Date: February 25, 2022
To: Public Health Committee & Committee on Children
From: Brunilda Ferraj, MSW, Vice President of Programs & Operations, The Alliance
Re: H.B. 5001 AAC Children's Mental Health & S.B. 2 AA Expanding Preschool and Mental and Behavioral Services for Children

Good morning, Senator Daughtery Abrams, Representative Steinberg, Senator Anwar, Representative Linehan, Senator Hwang, Senator Somers, Representative Petit, Senator Kelly, Representative Dauphinais and distinguished members of the Public Health Committee and Committee on Children.

Thank you for the opportunity to provide testimony today on H.B 5001 An Act Concerning Children's Mental Health and S.B. 2 An Act Expanding Preschool and Mental and Behavioral Services for Children.

I am Brunilda Ferraj, Vice President for Programs & Operations at the CT Community Nonprofit Alliance. The Alliance is the statewide organization representing the nonprofit sector. Community nonprofits provide essential services to more than half a million people and families in Connecticut every year and employ 115,000 Connecticut workers, improving the quality of life in communities across the State.

First, we want to thank members of these committees, legislative leaders and the bipartisan coalition of legislators and leaders who have identified the children's mental health crisis as the top priority for the General Assembly this year. This crisis is not new, and many of the changes proposed in this bill are long overdue. The pandemic has been two years of continuous trauma for children and families and Connecticut must act now to meet the behavioral health needs of children for years to come. I appreciate the legislature's intent to do so.

Due to the nature of the language proposed before the Committee today, this testimony will focus on H.B. 5001, which includes many new programs and services, which are needed and for which we are grateful.

But in addition to adding new services and programs to the system, we respectfully request that the Committee consider bolstering the foundation on which mental health services are provided – a foundation based on community services that has eroded over time due to chronic underfunding.

To be clear: there is no way to address the children's mental health crisis without addressing the chronic underfunding of the existing services provided by nonprofits. The legislature's

commitment children's mental health must extend to the appropriations process and must increase funding for community nonprofit services.

As one example, this bill proposes to expand assessments of the behavioral health needs to children at pediatrician offices and schools, but children will need a place to go to receive treatment once their needs have been identified. Without it, they will just be added to growing waiting lists where they will languish unless we increase capacity of community services at the same time.

In addition, the bill has successfully identified several important gaps in the structure of the children's behavioral health system, but the solutions proposed do not address closing them head on. Here are two examples:

- The bill proposes to allow prospective clinicians for whom English is a second language who have failed their licensing exam to receive an extension on their temporary license and to take the exam again in six months. If the Committees intend to address this issue in a comprehensive way, we respectfully request you mandate that licensure exams be offered in Spanish and the other non-English languages spoken in Connecticut. This would go a long way in bolstering the number of bilingual clinicians able to offer services.

- The bill also proposes several measures regarding truancy in schools and access to social work services in schools. In the school social worker system, social workers may only provide services during school hours in the school. When providers offer these services, they combine them with other grant-funded services like care coordination so they can address issues of family mental health and substance abuse, housing insecurity, etc. Often, community providers find truancy linked to these issues. We respectfully request that the Committee recommend these services be provided by a community nonprofit, who will be able to identify, address and help the family navigate through a range of services and programs to meet their needs in a holistic way.

We invite the Committees to seize the opportunity of this year's session to take concrete steps to fixing as many structural issues effecting Connecticut's children as possible.

We would also like to address an omission from the proposal that we hope the Committee will include in future drafts: while the bill proposes many new programs and services, it does not add oversight to or provide coordination for the system of behavioral health services in Connecticut. To date, several groups work in parallel to each other: The Children's Behavioral Health Plan Implementation Advisory Board, the Children's Committee of the Behavioral Health Partnership Oversight Council, and the various children's behavioral health workgroups organized by DCF and the Center for Health and Development Institute of Connecticut (CHDI). It is concerning to us that there is no formal coordination or leadership among these various groups.

In addition, Connecticut seems poised to soon exit the federal consent decree in Juan F., and when it does, the children's behavioral health system will lose critical independent oversight capacity. Without that oversight, connected with funding to, for example, conduct a needs assessment and make recommendations to the legislature, the legislature cannot how to hold the state and school districts accountable to implement the many changes proposed in this bill.

Too often, decisions regarding the future of the children's behavioral health system are made without adequate data.

For example, in recent years the residential capacity in the children's behavioral health system has been reduced substantially. The current year's budget closed several therapeutic group homes, and DCF is proposing to close a residential program called Short-term Integrated Family Integrated Therapy (S-FIT) next month, all while proposing to stand up five new "short-term acute crisis centers" with a residential component in the Governor's Budget. DCF has reported that the programs were experiencing low utilization and children were staying far beyond the intended length of stay, but providers report that lengths of stay were often extended beyond the proper length of time because children had no where to go from these placements. We've heard of children waiting extra weeks and months because the proper community-based services were not available. To us, this speaks to the need to bolster community services to ensure that children have access to all levels of care needed to meet their needs.

We are also concerned that the justification for closure of existing programs is low utilization. We appreciate that utilization is one of several valid reasons to make programmatic changes, but it has so far been presented in the absence of other data. In this case, if the demand exists for sub-acute crisis stabilization residential units, why was utilization low enough to close Therapeutic Group Homes and S-FIT programs?

Instead, these decisions should be made with a full understanding of the potential impacts on Connecticut's kids and the outcomes kids are experiencing in the behavioral health system, such as:

- For children leaving the emergency department (ED) or inpatient, what level of care were they referred to? What was the wait time for placement? What were their outcomes in terms of placement disruptions from there? (ED visits, educational success, clinical factors, court involvement)
- What are demographic and acuity characteristics of children being diverted from residential treatment? Of children in the ED with BH needs?
- What are the waiting times for placement with a foster family? And what are the rates of disruption and continued placement failures?
- Which services currently have waiting lists or how long until the next available appointment?
- Data demonstrating that intermediate levels of care available and accessible for those children for whom providers are coordinating care.

- What are the rates of rejection of children from Solnit and Solnit's PRTF, and to where are those children being referred?

We ask that, in the future, the legislature make these critical decisions with input from an independent oversight body that could collect and analyze data and ask important questions.

Please accept our comments and suggestions on the specific proposals in H.B. 5001:

Sections 2-5: Behavioral Health Licensure to increase a diverse workforce:

We appreciate the Committees' proposal to improve the licensing process, especially with an eye to increasing the diversity of the clinical workforce in the state. We respectfully offer the following comments.

As mentioned above, the real issue is the licensure tests in Connecticut are only offered in English. At a bare minimum, the legislature should mandate that Spanish-speaking clinicians be allowed to sit for their examination in Spanish.

While we appreciate Section 5's scholarship program for professional licensure, we remind the legislature that, in addition to the LMSW, two other associate licensures were added by the legislature in 2019 – Licensed Professional Counselor Associate and the Licensed Marital & Family Therapist Associate. Before this new law, unlicensed clinicians were required to meet stringent educational standards, as they worked towards the amount of supervision they would need to apply for licensure. In many cases, unlicensed clinicians decided not to sit for their full licensure exams, instead choosing to work under the supervision of a licensed clinician. The new associate licenses are mandatory, but unlike full licensure, there is no test or exam to become an "associate," only education requirements and an annual fee. Associates cannot practice independently and must work under the supervision of a licensed clinician. Many of the people impacted by this new law are clinicians of color and bilingual staff. Last year, the legislature grandfathered people whose degrees do not meet new educational standards to allow them to continue to practice. But there are still outstanding issues that will affect kids:

- There are several evidence-based programs that use staff with varying levels of education. The fidelity of these programs, and their funding, do not allow for staffing to all be LPCA-level practitioners, but state agencies and providers are concerned that the existence of LPCAs may not allow the programs to continue. Children's services are negatively impacted by the new LPC and LMFT licensure requirements, including Intensive In-Home Child & Psychiatric Services (IICAPS), Emergency Mobile Psychiatric Services (EMPS), and Multisystemic Therapy (MST), all essential services in the DCF and CSSD continuum of care.

- Some staff choose to practice under supervision for their entire careers without obtaining licensure and there should be specific acknowledgement in statute that choice is permitted.

- Licensed Alcohol & Drug Councilors (LADC) have very similar licensure requirements to LPCs and LMFTs but there is no associate LADC. With the creation of LPCAs, there is now no path to obtaining an LADC that does not lead through first becoming an LPCA. Given the scope restrictions of LPCs in addiction treatment, we are concerned this will create fewer addiction professionals in the future.

Section 9 – Regional Behavioral Health Consultation & Care Coordination Program.

This section expands ACCESS Mental Health to allow primary care patients telehealth appointments with a mental health provider. We support increasing access to services within a primary care office, but we're concerned this proposal as drafted may cause duplication with the existing Emergency Mobile Crisis system. We encourage the Committees to discuss this proposal with stakeholders as the legislative process continues.

Sections 17-22 – School Social Workers & Truancy

We appreciate the legislature's attention on the availability of mental health services in schools, including access to school social workers. In addition to the structural issue addressed earlier in our testimony, we encourage the Committee to consider that many of the barriers facing kids access to mental health services in schools could be addressed by more school districts contracting with community providers to deliver in and out of schools. When well executed, community providers embedded in schools can provide care coordination and expand access to behavioral health care not just for the child but for the entire family. So often, children in need of mental health care or truancy intervention are dealing with significant behavioral health issues at home with their parents and caregivers. The language in Section 21 regarding a behavioral and psychiatric evaluation of a truant child should be much more holistic, so it can encompass an evaluation of the child's ecosystem.

Sections 28-35 – Establishment of 9-8-8

We are pleased to see the beginnings of the implementation plan for 9-8-8, the new nationwide Suicide Prevention Lifeline. We look forward to working with the Committees and other stakeholders to ensure its successful rollout.

Section 36 – Changes to Certificates of Need.

The Alliance is opposed to this section. Section 36 would eliminate the requirement to obtain a Certificate of Need (CON) for certain new behavioral health facilities or modifications to existing facilities. Nonprofit organizations that contract with the State are required to serve all clients regardless of their ability to pay and are therefore exempt from the current CON process. We are concerned that eliminating the requirement for other facilities that do not contract with the State will have the effect of inviting healthcare providers who are not willing to accept clients

without regard to their ability to pay for services and that it will have the effect of further depressing the payer mix that the State's community providers rely on to fund their services.

Section 44 – Respite Fund

This section establishes a fund at DCF for respite services. We are encouraged to work with the Committee to propose a more detailed program as it relates to nonprofit providers that could provide the service.

Section 45 – Student Loan Forgiveness

This section directs CHESLA to establish a mental health loan forgiveness program for licensed behavioral health clinicians that have consolidated their loans through CHESLA, have been paying their loans for 10 years, or 120 months, provides mental health services primarily to children and is employed by a mental health provider in a designated shortage area. **We support creating a student loan repayment and/or forgiveness program** for community behavioral health providers.

However, Section 45 as drafted is too narrow. First, the program must include areas of the state beyond the federally designated Heath Professional Shortage Areas. If the program must be limited to include only those who have dedicated their careers to serving the neediest, then it should be limited to those working for Connecticut's community nonprofits. If eligibility is to be limited to shortage areas, final language should direct DPH to expand the areas they designate beyond these federally designated areas, which are extraordinarily limited in Connecticut include only its urban centers.

Second, the bill limits participation in the program to providers who serve primarily children. The mental health crisis is impacting everyone in Connecticut, adults and children alike. We respectfully request this program be expanded to include all practitioners who meet the other conditions of the bill.

We also request the Committees work in concert with your colleagues on the Human Services Committee (H.B. 5040) and the Higher Education Committee (H.B. 5130), who are each considering similar and related loan forgiveness programs.

Section 53 – School-Based Mental Health Clinics

This section directs DCF, DPH and SDE to develop a plan to promote access to mental health services for children who do not have a school-based health center or an expanded school heath site. We look forward to working with the Committees to ensure this proposal is developed to be inclusive of all providers qualified to deliver these services and taking into consideration some of the issues we have raised regarding Sections 17-22.

Sections 64 and 65 – Parity Studies

We support sections 64 and 65, which direct the State Department of Insurance and DSS to conduct studies related to behavioral health parity. We are particularly supportive of the language in Section 65 that direct DSS to make recommendations for rate increases for HUSKY services. In a 2015 study[1], The Alliance found that nearly every billing code in the Medicaid behavioral health system resulted in a loss for providers. Costs have only increased since then. In addition, the biggest barrier community providers report with relation to commercial insurance is the prevalence of High Deductible Health Plans. Most people seeking services cannot afford to meet their deductible, making the rates paid by private insurance companies irrelevant when nonprofits must write off thousands in unpaid deductibles. Unlike those in private practice, community nonprofits will continue services regardless of someone's ability to pay their deductible.

Section 70 – DCF Funds for Providers

We support Section 70, which directs DCF to use any funds available to the department to increase capacity at outpatient, Partial Hospitalization Program (PHP) and Psychiatric Residential Treatment Facility (PRTF) providers. We look forward to working with the Committees so this section can be expanded to include a designated appropriation for these payments.

Thank you for your consideration of this important issue and for your dedication to making meaningful change to the children's mental health system.

Brunilda Ferraj, MSW
bferraj@ctnonprofitalliance.org

[1] http://www.governor.ct.gov/malloy/lib/malloy/shac_doc_final_report_-_final-ccpa-report-february-2015.pdf