NASW National Association of Social Workers / Connecticut Chapter

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Testimony on HB 5001: An Act Concerning Children's Mental Health
Public Health & Committee on Children
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Submitted by: Stephen Wanczyk-Karp, LMSW

On behalf of the National Association of Social Workers, Connecticut Chapter representing over 2,300 members, we thank the Committees for the bi-partisan proposed bill HB 5001. This is a monumental piece of legislation that we look forward to working on as it develops. This testimony will speak to those sections of the bill that are most relevant to social work and to our recommendations for revisions and additions. First however brief comments on social workers in Connecticut that helps to frame the discussion.

There are 8,244 LCSWs in Connecticut and 4,362 LMSWs as of February 23, 2022. This is a larger number than all the licensed psychologists, marital & family therapists and professional counselors combined. From December 31, 2020 to now there has been an increase of 758 LCSWs and 921 LMSWs. Our state is home to six MSW programs that will graduate approximately 450 students in Spring 2022. Out-of-state schools are estimated to have at least another 150 graduating Connecticut students. The student bodies are quite diverse with students of color making up a range of 30-50%. There is a shortage of bilingual social workers and male social workers but **it is not clear to what degree there is a shortage of licensed social workers. What there is a shortage of is adequate compensation, especially in the non-profits sector**, which has led to difficulties in attracting licensed social workers for those employers who are unable to pay adequate salaries.

Section 1: As telehealth has taken hold and proven most beneficial for the delivery of mental health services, portability of licenses is more important than ever before. For the social work profession every state uses the same set of licensure exams and similar requirements for supervision and experience. This makes reciprocity especially sensible for our profession and we **fully support the language in Section 1**.

Section 2: We are **opposed to the language in Section 2 (except for sub-section g that we do support)** as we do not support allowing clinical social work practice to be performed without a license or temporary license. We also find the one-year period to be too long for practicing without some form of licensure. It seems to us that this

section will do little to assure an adequate supply of LMSWs. We do however support the intent of assisting licensure candidates to be able to practice while preparing for passage of the licensure exam, especially for ESL applicants. CT already has an accommodation for ESL applicants by allowing 2 extra hours for taking the exam and a translation dictionary. **We recommend that this section be redrafted by changing the procedures for the temporary license**. The current temporary license is good for 120 days starting at the date of graduation of the applicant. Given that applicants must show proof of attaining the MSW and then they have to apply for the temporary license, no one actually gets 120 days. Plus, failure to pass the exam revokes the temporary license, which we feel is not fair to those applicants who may have difficulty taking exams. **NASW/CT recommends that this section be revised to allow the temporary license to begin upon issuance of license by DPH, and be good for up to 180 days or failure to pass the examination twice, whichever comes first.** This will assist all applicants for licensure, not just ESL applicants and allows new graduates to enter the field upon graduation.

Section 3: We **oppose section 3** as we feel one-year is too long for holding a temporary license. As noted above we recommend 180 days maximum for the temporary license based on the temporary license starting upon issuance of license by DPH. **We note here, that upon the request of NASW/CT, DPH is filing a request with the Association of Social Work Boards to allow MSW students to take the LMSW exam in their final semester of school. If the student passes the exam DPH will license them as a LMSW upon completion of degree.** If this waiver is granted to Connecticut (it has been granted in other states) this will greatly assist students to enter the workforce sooner and gives licensure applicants an opportunity to take the exam prior to graduating. **We recommend that Section 3 be deleted.**

Section 4: We support section 4. Examination preparation classes are very effective. Costs for a two-day class can run $300-400 and a one-day class $150-200. **It needs to be clarified if this section only applies to classes and tutoring or if it includes home-study programs. We recommend that home study material be included**. For purposes of transparency NASW/CT sponsors a license prep course and splits net profits 50/50 with the vendor.

Section 5. NASW/CT has concerns as to this section. First of all, we do not believe that DPH has the capacity to administer a scholarship program. Secondly, **we suggest that such funds for a scholarship program are better applied to the examination preparation grants in Section 4.** The issues of equity that are addressed in this section can be applied to Section 4 with preference to those diverse applicant's seeking grants for prep classes. **Instead of a scholarship for the LMSW application we strongly urge the Legislature to LOWER THE LICENSURE FEES FOR ALL APPLICANTS.** CT has the highest annualized social work fees in the nation and we are one of only six states to renew licensure annually (see fee comparison report http://naswct.org/wp-content/uploads/2022/02/Licensure-fee-comparison-memo.pdf).

Section 7: We are in support of this Section as CT tends to be data short when it comes to social services delivery.

Section 9: We support increased support for pediatric practices and for the families they serve. **NASW/CT recommends this section be enlarged, or a new section added to create a pilot program of integrated health care whereby state grants are available to pediatric practices for start-up costs of employing licensed social workers within the pediatric practice.** Integrated Care has years of research supporting an evidenced based model - Primary Care Behavioral Health. PCBH embeds a social-work-licensed clinician in the medical office to provide interventions during the medical office visit and identifying additional needs or concerns. This has proven very effective at delivering mental health care to children and their families. We know that approximately half of all pediatrician referrals to a mental health provider are not followed up by patient's family. Having mental health services embedded in the pediatric practice is the best solution to this problem.

Sections 10, 11, 12, 13, 14, 15: We support extension of the Telehealth Law however **urge the Legislature to make the statute permanent rather than expiring on June 30, 2024.**

Section 16: We support having the Office of Healthcare Advocate designate an employee as stated in this section. We do question if adequate staffing exists in the Office of Healthcare Advocate or if an added employee is necessary to achieve this work. If the Healthcare Advocate seeks additional staffing, we will support such a request.

Section 17: We support the data collection on school social workers. We have found that such data is not available leaving it impossible to determine which school districts are lacking in school social work services and which systems are understaffed for school social workers. The *NASW Standards for School Social Work Services* call for a ratio of 250 students per one social worker.

Section 18: This is one of the most significant provisions in HB 5001. **NASW/CT strongly supports the grant program allowing school districts to hire additional student mental health specialists.** We know that mental health concerns are an obstacle to students learning and school social workers and other school based mental health staff are essential to meeting the current and future mental health needs of students.

Section 19: We support a grant program for school districts to enhance school-based mental health services. Schools are the one place where children can be reached thus school-based mental health services are essential to effectively addressing the crisis in children's mental health.

Section 31: We strongly support the inclusion of licensed mental health and substance use providers to address the immediate needs of callers and to make appropriate referrals to community based mental health and substance use services. Redirecting calls to an appropriate trained responder will greatly diminish the problem of responders to mental health calls not be trained for safe and effective response. **NASW/CT recommends that a grant program is created to assist those communities that do not currently have staff capacity to directly respond to calls by social workers or other mental health/substance use professionals.** We note that the Governor's Task Force on Police Accountability and Transparency offers positive recommendations regarding utilization of licensed social workers and appropriate responses to 911 calls related to persons with disabilities. We encourage the Legislature to adopt the recommendations of the Task Force.

Section 45: We strongly support the loan forgiveness program as a way to address the high costs of attaining a behavioral health degree. MSW programs can cost upwards of $80,000 and given the salaries for behavioral health providers excellent candidates may choose another career path. Loan forgiveness will encourage students to pursue a career in behavioral health. It will also make it easier to attract clinicians to stay in or relocate to Connecticut.

Section 53: School based mental health centers are a cost-effective means of delivering mental health services in schools. We are pleased to see that this Section includes school based mental health clinics as part of the mix of potential options in planning for services. **We strongly support development and expansion of school based mental health clinic**s.

Sections 56, 57: We support requiring insurers to cover collaborative care models as a means of expanding integrated health care as previously stated in this testimony.

Section 64: Reimbursement rates from insurers are woefully inadequate. Many providers report not having a rate increase in multiple years despite costs of practice rising over the years. While insurers have premium rate increases approved annually, such insurers continue to deny provider rate increases. This has caused providers to leave insurance panels in areas of the state where there are a sufficient number of individuals that can pay privately. Experienced practitioners with established practices are more likely to drop insurance panels. Before the pandemic this was a growing problem and since the start of the pandemic the astronomical increase in demand for mental health care has accelerated this trend. Simply stated, individuals with insurance coverage who cannot afford to pay out-of-pocket have diminished options for finding an available mental health provider. This is an issue that has been brought before the Insurance Department for years and the Department has either chosen to ignore it or has not seen it as their responsibility to address the problem. **We applaud finally requiring a study of these issues however recommend that an independent panel that**

includes representation of the Insurance Department but not solely under the Insurance Department conduct the study.

Section 65: We support a study of HUSKY to determine to what extent payment parity does or does not exist between physical health and mental health services. Furthermore, studying what rate of reimbursement is necessary to attract providers under HUSKY is supportable by us, though we note that historically providers have increased when HUSKY rates increase. Thus, the question is not will increased rates attract more providers, the question is how much of an increase is necessary to attract more mental health providers under HUSKY?

Section 66: As previously stated in this testimony we fully support integrated health care models. **We strongly support HUSKY using a Collaborative Care Model to best serve the Medicaid population**.

One additional provision we strongly recommend and have not touched on in this testimony is allowing a waiver for out-of-state licensed clinicians to treat current clients who are attending school in Connecticut or Connecticut students going to school out-of-state who start therapy with an out-of-state therapist and want to continue treatment while home in Connecticut for school breaks. For continuity of care an exemption from the Connecticut license will allow for ongoing treatment. DPH has indicated support for this limited exemption and conversations with members of both parties has generated complete support. **We strongly urge that this provision be added to HB 5001**.

We appreciate the opportunity to submit this testimony and NASW/CT looks forward to continuing to work with the Committees toward further refinements and improvements to this historic legislation.