to sign and date the notice and refused to do so and the representative of the department shall sign the notice as witness to the parent's or guardian's refusal to sign the notice. The department shall provide the parent or guardian with a copy of the signed notice at the time of the department's initial face-to-face contact with the parent or guardian.

Sec. 24. Section 17a-248g of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Subject to the provisions of this section, funds appropriated to the lead agency for purposes of section 17a-248, sections 17a-248b to 17a-248f, inclusive, this section and sections 38a-490a and 38a-516a shall not be used to satisfy a financial commitment for services that would have been paid from another public or private source but for the enactment of said sections, except for federal funds available pursuant to Part C of the Individuals with Disabilities Education Act, 20 USC 1431 et seq., except that whenever considered necessary to prevent the delay in the receipt of appropriate early intervention services by the eligible child or family in a timely fashion, funds provided under said sections may be used to pay the service provider pending reimbursement from the public or private source that has ultimate responsibility for the payment.

(b) Nothing in section 17a-248, sections 17a-248b to 17a-248f, inclusive, this section and sections 38a-490a and 38a-516a shall be construed to permit the Department of Social Services or any other state

agency to reduce medical assistance pursuant to this chapter or other assistance or services available to eligible children. Notwithstanding any provision of the general statutes, costs incurred for early intervention services that otherwise qualify as medical assistance that are furnished to an eligible child who is also eligible for benefits pursuant to this chapter shall be considered medical assistance for purposes of payments to providers and state reimbursement to the extent that federal financial participation is available for such services.

(c) Providers of early intervention services shall, in the first instance and where applicable, seek payment from all third-party payers prior to claiming payment from the birth-to-three system for services rendered to eligible children, provided, for the purpose of seeking payment from the Medicaid program or from other third-party payers as agreed upon by the provider, the obligation to seek payment shall not apply to a payment from a third-party payer who is not prohibited from applying such payment, and who will apply such payment, to an annual or lifetime limit specified in the third-party payer's policy or contract.

(d) The commissioner, in consultation with the Office of Policy and Management and the Insurance Commissioner, shall adopt regulations, pursuant to chapter 54, providing public reimbursement for deductibles and copayments imposed under an insurance policy or health benefit plan to the extent that such deductibles and copayments are applicable to early intervention services.

(e) **[**The commissioner shall establish and periodically revise, in accordance with this section, a schedule of fees based on a sliding scale for early intervention services. The schedule of fees shall consider the cost of such services relative to the financial resources of the state and the parents or legal guardians of eligible children, provided that on and after October 6, 2009, the commissioner shall (1) charge fees to such parents or legal guardians that are sixty per cent greater than the amount of the fees charged on the date prior to October 6, 2009; and (2)

charge fees for all services provided, including those services provided in the first two months following the enrollment of a child in the program. Fees may be charged to any such parent or guardian, regardless of income, and shall be charged to any such parent or guardian with a gross annual family income of forty-five thousand dollars or more, except that no fee may be charged to the parent or guardian of a child who is eligible for Medicaid. Notwithstanding the provisions of subdivision (8) of section 17a-248, as used in this subsection, "parent" means the biological or adoptive parent or legal guardian of any child receiving early intervention services. The lead agency may assign its right to collect fees to a designee or provider participating in the early intervention program and providing services to a recipient in order to assist the provider in obtaining payment for such services. The commissioner may implement procedures for the collection of the schedule of fees while in the process of adopting or amending such criteria in regulation, provided the commissioner posts notice of intention to adopt or amend the regulations on the eRegulations System, established pursuant to section 4-173b, within twenty days of implementing the policy. Such collection procedures and schedule of fees shall be valid until the time the final regulations or amendments are effective**]** The commissioner shall not charge a fee for early intervention services to the parents or legal guardians of eligible children.

(f) **[**The**]** With respect to early intervention services rendered prior to the effective date of this section, the commissioner shall develop and implement procedures to hold a recipient harmless for the impact of pursuit of payment for **[**early intervention**]** such services against lifetime insurance limits.

(g) Notwithstanding any provision of title 38a relating to the permissible exclusion of payments for services under governmental programs, no such exclusion shall apply with respect to payments made

pursuant to section 17a-248, sections 17a-248b to 17a-248f, inclusive, this section and sections 38a-490a and 38a-516a. Except as provided in this subsection, nothing in this section shall increase or enhance coverages provided for within an insurance contract subject to the provisions of section 10-94f, subsection (a) of section 10-94g, subsection (a) of section 17a-219b, subsection (a) of section 17a-219c, sections 17a-248, 17a-248b to 17a-248f, inclusive, this section, and sections 38a-490a and 38a-516a.

Sec. 25. Subdivision (10) of subsection (a) of section 10-76d of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(10) (A) Each local and regional board of education responsible for providing special education and related services to a child or pupil shall notify the parent or guardian of a child who requires or who may require special education, a pupil if such pupil is an emancipated minor or eighteen years of age or older who requires or who may require special education or a surrogate parent appointed pursuant to section 10-94g, in writing, at least five school days before such board proposes to, or refuses to, initiate or change the child's or pupil's identification, evaluation or educational placement or the provision of a free appropriate public education to the child or pupil.

(B) Upon request by a parent, guardian, pupil or surrogate parent, the responsible local or regional board of education shall provide such parent, guardian, pupil or surrogate parent an opportunity to meet with a member of the planning and placement team designated by such board prior to the referral planning and placement team meeting at which the assessments and evaluations of the child or pupil who requires or may require special education is presented to such parent, guardian, pupil or surrogate parent for the first time. Such meeting shall be for the sole purpose of discussing the planning and placement team process and any concerns such parent, guardian, pupil or surrogate parent has regarding the child or pupil who requires or may require

special education.

(C) Such parent, guardian, pupil or surrogate parent shall (i) be given at least five school days' prior notice of any planning and placement team meeting conducted for such child or pupil, (ii) have the right to be present at and participate in all portions of such meeting at which an educational program for such child or pupil is developed, reviewed or revised, [and] (iii) have the right to have (I) advisors of such person's own choosing and at such person's own expense, [and to have] (II) the school paraprofessional assigned to such child or pupil, if any, [to be present at and to] and (III) such child or pupil's birth-to-three service coordinator, if any, attend and participate in all portions of such meeting at which an educational program for such child or pupil is developed, reviewed or revised, and (iv) have the right to have each recommendation made in such child or pupil's birth-to-three individualized transition plan, as required by section 17a-248e, as amended by this act, if any, addressed by the planning and placement team during such meeting at which an educational program for such child or pupil is developed.

(D) Immediately upon the formal identification of any child as a child requiring special education and at each planning and placement team meeting for such child, the responsible local or regional board of education shall inform the parent or guardian of such child or surrogate parent or, in the case of a pupil who is an emancipated minor or eighteen years of age or older, the pupil of (i) the laws relating to special education, (ii) the rights of such parent, guardian, surrogate parent or pupil under such laws and the regulations adopted by the State Board of Education relating to special education, including the right of a parent, guardian or surrogate parent to (I) withhold from enrolling such child in kindergarten, in accordance with the provisions of section 10-184, and (II) have advisors and the school paraprofessional assigned to such child or pupil [to be present at, and to] attend and participate in [,]

all portions of such meeting at which an educational program for such child or pupil is developed, reviewed or revised, in accordance with the provisions of subparagraph (C) of this subdivision, and (iii) any relevant information and resources relating to individualized education programs created by the Department of Education, including, but not limited to, information relating to transition resources and services for high school students. If such parent, guardian, surrogate parent or pupil does not attend a planning and placement team meeting, the responsible local or regional board of education shall mail such information to such person.

(E) Each local and regional board of education shall have in effect at the beginning of each school year an educational program for each child or pupil who has been identified as eligible for special education.

(F) At each initial planning and placement team meeting for a child or pupil, the responsible local or regional board of education shall inform the parent, guardian, surrogate parent or pupil of (i) the laws relating to physical restraint and seclusion pursuant to section 10-236b and the rights of such parent, guardian, surrogate parent or pupil under such laws and the regulations adopted by the State Board of Education relating to physical restraint and seclusion, and (ii) the right of such parent, guardian, surrogate parent or pupil, during such meeting at which an educational program for such child or pupil is developed, to have (I) such child or pupil's birth-to-three service coordinator attend and participate in all portions of such meeting, and (II) each recommendation made in the transition plan, as required by section 17a-248e, as amended by this act, by such child or pupil's birth-to-three service coordinator addressed by the planning and placement team.

(G) Upon request by a parent, guardian, pupil or surrogate parent, the responsible local or regional board of education shall provide the results of the assessments and evaluations used in the determination of eligibility for special education for a child or pupil to such parent,

guardian, surrogate parent or pupil at least three school days before the referral planning and placement team meeting at which such results of the assessments and evaluations will be discussed for the first time.

(H) Each local or regional board of education shall monitor the development of each child who, pursuant to subsection (a) of section 17a-248e, as amended by this act, has been (i) referred for a registration on a mobile application designated by the Commissioner of Early Childhood, in partnership with such child's parent, guardian or surrogate parent, or (ii) provided a form for such child's parent, guardian or surrogate parent to complete and submit to such local or regional board of education that screens for developmental and social-emotional delays using a validated screening tool, such as the Ages and Stages Questionnaire and the Ages and Stages Social-Emotional Questionnaire, or its equivalent. If such monitoring results in suspecting a child of having a developmental delay, the board shall schedule a planning and placement team meeting with such child's parent, guardian or surrogate parent for the purposes of identifying services for which such child may be eligible, including, but not limited to, a preschool program under Part B of the Individuals with Disabilities Act, 20 USC 1471 et seq. If a parent, guardian or surrogate parent of any child referred for a registration on the mobile application or provided a form to complete and submit pursuant to subsection (a) of section 17a-248e, as amended by this act, fails to complete such registration or complete and submit such form after a period of six months from the date of such referral or provision of such form, the board shall send a reminder, in the form and manner determined by the board, to such parent, guardian or surrogate parent to complete such registration or complete and submit such form. The board shall send another reminder after a period of one year from such referral or provision of such form if such registration remains incomplete or such form is not submitted.

Sec. 26. Subsection (i) of section 10-76d of the general statutes is

repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(i) (1) No local or regional board of education shall discipline, suspend, terminate or otherwise punish any member of a planning and placement team employed by such board who discusses or makes recommendations concerning the provision of special education and related services for a child during a planning and placement team meeting for such child.

(2) No birth-to-three service coordinator or qualified personnel, as those terms are defined in section 17a-248, who discusses or makes recommendations concerning the provision of special education and related services for a child during a planning and placement team meeting for such child or in a transition plan, as required by section 17a-248e, as amended by this act, shall be subject to discipline, suspension, termination or other punishment on the basis of such recommendations.

Sec. 27. Subsection (a) of section 17a-248e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(a) Each eligible child and his or her family shall receive (1) a multidisciplinary assessment of the child's unique needs and the identification of services appropriate to meet such needs, (2) a written individualized family service plan developed by a multidisciplinary team, including the parent, within forty-five days after the referral, **[**and**]** (3) review of the individualized family service plan with the family at least every six months, with evaluation of the individualized family service plan at least annually, and (4) not later than two months after the date on which any child is determined to be ineligible for participation in preschool programs under Part B of the Individuals with Disabilities Act, 20 USC 1471 et seq., a referral to register for a mobile application designated by the Commissioner of Early Childhood

for the purpose of continued screening for developmental and social-emotional delays in partnership with the local or regional board of education for the school district in which such child resides pursuant to subparagraph (H) of subdivision (10) of subsection (a) of section 10a-76d, as amended by this act, provided a form used for screening for developmental and social-emotional delays using a validated screening tool, such as the Ages and Stages Questionnaire and the Ages and Stages Social-Emotional Questionnaire, or its equivalent, is provided to any family upon the request of such family for the purpose of completing and submitting such form to the local or regional board of education for the school district in which such child resides.

Sec. 28. (NEW) (*Effective from passage*) Not later than July 1, 2022, the Commissioner of Early Childhood shall develop and implement a plan to expand the birth-to-three program, established pursuant to section 17a-248b of the general statutes, as amended by this act, to provide early intervention services to any child who is (1) enrolled in the program, (2) turns three years of age on or after May first and not later than the first day of the next school year commencing July first, and (3) is eligible for participation in preschool programs under Part B of the Individuals with Disabilities Act, 20 USC 1471 et seq., provided such services shall terminate upon such child's participation in such a preschool program. The commissioner may adopt regulations in accordance with chapter 54 of the general statutes to implement the provisions of this section.

Sec. 29. (NEW) (*Effective July 1, 2021*) For the school year commencing July 1, 2022, and each school year thereafter, in any school district that serves a town that has not convened or established a local or regional school readiness council pursuant to section 10-16r of the general statutes, the local or regional board of education for such school district shall designate a school readiness liaison. Such liaison shall (1) be an existing employee of such school district, and (2) serve as an informational resource for parents of children transitioning from the

birth-to-three program established pursuant to section 17a-248 of the general statutes, to enrollment in a public elementary school in such school district.

Sec. 30. (*Effective from passage*) (a) There is established a task force to study the comprehensive needs of children in the state and the extent to which such needs are being met by educators, community members and local and state agencies. The task force shall (1) identify the needs of children using the following tenets of the whole child initiative developed by the Association for Supervision and Curriculum Development: (A) Each student enters school healthy and learns about and practices a healthy lifestyle, (B) each student learns in an environment that is physically and emotionally safe for students and adults, (C) each student is actively engaged in learning and is connected to the school and broader community, (D) each student has access to personalized learning and is supported by qualified, caring adults, and (E) each student is challenged academically and prepared for success in college or further study and for employment and participation in a global environment; (2) recommend new programs or changes to existing programs operated by educators or local or state agencies to better address the needs of children in the state; (3) recognize any exceptional efforts to meet the comprehensive needs of children by educators, community members or local or state agencies; (4) identify and advocate for resources, including, but not limited to, funds, required to meet the needs of children in the state; (5) identify redundancies in existing services or programs for children and advocate for the elimination of such redundancies; and (6) assess all publicly available data concerning the comprehensive needs of children identified pursuant to subdivision (1) of this subsection and collect, or make recommendations for the state to collect, any data that is not being collected by educators, community members or local or state agencies. As used in this section, "community member" means any individual or private organization that provides services or programs for children.

(b) The task force shall consist of the following members:

(1) Two appointed by the speaker of the House of Representatives, one of whom is an educator employed by a local or regional board of education and one of whom is a social worker licensed pursuant to chapter 383b of the general statutes who works with children;

(2) Two appointed by the president pro tempore of the Senate, one of whom is a representative of the board of directors of the Association for Supervision and Curriculum Development affiliate in the state, and one of whom is representative of an institution of higher education in the state;

(3) One appointed by the majority leader of the House of Representatives, who is a school administrator employed by a local or regional board of education;

(4) One appointed by the majority leader of the Senate, who is a chairperson of a local or regional board of education;

(5) One appointed by the minority leader of the House of Representatives, who is a director or employee of a private nonprofit organization in the state that provides services or programs for children;

(6) One appointed by the minority leader of the Senate, who is a director or employee of a private nonprofit organization in the state that provides health-related services or programs for children;

(7) The Commissioner of Education, or the commissioner's designee;

(8) The Commissioner of Early Childhood, or the commissioner's designee;

(9) The Healthcare Advocate, or the advocate's designee;

(10) The Labor Commissioner, or the commissioner's designee;

(11) The executive director of the Commission on Human Rights and Opportunities, or the executive director's designee;

(12) The Commissioner of Agriculture, or the commissioner's designee;

(13) The Commissioner of Economic and Community Development, or the commissioner's designee;

(14) The Commissioner of Housing, or the commissioner's designee;

(15) The Commissioner of Public Health, or the commissioner's designee;

(16) The Commissioner of Developmental Services, or the commissioner's designee;

(17) The Commissioner of Mental Health and Addiction Services, or the commissioner's designee;

(18) The Commissioner of Transportation, or the commissioner's designee;

(19) The Commissioner of Social Services, or the commissioner's designee;

(20) The superintendent of the Technical Education and Career System, or the superintendent's designee;

(21) The Commissioner of Children and Families, or the commissioner's designee;

(22) The Chief Court Administrator, or the Chief Court Administrator's designee; and

(23) The director of Special Education Equity for Kids of Connecticut, or the director's designee.

(c) Any member of the task force appointed under subdivisions (1) to (6), inclusive, of subsection (b) of this section may be a member of the General Assembly.

(d) All initial 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 not later than thirty days after the vacancy occurs. If a vacancy is not filled by the appointing authority, the chairpersons of the task force may fill such vacancy.

(e) The speaker of the House of Representatives and the president pro tempore of the Senate shall select the chairpersons of the task force from among the members 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.

(f) 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.

(g) Not later than January 1, 2022, the task force shall submit a report on its findings and recommendations to 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 January 1, 2022, whichever is later.

Approved June 16, 2021