

2013-2018 Behavioral Health Legislation

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July 12, 2018 | 2018-R-0165

Issue

Provide a brief summary of behavioral health legislation enacted by the Connecticut General Assembly between 2013 and 2018. For the purposes of this report, “behavioral health” includes mental health and substance use disorders. It updates OLR Report [2016-R-0002](#). This report has been updated by OLR Report [2019-R-0247](#).

Summary

Over the last five years, the General Assembly enacted a number of acts that affect behavioral health, including (1) increasing access to behavioral health services, (2) improving children’s behavioral health service delivery, (3) preventing and treating opioid use disorders, (4) regulating health care facilities and professions, and (5) increasing health insurance coverage for behavioral health services.

Below we briefly summarize relevant provisions of these acts. Not all provisions of the acts are included; complete summaries are available on the General Assembly’s [website](#). Additionally, the report does not include provisions that are (1) budgetary or (2) minor or technical.

Table of Contents

Access to Services	4
Assertive Community Treatment (ACT)	4
Behavioral Health Services Task Force	4
DMHAS Acute Care and Emergency Behavioral Services Grant Program.....	4
Information and Referral Service.....	4
Off-Site Services by Multi-Care Institutions	5
Probate Court-Related Case Management and Care Coordination Services	5
Children’s Behavioral Health	5
Animal Assisted Therapy	5
Behavioral Health Partnership Oversight Council.....	5
Children's Mental, Emotional, and Behavioral Health Plan Implementation Advisory Board	6
Comprehensive Plan for Children’s Services	6
Safe Care of Substance Exposed Newborns.....	7
School-Based Primary Mental Health Programs.....	7
School-Based Trauma-Informed Practice Training	8
Youth Suicide Advisory Board	8
Health Care Facilities	8
DMHAS Facility Task Force.....	8
Patient Abuse at DMHAS Behavioral Health Facilities	8
Regulation of Whiting Forensic Hospital	9
Transferring Patients Under Psychiatric Security Review Board Jurisdiction For Medical Treatment.....	9
Health Care Professions	9
Alcohol and Drug Counselors	9
Certified Behavioral Analysts	10
Continuing Education for Physicians	10
Continuing Education on Veterans’ Mental Health Conditions.....	10
Conversion Therapy Prohibition	11
Marriage and Family Therapy, Professional Counseling, and Psychology Students	11
Parental Notification for Hospital Admission	11
Professional Counselors.....	11
Psychology Technicians	12
Regional Behavioral Health Consultation System for Pediatricians.....	12
Reporting of Impaired Health Care Professionals	12
Insurance	13
Adverse Determinations and Mental Health Insurance Coverage	13
Behavioral Health and Autism Spectrum Disorder Services (ASD)	13
Elimination of Medicaid Case Management Requirements	13
Health Insurance Coverage for Mental and Nervous Conditions	13
Insurance Department Data Collection Working Group.....	14
Medicaid Rate Increase for Private Psychiatric Residential Treatment Facilities	14
Medicaid State Plan Provider Expansion	14
Mental Health Parity and Compliance Checks.....	15

Miscellaneous	15
Gun Credential Eligibility.....	15
Mental Health First Aid Training.....	15
Sandy Hook Workers Assistance Program	15
Substance Use Disorders.....	16
Opioid Drug Abuse	16
Prescribing Controlled Substances Using Telehealth.....	16
Sober Living Homes	16
Studies	17
Psychiatric Services Study.....	17
Study on the Provision of Behavioral Health Services at School-Based Health Centers (SBHCs).....	17

Access to Services

Assertive Community Treatment (ACT)

Legislation passed in 2013 required the Department of Mental Health and Addiction Services (DMHAS) commissioner to implement an ACT program in three cities that, on June 30, 2013, did not have such a program. The program uses a person-centered, recovery-based approach that provides people diagnosed with a severe and persistent mental illness with specified services in community settings ([PA 13-3](#)).

Behavioral Health Services Task Force

A 2013 law created a 20-member task force to study the provision of behavioral health services in Connecticut, with particular focus on providing these services to people ages 16 to 25. The task force issued its [final report](#) in April 2014 ([PA 13-3](#)).

DMHAS Acute Care and Emergency Behavioral Services Grant Program

Legislation passed in 2015 established a DMHAS grant program that awards funds to organizations providing acute care and emergency behavioral health services. The grants are used to provide community-based behavioral health services, including (1) care coordination and (2) access to information on and referrals to available health care and social service programs ([PA 15-5, June Special Session](#)).

A 2016 law modified the program by, among other things, (1) requiring DMHAS to administer it within available appropriations and (2) allowing, rather than requiring, the grants to be used to provide specified community-based behavioral health services ([PA 16-3, May Special Session](#)).

Information and Referral Service

Legislation passed in 2014 required the Office of the Healthcare Advocate, by January 1, 2015, to establish an information and referral service to help residents and providers get information, timely referrals, and access to behavioral health care providers.

Additionally, the act requires the office to annually report to the Children's, Human Services, Insurance, and Public Health committees. The report must identify service gaps and the resources needed to improve behavioral health care options for Connecticut residents ([PA 14-115](#)).

Off-Site Services by Multi-Care Institutions

A 2014 law allows a multi-care institution (e.g., hospital or psychiatric outpatient clinic) to provide behavioral health services or substance use disorder treatment services on the premises of more than one facility, at a satellite unit, or at another location outside of its facilities or satellite units that is acceptable to the patient and consistent with his or her treatment plan ([PA 14-211](#)).

Probate Court-Related Case Management and Care Coordination Services

Legislation passed in 2013 requires the DMHAS commissioner to provide case management and care coordination services to up to 100 people with mental illness who are involved in the probate court system and who, on June 30, 2013, were not receiving those services ([PA 13-3](#)).

Children's Behavioral Health

Animal Assisted Therapy

Legislation passed in 2013 required the Department of Children and Families (DCF), by July 1, 2014 and within available appropriations, to consult with the Governor's Prevention Partnership and the animal-assisted therapy community to develop a crisis response program using a coordinated volunteer canine response team developed under the act to provide animal-assisted therapy to children.

It also required DCF to (1) develop and implement training for certain department staff and mental health care providers on the value of animal-assisted therapy and (2) consult with the Department of Agriculture commissioner to identify a coordinated canine crisis response team ([PA 13-114](#)).

[PA 15-208](#) modified the law, primarily by (1) delaying by two years the identification of the crisis response team and DCF training development and (2) requiring DCF to develop a protocol to identify animal-assisted activity organizations and therapy providers, instead of a crisis response program.

Behavioral Health Partnership Oversight Council

Legislation passed in 2015 added two nonvoting, ex-officio members to the Behavioral Health Partnership Oversight Council: one each appointed by the Department of Public Health (DPH) commissioner and health care advocate, to represent their department or office respectively.

The council advises the DCF, social services, and DMHAS commissioners on planning and implementing the Behavioral Health Partnership, an integrated behavioral health system for Medicaid patients ([PA 15-242](#)).

Children's Mental, Emotional, and Behavioral Health Plan Implementation Advisory Board

Legislation passed in 2015 established a Children's Mental, Emotional, and Behavioral Health Plan Implementation Advisory Board to advise various individuals and entities on:

1. executing DCF's comprehensive behavioral health plan developed in 2014 (see below);
2. cataloging the mental, emotional, and behavioral services available to Connecticut families with children to reflect the services' capacities and uses; and
3. fostering collaboration among agencies, providers, advocates, and others interested in child and family well-being to prevent or reduce the long-term negative impact of children's mental, emotional, and behavioral health issues.

The act requires the board to annually report on its activities to the Children's Committee ([PA 15-27](#)).

Comprehensive Plan for Children's Services

2013 legislation required DCF and the Office of Early Childhood (OEC) to consult and collaborate with various individuals and agencies, to address Connecticut children's mental, emotional, and behavioral health needs. Among other things, it required 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 also required:

1. OEC to (a) provide recommendations to several legislative committees on coordinating home visitation programs that offer services to vulnerable families with young children and (b) design and implement a public information and education campaign on children's mental, emotional, and behavioral health issues;
2. DCF, in collaboration with agencies that train mental health care providers, to provide ongoing training for mental health care providers in evidence-based and trauma-informed interventions and practices;

3. school resource officers, pediatricians, and child care providers to also receive mental health training, to the extent funding is available;
4. the state to seek existing public and private reimbursement for mental, emotional, and behavioral health services; and
5. the Birth-to-Three program to provide mental health services to children eligible for early intervention services under federal law.

Additionally, the act (1) allowed the Judicial Branch to seek funding to study 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) established 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 ([PA 13-178](#)).

Safe Care of Substance Exposed Newborns

By January 1, 2019, a new law requires the DCF commissioner to develop guidelines for the safe care of high-risk newborns born with signs indicating prenatal substance exposure or fetal alcohol syndrome. The guidelines must instruct health care providers on their participation in the discharge planning process, including creating written safe care plans between the provider and the newborn's mother.

Under the new law, a provider involved in delivering or caring for a substance exposed newborn must notify DCF of the newborn's condition. The law applies to the following licensed health care providers: physicians, surgeons, homeopathic physicians, physician assistants, nurse-midwives, practical nurses, registered nurses, and advanced practice registered nurses ([PA 18-111](#), effective July 1, 2018).

School-Based Primary Mental Health Programs

A 2015 law requires school-based primary mental health programs administered by boards of education to include a component for systematic early detection and screening to identify children experiencing behavioral or disciplinary problems. (Prior law required only the identification of children experiencing early school adjustment problems.)

It also requires the (1) programs to include services to address those problems and (2) education commissioner to consider, as an additional factor when awarding school-based primary mental health program grants to boards of education, the number of children enrolled in grades kindergarten to two who experience behavioral, disciplinary, or early school adjustment problems ([PA 15-96](#)).

School-Based Trauma-Informed Practice Training

Legislation passed in 2015 requires the State Board of Education to assist and encourage school boards to provide in-service training on trauma-informed practices for the school setting, so that school employees can more adequately respond to students with mental, emotional, or behavioral health needs ([PA 15-232](#)).

Youth Suicide Advisory Board

A 2015 law requires DCF's Youth Suicide Advisory Board to periodically offer, within available appropriations, youth suicide prevention training for health care providers, school employees, and other people who provide services to children, young adults, and families ([PA 15-232](#)).

Health Care Facilities

DMHAS Facility Task Force

A new law establishes an eight-member task force to, among other things, (1) review and evaluate DMHAS facility operations and conditions, including those of Connecticut Valley Hospital and Whiting Forensic Hospital; (2) evaluate the feasibility of creating an Office of Inspector General to receive and investigate complaints about DMHAS hospitals; and (3) examine complaints and other reports of discriminatory employment practices at these hospitals.

The task force must submit to the Public Health Committee a (1) preliminary report on its findings and recommendations by January 1, 2019, and (2) final report by January 1, 2021. The task force terminates on the date it submits the final report or January 1, 2021, whichever is later ([PA 18-86](#), effective upon passage).

Patient Abuse at DMHAS Behavioral Health Facilities

A new law creates a new category of mandated reporter for abuse of patients at DMHAS-operated behavioral health facilities that provide services to adults. Under the new law, a mandatory reporter for this purpose is (1) anyone paid to provide direct care to patients at such a facility or (2) any

licensed health care provider who is an employee, contractor, or consultant of such a facility. It also sets procedural requirements for the mandatory reporting and penalties for noncompliance ([PA 18-86](#), effective upon passage).

Regulation of Whiting Forensic Hospital

In December 2017, the governor issued Executive Order 63, which designated the Whiting Forensic Hospital as an independent division within DMHAS, instead of a division of Connecticut Valley Hospital.

A new law makes various changes affecting Whiting Forensic Hospital, such as (1) subjecting the hospital to DPH licensure and regulation; (2) requiring DPH, by January 1, 2019, to conduct an on-site inspection and records review of the hospital; and (3) establishing the mandatory reporting and investigation of suspected patient abuse at DMHAS-operated behavioral health facilities ([PA 18-86](#), various effective dates).

Transferring Patients Under Psychiatric Security Review Board Jurisdiction For Medical Treatment

A 2017 law codified existing practice by allowing DMHAS to transfer an “acquittee” (i.e., a person found not guilty of a crime by reason of mental disease or defect) from maximum security confinement to another facility (e.g., hospital or emergency department) for medical treatment ([PA 17-179](#)).

Health Care Professions

Alcohol and Drug Counselors

Legislation passed in 2017 specified that a licensed alcohol and drug counselor may provide counseling services to a person diagnosed with a co-occurring mental health condition other than alcohol and drug dependency if such counseling is within the licensee's scope of practice ([PA 17-146, § 22](#)).

This session, a new law updates statutory definitions and licensure requirements for alcohol and drug counselors. Among other things, it:

1. distinguishes between the scope of practice of alcohol and drug counselors who are licensed and those who are certified and

2. specifies that the practical training and paid work experience required for licensure or certification must be supervised by a licensed alcohol and drug counselor or other licensed mental health professional whose scope of practice includes screening, assessing, diagnosing, and treating substance use disorders and co-occurring disorders ([PA 18-168](#)).

Certified Behavioral Analysts

Legislation passed in 2015 required the education commissioner, in consultation with the DPH commissioner, to study the (1) potential advantages of licensing board certified behavior analysts and assistant behavior analysts credentialed by the Behavior Analyst Certification Board and (2) inclusion of board certified behavior analysts and assistant behavior analysts in school special education planning and placement teams. The education commissioner reported to the Public Health and Education committees on these studies in 2016 ([PA 15-242](#)).

Based on the report's recommendations, the legislature enacted legislation in 2017 requiring behavior analysts to obtain a license from DPH by proving they are either (1) certified by the Behavior Analyst Certification Board or (2) eligible for licensure by endorsement. The act did not create a new regulatory board for behavior analysts and requires that assistant behavior analysts work under a licensed behavior analyst's supervision ([PA 17-2, JSS](#)).

Continuing Education for Physicians

Legislation passed in 2013 added behavioral health to the list of mandatory topics physicians must take for continuing medical education, which already included infectious diseases, risk management, sexual assault, domestic violence, and cultural competency ([PA 13-217](#)).

Continuing Education on Veterans' Mental Health Conditions

A 2015 law requires certain health care professionals to take at least two contact hours of training or education on mental health conditions common to veterans and their family members, during the first renewal period in which continuing education is required and once every six years thereafter. This includes (1) determining whether a patient is a veteran or a veteran's family member; (2) screening for conditions such as post-traumatic stress disorder, risk of suicide, depression, and grief; and (3) suicide prevention training.

The requirement applies to advanced practice registered nurses, alcohol and drug counselors, chiropractors, marital and family therapists, professional counselors, psychologists, and social workers ([PA 15-242](#)).

Conversion Therapy Prohibition

A 2017 law prohibits health care providers, or anyone else while conducting trade or commerce, from practicing or administering “conversion therapy” (i.e., any practice or treatment that seeks to change a minor’s sexual orientation or gender identity). It identifies certain types of counseling that are not considered conversion therapy, such as counseling intended to assist a person undergoing gender transition or facilitate a person’s identity exploration. It also prohibits the use of public funds for conversion therapy or related actions ([PA 17-5](#)).

Marriage and Family Therapy, Professional Counseling, and Psychology Students

A new law modifies the length of time during which marriage and family therapy, professional counseling, and psychology students may practice without a license in order to complete the supervised work experience required for licensure.

It allows these graduates to practice in this unlicensed capacity for up to two years after completing the supervised work experience, if they failed the respective licensing exam.

Under prior law, professional counseling and psychology students could practice in this manner until they were notified that they failed the respective licensing examination, or one year after completing the supervised work experience, whichever occurred first. For marital and family therapy students, prior law did not specify that the licensure exemption ended on the earlier of these two dates ([PA 18-168](#)).

Parental Notification for Hospital Admission

A 2013 law reduced, from five days to 24 hours, the time within which a hospital must notify a parent or guardian of a child (1) age 14 or older or (2) in DCF custody, that the child was admitted for the diagnosis or treatment of a mental disorder without the parent’s or guardian’s consent ([PA 13-130](#)).

Professional Counselors

A 2017 law establishes new qualifications for professional counselor licensure, starting in 2019. For example, it requires applicants to have graduated from a (1) program accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP) or (2) regionally accredited program and meet other requirements similar to existing CACREP standards.

In some circumstances, the act allows applicants who were enrolled in a graduate program on or before July 1, 2017 to apply for licensure under the current requirements after the new ones take effect in 2019. It also requires professional counselors' continuing education to include three contact hours in professional ethics annually ([PA 17-94](#)).

Psychology Technicians

A 2016 law allows psychology technicians with specified education and training to provide certain psychological testing services, if acting under a psychologist's supervision and direction ([PA 16-66](#)). Legislation passed in 2017 establishes certain requirements for the supervising psychologist, such as verifying the technician's credentials and remaining on-site while the technician is providing services ([PA 17-128](#)).

Regional Behavioral Health Consultation System for Pediatricians

Legislation passed in 2013 required the DCF commissioner, by January 1, 2014, to establish and implement a regional behavioral health consultation and care coordination program for primary care providers who serve children. The program gives providers:

1. timely access to a consultation team that includes a child psychiatrist, social worker, and care coordinator;
2. patient care coordination and transitional services for behavioral health care; and
3. training and education on patient access to behavioral health services ([PA 13-3](#)).

Reporting of Impaired Health Care Professionals

By law, physicians, physician assistants, and hospitals must notify DPH if a physician or PA is or may be unable to practice with skill and safety due to impairment. The law also establishes procedures for DPH to follow when it receives such notice. A 2015 law expanded the reporting requirement to cover all licensed or permitted health care professionals and established similar procedures for DPH to follow when it receives such notice ([PA 15-5, JSS](#)).

Legislation passed in 2017 eliminated the requirement that health professionals notify DPH if they were diagnosed with a mental illness or behavioral or emotional disorder. Previously, professionals had to provide the notice within 30 days of the diagnosis and could satisfy the requirement by seeking intervention with the professional assistance program for DPH-regulated health professionals ([PA 17-178](#)).

Insurance

Adverse Determinations and Mental Health Insurance Coverage

A 2013 law made various changes to the process for appealing adverse determinations (e.g., claims denials) by health insurers. Among other things, it reduced the time health insurers have to (1) make initial determinations on requests for treatments for certain mental or substance use disorders and (2) review claim denials and other adverse determinations of such requests ([PA 13-3](#)).

Behavioral Health and Autism Spectrum Disorder Services (ASD)

Legislation passed in 2015 expanded certain individual and group health insurance policies' required coverage of ASD services and treatment. For example, it required individual policies to conform to several coverage and limitation provisions that existing law requires of group policies. It also eliminated maximum coverage limits on the Birth-To-Three program ([PA 15-5, JSS](#)).

Elimination of Medicaid Case Management Requirements

A 2015 law eliminated specific requirements related to providing intensive case management (ICM) services to certain Medicaid recipients. For example, it eliminated provisions requiring Medicaid administrative service organizations (ASOs), beginning July 1, 2016, to provide ICM services that include (1) identifying hospital emergency departments with high numbers of frequent users and (2) creating regional ICM teams to work with emergency department doctors.

The act instead allowed DSS to contract with the behavioral health ASO to provide intensive care management ([PA 15-5, JSS](#)).

Health Insurance Coverage for Mental and Nervous Conditions

Legislation passed in 2015 expanded the services certain health insurance policies must cover for mental and nervous conditions. By law, a policy must cover the diagnosis and treatment of such conditions on the same basis as medical, surgical, or other physical conditions. The 2015 act required policies to cover, among other things:

1. medically necessary acute treatment and clinical stabilization services;
2. general inpatient hospitalization, including at state-operated facilities; and
3. programs to improve health outcomes for mothers, children, and families.

Under the act, a policy may not prohibit an insured from receiving, or a provider from being reimbursed for, multiple screening services as part of a single-day visit to a provider or multicare institution ([PA 15-226](#), as amended by [PA 15-5, JSS](#)).

Insurance Department Data Collection Working Group

A 2015 law required the insurance commissioner to convene a working group to develop recommendations for uniformly collecting behavioral health utilization and quality measures data from various entities, such as (1) insurers and (2) state agencies that pay health care claims. The commissioner submitted the recommendations to the governor and the Children's, Human Services, Insurance and Real Estate, and Public Health committees in 2016 ([PA 15-5, JSS](#)).

Medicaid Rate Increase for Private Psychiatric Residential Treatment Facilities

Legislation passed in 2014 required the DSS commissioner to submit to the federal Centers for Medicare and Medicaid Services a state plan amendment to increase the Medicaid rate for private psychiatric residential treatment facilities. The increase must be within available state appropriations.

The law defines a "private psychiatric residential treatment facility" as a nonhospital facility with an agreement with a state Medicaid agency to provide inpatient services to Medicaid-eligible people who are younger than age 21 ([PA 14-217](#)).

Medicaid State Plan Provider Expansion

A 2014 law required the DSS commissioner, by October 1, 2014, to amend the Medicaid state plan to include services provided to Medicaid recipients age 21 or older by licensed (1) psychologists, (2) clinical social workers, (3) alcohol and drug counselors, (4) professional counselors, and (5) marriage and family therapists. The commissioner was required to (1) include the clinicians' services as optional services under the Medicaid plan and (2) provide direct reimbursement to Medicaid-enrolled providers who treat Medicaid recipients in independent practice settings ([PA 14-217](#)).

Mental Health Parity and Compliance Checks

Legislation passed in 2013 required the insurance commissioner, by September 15, 2013, to seek input from various stakeholders on methods the department might use to check for compliance with state and federal mental health parity laws by health insurance companies and other entities under its jurisdiction. The stakeholders had to include the Healthcare Advocate, health insurance companies, health care professionals, and behavioral health advocacy groups ([PA 13-3](#)).

Miscellaneous

Gun Credential Eligibility

A 2013 law expanded the circumstances in which mental health history disqualifies a person for a gun permit or other gun credential, by (1) extending the look-back period for psychiatric commitments from 12 to 60 months and (2) disqualifying people with voluntary psychiatric admissions (other than solely for alcohol or drug treatment) within the prior six months. As part of this process, the act (§ 10) requires psychiatric hospitals, without delay, to notify the DMHAS commissioner about such voluntary admissions ([PA 13-3](#)).

Mental Health First Aid Training

Legislation passed in 2013 requires the DMHAS commissioner, in consultation with the State Department of Education commissioner, to administer a mental health first aid training that teaches participants how to (1) recognize signs of mental disorders in children and young adults and (2) connect such children and youth with professionals who can provide suitable mental health services. In administering this training, the commissioners may seek funding from the federal or state government, as well as from private donors.

The 2013 law requires all district safe school climate coordinators to participate in the training and allows teachers, school nurses, counselors, and other school employees to participate at the discretion of each local or regional board of education.

It also requires the State Board of Education, within available resources, to help and encourage school boards to include such training as part of their in-service programs ([PA 13-3](#)).

Sandy Hook Workers Assistance Program

A 2013 law established the Sandy Hook Workers Assistance Program and Fund to provide financial assistance to certain people who suffered a mental or emotional impairment related to the events at Sandy Hook Elementary School ([SA 13-1](#)).

Substance Use Disorders

Opioid Drug Abuse

In recent years, the legislature has enacted various laws to reduce and prevent opioid drug abuse, such as (1) increasing access to opioid antagonists (i.e., medication to treat a drug overdose); (2) providing immunity for people who (a) seek emergency medical assistance for themselves or another person experiencing a drug overdose or (b) prescribe and administer opioid antagonists to a person experiencing a drug overdose (“Good Samaritan” laws); (3) establishing a statewide prescription drug monitoring program; and (4) limiting the amount of certain opioid drugs that may be prescribed to adults and minors. For more detailed information on these laws, see [OLR Report 2018-R-0127](#).

Prescribing Controlled Substances Using Telehealth

A new law allows telehealth providers to prescribe non-opioid Schedule II or III controlled substances using telehealth to treat a psychiatric disability or substance use disorder, including medication-assisted treatment.

Providers may only do this (1) in a manner consistent with the federal Ryan Haight Online Pharmacy Consumer Protection Act; (2) if it is allowed under their current scope of practice; and (3) if they submit the prescription electronically, in accordance with existing law. Prior law prohibited telehealth providers from prescribing any Schedule I, II, or III controlled substances using telehealth.

The new law also modifies requirements for telehealth providers to obtain and document patient consent to provide telehealth services and disclose related records ([PA 18-148](#), effective July 1, 2018).

Sober Living Homes

A new law contains several provisions on the oversight of sober living homes. Among other things, it (1) allows a certified sober living home’s owner to report the home’s certified status to DMHAS, (2) requires DMHAS to post on its website a list of these certified homes as well as the number of available beds at each home and update the information weekly, and (3) establishes certain advertising requirements and restrictions for operators.

The new law also requires operators who report their home's certified status to maintain at least two doses of an opioid antagonist (i.e., Narcan) on the premises and train all residents in how to administer it. The operator must do this when the home is occupied by at least one resident diagnosed with an opioid use disorder ([PA 18-171](#), October 1, 2018).

Studies

Psychiatric Services Study

A 2015 law required the DMHAS commissioner, in consultation with certain officials and groups, to study the current adequacy of psychiatric services (e.g., how many psychiatric beds are needed in each region of the state). The commissioner reported on the study to the Appropriations, Human Services, and Public Health committees in 2017 ([PA 15-5, JSS](#)).

Study on the Provision of Behavioral Health Services at School-Based Health Centers (SBHCs)

A 2013 law required the DPH commissioner to study and report to the Public Health Committee by February 1, 2014 on the provision of behavioral health services by SBHCs in the state. The commissioner was required to do this (1) in consultation with the SBHC advisory committee and DCF commissioner and (2) only if DPH received private or federal funds to conduct the study ([PA 13-287](#)).

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