

DRAFT MENTAL HEALTH BILL

AN ACT CONCERNING A SYSTEM OF MENTAL HEALTH SERVICES AND ACCESS FOR CHILDREN.

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

Section 1. (NEW) (*Effective July 1, 2013*) (a) The State of Connecticut shall design and implement a comprehensive prevention-focused child and youth mental health system. The system shall have an interconnected framework of supports in which schools, mental health services, child and family services, and early childhood programs are organized in a continuum of prevention and intervention services and systems to assure that every child with emotional-behavioral problems will have access to mental health services by 2023. Such plan shall include biennial benchmarks to track improvements in quality and access up to the ten year point.

(b) The child and youth mental health system in paragraph (a) of this section shall be: (1) Prevention-focused, with emphasize on early identification and intervention; (2) Age informed, ensuring access to developmentally appropriate services for early childhood, school aged children, adolescents and young adults; (3) Designed to offer a comprehensive continuum of care from prevention and early identification to intensive interventions addressing children with a range of mental health needs; (4) Family-driven, with parents and youth engaged in the planning, delivery and evaluation of services; (5) Culturally-competent, reflecting awareness of race, culture and language relevant to family identification and social health; (6) Community based, with access to services that are delivered in the home, school and community and with reduced reliance on the most costly and restrictive forms of congregate and residential care; (7) Evidence- based, expanding access to services and systems that are known to work; and (8) Informed by data, applying quality assurance strategies and the results-based accountability framework to ensure children and families have access to quality care.

Sec. 2 (NEW) (*Effective July 1, 2013*) The child and youth mental health system in paragraph (a) of Sec. 1 of this act shall develop within early childhood: (a) family strengthening through a system of proven home visitation programs as delineated in Sec. 13 of this act; (b) professional development for early childhood providers and pediatricians in the prevention and early identification of mental health problems utilizing Infant and Early Childhood Mental Health Competencies; (c) increased capacity for evidence-based mental health treatment that has been specifically developed for young children and their parents/caregivers including trauma-informed interventions, particularly for young children involved with the Department of Children and Families, with emphasis on protective relationships; (d) development of an early intervention mental health system including identification, assessment and treatment with full utilization of federal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program requirements; (e) Revision of the Birth to Three system criteria for determining eligibility to include emotional/behavioral problems consistent with standard utilization of recognized mental health assessment tools; (f) Birth to Three referral to licensed early childhood mental health practitioners for any child needing psycho-social intervention; (g) coordinated training for child and family health practitioners in identification of maternal depression and its impact on child development; and (h) facilitation of home-based treatment with reimbursement for mothers of young children experiencing depression.

Sec. 3 (NEW) (*Effective July 1, 2013*) The child and youth mental health system in paragraph (a) of Sec. 1 of this act shall include within schools: (a) at least one school-based care coordinator for every school district; (b) a child psychiatry consultation network to support primary care physicians and school-

employed mental health staff; (c) tiered and proven responses to behavioral challenges in schools including positive behavioral intervention supports; (d) a memoranda of understanding between Emergency Mobile Psychiatric Service (EMPS) providers, community based mental health care agencies and all schools, within their respective catchment areas, to foster identification and referral of children with mental health needs and to foster on-going communication and collaboration; (e) school-based programs and staffing to assess and promptly intervene in mental health cases that include one social worker and one school psychologist in each school building, with minimum professional staffing ratios, and school based health centers; (f) mental health consultants who can assist schools, with quality and efficient interventions, modeled after the early childhood consultation partnership; and (g) training of school resource officers to assure proven and proper response with minimal over or under referrals based on demographics.

Sec. 4 (NEW) (Effective July 1, 2013) The child and youth mental health system in paragraph (a) of Sec. 1 of this act shall have systems improvements in access, coordination, professional development, family and customer service, services linkages and quality assurances to include: (a) training in and expansion of evidence-based trauma-informed interventions and practices; (b) access for pediatricians to child and adolescent psychiatry consultation or co-location of services between pediatricians and mental health providers; (c) increased family and consumer engagement in medical homes; (d) treatment of children with mental health needs involved in the judicial system provided with appropriate services and treatment setting within 7 days of referral; (e) expansion of a range of evidence-based practices to meet identified needs of the population; (f) incentives within the system of care to coordinate mental health services and communications between the family, school and community; (g) public information for parents on how to utilize 2-1-1 regarding stages of child development, and how the family can identify and help a child who may benefit from mental health intervention; (h) expansion of mental health screening programs, across the age spectrum, including pediatric primary care, early care settings, community agencies and schools to be accompanied by accessible and proven clinical services; (i) development of an enhanced statewide data network to facilitate improved utilization of data, data-driven planning and quality assurance across pertinent domains in child mental health through for quality assurance; and (j) a requirement that every program addressing mental health and behavioral needs is mandated to collect data on outcomes and that 10% of every mental health contract is directed to quality assurance services.

Sec. 5. (NEW) (Effective July 1, 2013) The child and youth mental health system in paragraph (a) of Sec. 1 of this act shall support financing that maximizes coordination, efficiencies, quality and consumer use in the best interest of the child, to include: (a) private and public reimbursement for mental health care services delivered in the home and in school settings; (b) private and public reimbursement for care coordination of services; (c) accountability and adherence to the Mental Health Parity and Addiction Equity Act of 2008; (d) reimbursement for mental health services through Early and Periodic Screening Diagnosis and Treatment (EPSDT) to prevent high risk children from developing mental health disorders, particularly when exposed to trauma or maternal depression; (e) reimbursement for treatment of maternal depression in the home; (f) a review of reimbursement policies and support networks in training and quality assurance for the statewide network of community based providers and child guidance clinics offering mental health services to families; and (g) allowances for cross-system funding, which may include co-location and braiding of resources to ensure that all children have access to mental health services based on child and family need, irrespective of insurance status, setting or system involvement, to eliminate barriers to quality care created by such silos.

Sec. 6. (NEW) (Effective July 1, 2013) The State of Connecticut shall (a) perform a study to determine whether youth and young adults whose primary need is mental health intervention are, instead, placed into the juvenile justice system and correction as a *de facto* mental health system, due to untreated behavioral or mental health challenges or learning disabilities; (b) study and determine the cost to youth and to the state for inappropriate referrals to the juvenile justice system and correction; and (c) analyze what programs need to be put in place to reduce inappropriate referrals, any disproportionality by race, and to ensure proper treatment within the mental health continuum of services described in Sec. 1 of this act.

Sec. 7. (NEW) (Effective July 1, 2013) (a) The Office of Early Childhood, in consultation with the Departments of Social Services, Children and Families, Developmental Services, Public Health, Mental Health and Addiction Services, the Commission on Children, the Office of the Child Advocate, the Office of the Healthcare Advocate, the Behavioral Health Partnership and selected non-profit institutions, shall implement the provisions of Sec. 2 of this act by June 2014.

(b) An implementation progress report shall be submitted to the Children Committee and other committees of cognizance by December 2013. Planning for improved early childhood mental health shall be linked and integrated with current reform efforts and statewide initiatives that seek to address any pertinent component of the mission, mandate or values in Sec. 1 through Sec. 6 of this act.

Sec. 8. (NEW) (Effective July 1, 2013) (a) The Department of Education, in consultation with the Departments of Higher Education, Children and Families, Public Health, Social Services, Developmental Services, Mental Health and Addiction Services, the Chief Court Administrator, the Office of the Child Advocate, the Office of the Health Care Advocate, the Commission on Children, the Behavioral Health Partnership and selected non-profit institutions, shall implement the provisions of Sec. 3 by January 2015.

(b) An implementation progress report shall be submitted to the Education Committee and other committees of cognizance by December 2014. Planning for improved child and youth mental health in schools shall be linked and integrated with current reform efforts and statewide initiatives that seek to address any pertinent component of the mission, mandate or values in Sec. 1 through Sec. 6 of this act.

Sec. 9. (NEW) (Effective July 1, 2013) (a) The Department of Children and Families, in consultation with the Departments of Social Services, Public Health, Mental Health and Addiction Services, the Office of the Health Care Advocate, the Office of the Child Advocate, the Behavioral Health Partnership and selected non-profit institutions, shall implement the provisions of Sec. 4 by January 2016.

(b) An implementation progress report shall be submitted to the Human Services Committee and other committees of cognizance by December 2015. Planning for an improved child and youth mental health system shall be linked and integrated with current reform efforts and statewide initiatives that seek to address any pertinent component of the mission, mandate or values in Sec. 1 through Sec. 6 of this act.

Sec. 10. (NEW) (*Effective July 1, 2013*) (a) The Department of Social Services, in consultation with the Departments of Children and Families, Insurance, and the Office of the Health Care Advocate, shall implement the provisions of Sec. 5 by January 2018.

(b) An implementation progress report shall be submitted to the Appropriations and Human Services Committee and other committees of cognizance by December 2017. Planning for improved child and youth mental health financing shall be linked and integrated with current reform efforts and statewide initiatives that seek to address any pertinent component of the mission, mandate or values in Sec. 1 through Sec. 6 of this act.

Sec. 11. (NEW) (*Effective July 1, 2013*) The study described in Section 7 shall be performed by PRI, in consultation with DCR and CSSD. Findings shall be reported to the Children's and Human Services Committees by September 2014.

Sec. 12. (NEW) (*Effective July 1, 2013*) The planning and implementation in Sections 8-11 may include support from philanthropy and shall be aligned with other federal and state opportunities.

Sec. 13. (NEW) (*Effective July 1, 2013*) (a) The home visitation system, as described in Sec. 2 of this act shall include the development of: (a) a common referral process for families requesting home visitation and parenting education programs; (b) a common set of competencies and required training for all home visitors; (c) a common set of standards and outcomes for all programs. Standards would include requirements for model fidelity and a monitoring framework; (d) a family assessment to be used upon enrollment to determine the family and children needs, prioritizing the family's goals and intentions; (e) a system of universal, simple health and development screening for all young children; (f) one site for all home visitors and their collaborators to find information on training, workshops, materials which would include a system for regular communication among models programs and staff; (g) coordinated training for the home visitation and early care and education providers on issues such as child trauma, poverty and family supports, family stressors, mental health, special health care needs, early literacy and language acquisition; (h) a tracking system for common outcomes; and (i) a shared reporting system to the Appropriations Committee and the committees of cognizance for all home visitation programs, including a breakout of results from the various programs.

(b) "Home visitation" means an effective early childhood service delivery strategy that promotes healthy child development, provides parenting support, and facilitates linkages to community resources.