
OLR Bill Analysis

sSB 972 (File 195, as amended by Senate "A")*

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

SUMMARY:

The bill requires the Department of Children and Families (DCF) and the Office of Early Childhood (OEC), in consultation and collaboration with various individuals and agencies, to take several steps to address Connecticut children's mental, emotional, and behavioral health needs. It requires DCF to develop a comprehensive plan to (1) meet these needs and (2) prevent or reduce the long-term negative impact of mental, emotional, and behavioral health issues on children. It requires OEC, which currently does not exist (see BACKGROUND), to (1) provide recommendations to several committees for implementing the coordination of home visitation programs that offer services to vulnerable families with young children and (2) design and implement a public information and education campaign on children's mental, emotional, and behavioral health issues.

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

The bill also (1) allows the Judicial Branch to seek funding to perform a study to determine whether children and young adults who primarily need mental health interventions are placed in the juvenile justice or corrections systems instead of receiving appropriate treatment and (2) establishes a 14-member task force to study the

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

*Senate Amendment "A" strikes the underlying bill and, in doing so, eliminates the requirement that DCF develop and implement a youth mental health care system. Instead, it requires the department to develop an implementation plan to address children's mental, emotional, and behavioral health issues. It imposes several agency, training, and other requirements related to addressing these issues. It also changes the task force membership and charge.

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

§ 1 — DCF IMPLEMENTATION PLAN AND TRAINING REQUIREMENTS

Implementation Plan

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

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

1. employing prevention-focused techniques that emphasize early identification and intervention;
2. ensuring access to developmentally appropriate services;
3. offering comprehensive care within a service continuum;

4. engaging communities, families, and youths in mental, emotional, and behavioral health care services planning, delivery, and evaluation;
5. being sensitive to diversity by reflecting race, culture, language, and ability awareness;
6. establishing results-based accountability (RBA) measures to track progress towards the bill's goals and objectives;
7. applying data-informed quality assurance strategies to address mental, emotional, and behavioral health issues in children; and
8. improving school and community-based mental health services integration.

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

1. family and youth engagement in medical homes, in collaboration with the Department of Public Health (DPH) (see BACKGROUND);
2. data collection on each program's results, including information on issues related to treatment response times, provider availability and access to treatment options, in collaboration with each program that addresses the mental, emotional, or behavioral health of children and receives state public funds; and
3. awareness of the 2-1-1 Infoline, a single telephone source for information about community services, referrals to human services programs, and crisis intervention, in collaboration with the Department of Social Services (DSS). The bill does not specify how DSS and DCF must increase 2-1-1 awareness.

Reporting Requirements. The bill requires the DCF commissioner to submit and present to the governor and the Children's and

Appropriations committees (1) a status report on the implementation plan's progress by April 15, 2014 and (2) the implementation plan by October 1, 2014.

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

Mental Health Care Provider Training

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

§ 1 — SCHOOL BOARD REQUIREMENTS

Collaboration Between Health Care Providers and School Boards

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

School Resource Office (SRO) Training

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

because of their mental health issues.

§§ 2, 5, & 6 — OEC

Pediatrician and Child Care Provider Training

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

Home Visitation Programs

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

1. a common referral process for families requesting home visitation programs;
2. a core set of (a) competencies and required training for all home visitors and (b) standards and outcomes for all programs, including requirements for a monitoring framework;
3. coordinated training for home visitation and early care providers, to the extent that training is currently provided, on cultural competency, mental health awareness and issues such as child trauma, poverty, literacy, and language acquisition;

4. established common outcomes;
5. a shared reporting system capable of disaggregating results by agency and program and providing such results, including information on existing gaps in services, to the Appropriations, Children's, and Human Services committees;
6. home-based treatment options for parents of young children suffering from severe depression; and
7. intensive intervention services for children experiencing mental, emotional, or behavioral health issues, including relationship-focused intervention services for young children.

Public Information and Education Campaign

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

1. information on (a) access to support and intervention programs providing mental, emotional, and behavioral health care services to children, (b) the importance of a relationship with and connection to an adult in the early childhood years, and (c) existing public and private reimbursement for services rendered (the bill does not specify by whom the services are rendered);
2. a list of emotional landmarks and the typical ages at which they are attained;
3. strategies (a) that parents and families can use to improve their child's mental, emotional, and behavioral health, including executive functioning and self-regulation and (b) to address mental illness stigma; and
4. information to parents on methods to address and cope with mental, emotional, and behavioral health issues at various stages

of a (a) child's development and (b) parent's work and family life.

The bill requires OEC, by October 1, 2014 and to the extent private funding is available, to begin reporting annually to the Children's and Public Health committees on the status of the public information and education campaign.

§ 3 — BIRTH-TO-THREE PROGRAM

The Birth-to-Three program administered by the Department of Developmental Services provides early intervention services as defined by federal regulation (CFR 303.12) to children eligible under Part C of the Individuals with Disabilities Education Act (IDEA) (see BACKGROUND). The bill requires the program to provide mental health services to any child eligible for early intervention services under Part C of IDEA. The program must refer any child not eligible for services under the act to a licensed mental health care provider for evaluation and treatment, as needed.

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

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

§ 7 — JUVENILE JUSTICE AND CORRECTIONS REFERRALS

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

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

receiving mental health treatment;

2. to determine the (a) consequences of inappropriate referrals to the juvenile justice or correctional systems, including the impact on children and young adults' mental, emotional, and behavioral health and the cost to the state and (b) programs that would reduce inappropriate referrals; and
3. to make recommendations to ensure proper treatment is available for children suffering from mental, emotional, or behavioral health issues.

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

§ 8 — CHILDREN'S MENTAL HEALTH TASK FORCE

The bill establishes a task force to study the effects of nutrition, genetics, complementary and alternative treatments, and psychotropic drugs on Connecticut children's mental, emotional, and behavioral health. The task force must also (1) gather and maintain current information on those effects and (2) advise the governor and General Assembly on how to coordinate and administer state programs to address the impact of those effects on children's mental, emotional, and behavioral health using a RBA framework.

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

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

2. a licensed and board-certified physician specializing in genetics, appointed by the Senate majority leader;
3. a public health expert in children's health issues, appointed by the Senate minority leader;
4. an educator with expertise providing mental health services in collaboration with community-based mental health service providers, appointed by the House minority leader;
5. a complementary and alternative medicine or integrative therapy expert specializing in the treatment of physical, mental, emotional, and behavioral health issues in children, appointed by the Children's Committee House chairperson;
6. a psychotropic pharmacologist, appointed by the Children's Committee House ranking member; and
7. a pharmacologist appointed by the governor.

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

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

BACKGROUND

Office of Early Childhood (OEC)

HB 6359, if enacted, will create OEC. It would bring together in one agency early childhood programs currently administered by four different agencies.

Medical Homes

Medical homes, as defined by federal law, are for people eligible for

Medicaid or Medicaid waivers who have (1) two chronic conditions, (2) one chronic condition with a risk of developing a second, or (3) a serious and persistent mental health or substance abuse condition. Medical home care includes:

1. comprehensive case management;
2. care coordination and health promotion;
3. comprehensive transitional care, including appropriate follow up, from inpatient to other settings;
4. patient and family support;
5. referral to community and social support services, if relevant; and
6. use of health information technology to link services.

IDEA – Part C

Part C of IDEA (20 USC 1431 et seq) provides federal grants to states for early intervention services for infants and toddlers up to age three with disabilities and their families. Under Part C, a child under age three needs early intervention services if he or she (1) is experiencing developmental delays as measured by appropriate diagnostic instruments and procedures in one or more of the areas of cognitive development, physical development, communication development, social or emotional development, and adaptive development or (2) has a diagnosed physical or mental condition that has a high probability of resulting in developmental delay.

The federal law does not define “developmental delay” but instead leaves it to each state to define eligible developmental delays. Under state regulations, a child age three or younger has a developmental delay that makes him or her eligible for early intervention services if his or her scores on an appropriate norm-referenced standardized diagnostic instrument are (1) two standard deviations below the mean in one area of development or (2) one and one-half standard deviations

below the mean in at least two areas of development.

Under the federal regulations (CFR 303.12), early intervention services include family training, counseling, home visits, and psychological and social work services.

COMMITTEE ACTION

Children Committee

Joint Favorable Substitute

Yea 12 Nay 0 (03/12/2013)

Public Health Committee

Joint Favorable

Yea 23 Nay 5 (05/01/2013)