Strengthening the Behavioral Health Workforce for Children, Youth, and Families

A Strategic Plan for Connecticut

NOVEMBER 2023

Aleece Kelly, MPP
Child Health and Development Institute

Michael Hoge, PhD
Yale School of Medicine;
The Annapolis Coalition on the Behavioral Health Workforce

Jason Lang, PhD
Child Health and Development Institute

CHDI® Child Health and Development Institute | Bridge to Better.™

CHDI.org

This report was produced by CHDI in collaboration with the Connecticut Children's Behavioral Health Plan Implementation Advisory Board with funding from the Connecticut State Department of Children and Families.

ACKNOWLEDGEMENTS

The authors are deeply grateful for the contributions of time and expertise provided by the Strategic Plan Advisors (listed below) and the Connecticut Children's Behavioral Health Plan Implementation Advisory Board who together offered guidance on the planning process and reviewed draft recommendations. We are also thankful to the many individuals who volunteered their time in interviews, as well as the 200 members of the workforce, families, and other stakeholders in Connecticut who responded to our survey. The information shared across the interviews and survey responses was integral to this report. Julie Tacinelli provided valuable edits and coordinated the production and distribution of the report. This strategic plan was made possible through funding from the Connecticut State Department of Children and Families.

STRATEGIC PLAN ADVISORS

Elisabeth Cannata, PhD
Vice President, Community Based Family Services and Practice Innovation, Wheeler Clinic; Tri-Chair, Connecticut Children's Behavioral Health Plan Implementation Advisory Board

Joanne Corbin, PhD, MPhil, MSS
Dean, School of Social Work, Adelphi University *Formerly UConn School of Social Work*

Sarah Eagan, JD
Child Advocate, State of Connecticut Office of the Child Advocate

Alice Forrester, PhD
Chief Executive Officer, Clifford Beers Community Health Partners

Francis Gregory, PhD
Administrator, Children's Behavioral Health Community Service System, Connecticut Department of Children and Families

Loida Reyes, PhD
Chairperson and Assistant Professor, Department of Social Work, Southern Connecticut State University

Jeff Shaw, MA MPH
Senior Public Policy Advisor, The Alliance

Marie M. Spivey, EdD, RN, MPA
Principal, Diversity & Life Skills Coach, System for Education, Equity, & Inclusion, SEET, LLC

Beresford Wilson
Executive Director, FAVOR

Strengthening the Behavioral Health Workforce for Children, Youth, and Families: A Strategic Plan for Connecticut

This strategic plan was developed to guide the State in building a sustainable workforce capable of meeting the behavioral health needs of Connecticut's children, youth, and families.

EXECUTIVE SUMMARY

Like nearly every other state in the country, Connecticut is facing two urgent challenges that are resulting in long waitlists and delays in care:

1. Increasing behavioral health needs among the state's children
2. A workforce shortage among those who serve children with behavioral health needs

When we strengthen the behavioral health workforce, children and communities in Connecticut are stronger.

This Plan identifies best practices and innovative solutions from across the nation that will help Connecticut address both immediate and long-term needs of the pipeline, recruitment, retention, diversity, and competencies of the workforce. It also reviews the conditions contributing to the current workforce challenges and the support systems that behavioral health workers need to do their jobs well. When we truly support those who are working hard to serve our youngest citizens with behavioral health needs, we provide our children with a high-quality foundation of health and well-being upon which to grow.

RECOMMENDATIONS

The following recommendations provide Connecticut with a blueprint for supporting a strong, diverse, and competent workforce to meet the behavioral health needs of children, youth, and families.

1. Increase reimbursement rates for children's behavioral health services to cover actual costs of high-quality care and establish a transparent and systematic rate-setting process.
2. Make immediate and significant investments in behavioral health workforce recruitment and retention.
3. Develop a children's behavioral health workforce center that can track and respond to trends in supply and demand and sustain workforce development efforts.
4. Grow and diversify the children's behavioral health workforce pipeline.
5. Increase behavioral health training across the child-serving workforce.
6. Remove administrative barriers to workforce entry and retention.
7. Expand the youth and family peer support workforce.
8. Expand the role and capacity of community-based organizations in prevention and early intervention.

ABOUT THE PLAN DEVELOPMENT

The Plan was developed through a comprehensive and collaborative process inclusive of workforce, family, faculty, and national expert perspectives.

The process to identify recommendations for policy and system changes included:

- Guidance from a group of advisors with expertise and experience in Connecticut's children's behavioral health system
- A survey of Connecticut stakeholders resulting in **more than 200 responses**
- A review of national and state-level initiatives, including **40 different initiatives** across states
- Interviews with **20 Connecticut and national experts** in children's behavioral health

Key Findings from the Plan: A Solid Foundation Has Been Severely Strained

Connecticut's system of care for children has many strengths on which to build, including a robust continuum of services, a specific focus on the child and youth population, a dedicated network of providers, and comparatively good access to evidence-based practices. However, for years reimbursement rates and grant funding have failed to keep pace with inflation and the true costs of delivering effective care. In addition, the COVID-19 pandemic has increased needs and changed care delivery, severely straining the workforce.

Connecticut is Resourceful and Can Apply Best Practice Solutions to Address Our State's Workforce Challenges

While there are many factors straining the children's behavioral health workforce, the Plan provides guidance on what supports are needed, why they are important, and how they work so that our state's decision-makers can implement them. A review of Connecticut's prior and current efforts specific to the workforce found that Connecticut's relatively strong and nationally recognized infrastructure of behavioral health services for children offers a solid foundation to build upon. The Plan also identifies several best practices and innovative approaches for improving the workforce that are being used by other states and national organizations with success. States such as Oregon, Nebraska, and Massachusetts, have made significant investments in the behavioral health workforce and are finding that these solutions are working.

Growing and strengthening the children's behavioral health workforce requires a coordinated effort and sustained long-term commitment from policymakers, payers, educators, and behavioral health administrators. The result is a stronger and healthier future for our state.

The Plan Identified the Following Workforce Challenges:

- Rising acuity (i.e., severity of behavioral health symptoms) and staffing shortages are creating a cycle of workforce burnout and delays in care.
- Insurance reimbursement rates do not cover the true costs of delivering high-quality services, have not kept pace with inflation, do not reflect staff education and skill level, and are restricting the ability to offer compensation that attracts and retains qualified staff to the field.
- Telehealth has presented the workforce with more flexibility in private practice, pulling clinicians away from settings where more underserved children are treated, potentially widening disparities in care.
- There is an ongoing lack of parity between mental and physical health insurance in spite of existing laws.
- Behavioral health workforce demographics are less diverse than the population served, and there are systemic barriers to entering the workforce.
- Some members of the workforce lack the training and competencies needed to serve specific populations.
- There are gaps in Connecticut's workforce data that limit our ability to understand service and staffing needs and quality.

Introduction

Connecticut's behavioral health system for children, youth, and families stands upon a sturdy foundation, including a robust continuum of services, a specific focus on the child and youth population, comparatively good access to evidence-based practices, and a dedicated network of providers. However, stagnant reimbursement rates and an increased need for behavioral health services have put immense strain on the system and the committed workforce. As a result, the very foundation upon which Connecticut's children's behavioral health system was built is eroding. Growing and strengthening the children's behavioral health workforce using innovative solutions and best practices from across the nation is a top priority. The result will be a stronger workforce, healthier children, and a brighter future for our state.

The current workforce shortage is resulting in long wait lists and delays in care

Throughout the country, staffing shortages have undermined the children's behavioral health sector resulting in declining access to and quality of services for children and families. Connecticut is no different.

A recent survey of Connecticut non-profit providers found more than one in five positions were vacant, and there was a 39% rate of staff turnover in the last year.[1]

The current workforce needs are the result of years of reimbursement rates and grants failing to keep pace with inflation and the true costs of delivering effective care,[2] combined with increasing behavioral health needs among children and youth and changes to care delivery associated with the COVID-19 pandemic that severely strained the workforce. For example, the annual Youth Risk Behavior Survey conducted among a representative sample of Connecticut high school students has found rising rates of youth reporting feeling sad or helpless (increasing from 25% in 2005 to 36% in 2021),[3] with even higher rates among females, Black and Latinx youth, and lesbian, gay and bisexual youth.[4] These dual stressors of rising behavioral health needs and insufficient funding to provide appropriate care have resulted in an escalating cycle of high staff vacancies, higher caseloads and burnout among remaining staff, greater staffing shortages, longer waitlists, and ultimately delays in care for children and families.

Connecticut is seeking solutions to solve this challenge

These concerns have been voiced locally by providers, families, researchers, and other stakeholders across the children's behavioral health system, including during Behavioral Health Plan Implementation Workgroups held by the Department of Children and Families (DCF) and the Connecticut Children's Behavioral Health Plan Implementation Advisory Board (CCBHPIAB) in 2021 and 2022 to develop recommendations for strengthening implementation of the Behavioral Health Plan for Children (see sidebar). Workgroup members raised alarms regarding workforce shortages and the need for service expansion to be accompanied by significant investments in workforce development. While subsequent state legislation addressed several of the recommendations related to service expansion, there has been limited parallel action to address the workforce needs.

In 2022, the Connecticut General Assembly passed PA22-47, which created a new committee to focus on children's behavioral health. In 2023 PA23-90 formally named the committee the Transforming Children's Behavioral Health Policy and Planning Committee (TCBHPPC). The TCBHPPC began convening in July 2023. Its priorities and scope are still being developed. For the purposes of this strategic plan, we refer to the CCBHPIAB to support the implementation of some recommendations; however, TCBHPPC may also be an appropriate body to further recommendations as the committee's priorities are finalized.

In response to the concerns raised within the workgroups, DCF contracted with the Child Health and Development Institute (CHDI), which partnered with Dr. Michael Hoge (Yale School of Medicine and the Annapolis Coalition on the Behavioral Health Workforce), to develop a strategic plan to strengthen the children's behavioral health workforce.

The resulting plan provides Connecticut with a blueprint for supporting a strong, diverse, and competent workforce to meet the behavioral health needs of children, youth, and families. It identifies short- and long-term strategies to address the needs related to the workforce pipeline, recruitment, retention, diversity, and competencies and highlights best practices and innovative solutions from across the nation.

Implementing this plan requires a coordinated effort and sustained long-term commitment from policymakers, payers, educators, and behavioral health administrators. When we truly support those working hard to serve our youngest citizens with behavioral health needs, we provide our children with a high-quality foundation of health and well-being upon which to grow. The result is a stronger and healthier future for our state.

Connecticut's Behavioral Health Plan for Children

In response to the tragic murders that took place at Sandy Hook Elementary School in 2012, the Connecticut General Assembly passed Public Act (PA)13-178, which required creation of a state Behavioral Health Plan for Children as well as the Connecticut Children's Behavioral Health Plan Implementation Advisory Board to monitor its implementation. Since its enactment in 2014, it has served as a blueprint for the state's work to strengthen systems and services for children's behavioral health.

METHODOLOGY

The Annapolis Framework for Workforce Planning in Behavioral Health[5] was adapted for the child, youth and family focus (see Attachment A) and used as a guiding document throughout the strategic planning process. CHDI convened a small group of leaders within the state representing diverse stakeholder groups. These Strategic Plan Advisors (see Acknowledgements for full list) provided input and guidance during the planning process and feedback on draft recommendations.

The following methods were used to inform the plan's recommendations:

1. Children's Behavioral Health Stakeholder Survey

The survey questions solicited information on what respondents identified as the most pressing challenges facing the workforce as well as suggested solutions. The survey was shared widely with children's behavioral health providers, family advocate organizations and families with lived experience, higher education faculty, professional associations, Black and Latinx professional associations, trainers, and technical assistance providers. All stakeholders were asked to share the survey with their networks, and it was also posted on the CHDI website, shared on social media, and presented at stakeholder group meetings.

The survey resulted in 176 individual responses and 23 responses submitted on behalf of an organization. Of the individual responses, 77% identified as a current member of the workforce (including both direct service and supervisory positions), and 16% identified as family members of a child receiving behavioral health services, 6% as family advocate staff or volunteers, and 8% as higher education faculty. The other categories of stakeholders (e.g., students and trainers) had limited representation among survey responses. Note that respondents were able to select more than one role.

2. Review of National and Out-of-State Initiatives

A comprehensive review of investments in behavioral health workforce development across the country was completed to identify best practices and innovative approaches. Since most if not all states are experiencing both rising behavioral health needs and workforce shortages, many states and national organizations are exploring solutions and, in some cases, making ***significant*** investments in the behavioral health workforce. The review found more than 40 different initiatives across 14 states and several national organizations and federal agencies. The strategic themes found from the review have informed the selection of recommendations. Throughout the recommendations examples from the review have been included as ***"strategies in practice."***

3. Inventory of Connecticut Efforts

This plan and the included recommendations are building upon Connecticut's relatively strong and nationally recognized infrastructure of behavioral health services for children, as well as prior and current efforts specific to the workforce. The recommendations are intended to leverage and, in some instances, expand but not duplicate what has or is being implemented.

4. Expert Interviews

Twenty interviews were conducted to inform development of the recommendations. Interviewees were selected as national experts on specific components of workforce development, key stakeholders within the state of Connecticut, or represented states identified through the review of out-of-state initiatives as having particularly innovative or significant investments in the workforce.

FINDINGS

Across interviews and survey responses, the urgency and extent of the crisis within Connecticut and beyond was stressed. A national expert working with behavioral health agencies across the country stated that **"the *number one problem* in *every state* is the workforce shortage".** Findings from survey responses, interviews, and out-of-state initiatives regarding challenges in recruitment and retention, pipeline shortages, staff diversity, and workforce competencies are identified below.

> "I enjoy my profession and would love to remain as a behavioral [health] provider for the rest of my career. However this year has been extremely stressful, challenging, and tiring. I have...taken a couple of days to recover from burnout and still not fully recovered upon my return to work."
>
> – BEHAVIORAL HEALTH PROVIDER

Recruitment and Retention

The lack of adequate pay was among the most cited challenges from survey respondents (both from staff referring to their own compensation, as well as supervisors and agency leadership unable to attract qualified applicants for open positions). In multiple interviews, experts contended that current salaries among both clinical (licensed/license-eligible) and non-clinical staff (direct care staff, etc.) are insufficient to attract and retain staff, are not commensurate with staff education, skills, and experience, and have been relatively flat for years. Some respondents noted that nearly doubling the salaries was necessary to effectively recruit staff.

Compared to private practice, where many clients pay out-of-pocket and insurance may not be accepted, nonprofit community-based services and hospitals rely more on public and private insurance reimbursement payments to cover their costs.

> "It took four months to get an initial appointment and at least a half day on the phone trying to find one who was available."
>
> – FAMILY MEMBER

These providers are serving the state's highest need children and families, are more likely to provide evidence-based (and more effective) treatments and offer comprehensive care including family services and coordination with schools, pediatricians, and other providers. **But due to chronically low reimbursement rates, these providers cannot pay staff sufficiently** to sustain staffing levels much less to support increasing caseloads and rising acuity of children's behavioral health concerns. This negatively impacts families, particularly those who are traditionally underserved and seeking care at community-based organizations, resulting in waitlists and disruption in care due to staff turnover.

Non-profit community-based providers, which provide the majority of publicly funded behavioral health services within the state, are challenged to compete with private practice's flexible schedules, comparatively minimal administrative burden, lack of requirements around evidence-based practices, lower acuity of children, and higher pay rates than can be offered by public agencies. The expansion of telehealth during the pandemic has been beneficial to the system, including expanding access to services.[6] However, **telehealth has changed the workforce landscape**, expanding opportunities for clinicians to work from home for some Connecticut-based providers and private practices, but also national telehealth companies. **Private practices and national companies often do not accept insurance**, allowing them to charge families who can pay for services out-of-pocket at higher rates. An exodus of clinicians from community-based organizations appears to be widening the gap in access to care for marginalized populations.

Interviews with experts working to expand school-based health centers (SBHCs) within Connecticut noted that demand for behavioral health care within SBHCs is high with pressure from parents who have increasing concerns about the mental health of their children. Funding has been dedicated in recent years to expansion of SBHCs, however staffing shortages have made implementation challenging. Centers find that while the reimbursement model generally works for primary care, it is burdensome

and may not be worth the work for behavioral health services. **Reimbursement is often significantly lower than the cost of the service and, compared to primary care, requires more administrative processes and justification by the clinician. While mental health parity is a federal law, the reality of billing for and receiving approval for services is not comparable to primary care.** In one interview, a national expert referred to mental health parity as laughable given the lack of enforcement.

"We need the ability to practice without red tape and with ample compensation...please create more oversight of how insurance companies conduct business so that we can spend our time helping families."

– BEHAVIORAL HEALTH PROVIDER

Considering the extensive education and licensing requirements associated with becoming a behavioral health clinician (e.g., social worker, marriage and family therapist, professional counselor at the masters level and clinical psychologist at the doctoral level, etc.), the inherent pressure of these positions, added stress of high caseloads and children with high acuity, it is understandable that members of the workforce are feeling burnt out and seeking other opportunities. This stress impacts retention and raises concerns about staff wellness overall. In the survey, some members of the workforce even raised concerns regarding their own mental health. In general, the comparably low pay (see sidebar),[7,8] is a deterrent to entering and remaining in the behavioral health field overall, and especially to serving children and adolescents and working in settings serving high need populations. Considering the critical contributions this workforce makes to children's well-being[9] and long-term outcomes as adults,[10] the pay does not reflect the training required, job demands, or recognition of the significant value clinicians provide to our society.

Families and family advocates who responded to the survey were less likely to directly mention salaries or reimbursement rates, however they regularly referenced the service shortages in the state that are the result of inadequate funding, including long waitlists and staff turnover. **Staffing shortages keep families waiting for care while their children's acuity may increase, resulting in a need for higher levels of care that are more costly.**

Both members of the workforce and families identified gaps in available care for specific populations, including families needing services in a language other than English, children with developmental disabilities, undocumented families, children with co-occurring diagnoses and complex needs, as well as a shortage of acute and sub-acute levels of care (e.g., inpatient hospitalization, in-home services, intensive outpatient, psychiatric residential treatment facilities, etc.).

This in turn leads to placement of children in outpatient settings as a last resort when their needs are often not appropriate for that level of care. Unfortunately, it is challenging to disentangle the staffing shortages from service shortages (e.g., is there a long waitlist due to vacancies within the given service? Or is there not sufficient service *availability even when fully staffed?*).

SALARIES ACROSS COMPARABLE CLINICAL POSITIONS

Position	Low	High
Non-Profit	$58,839	$72,905
Private Practice	$82,400	$117,350
Public Agency	$80,489	$109,50

Living wage annual salary in Connecticut for one adult and one child is $78,475.

Systematic, integrated data about service referrals, waitlists, and staff vacancies – which is not currently available in any fashion for the state – **would help discern where additional service availability is needed versus where additional staff recruitment is needed.** This data on service availability would also provide an invaluable resource for families seeking services (and providers referring families to services) to know what services are available and when. Interviews noted that the lack of predictive models to scale levels of care based on observed changes in need is a challenge nationally as well.

"We could not find a play therapist within 1 hour of our home."

– FAMILY MEMBER

"The waitlists for more intensive services leave outpatient providers maintaining clients who are high-risk and not appropriate for that level of care."

- BEHAVIORAL HEALTH PROVIDER

Workforce Diversity

Families, family advocate staff, and behavioral health managers emphasized in survey responses the need for more diverse as well as bilingual staff representative of the clients they serve.

Actively working to increase the diversity of the children's behavioral health workforce in Connecticut both addresses system inequities for the existing and potential workforce who are Black, Indigenous, or people of color (BIPOC), and also can support engagement of diverse children and families in behavioral health care. Among licensed behavioral health professionals in Connecticut, approximately 80% are White, with 6% identifying as Hispanic or Latinx and 15% identifying as Black or African American. In contrast, only about 50% of the child population in the state identifies as White Non-Hispanic. The state has recently invested in prioritizing workforce initiatives for students from low-income families and historically marginalized populations (e.g., CT Health Horizons, loan repayment programs, etc.). To expand the diversity of the workforce, it will be critical to continue to make intentional investments to address the systemic racism that has created barriers to accessing education and career advancement opportunities in the field.

Interviewees emphasized the need to diversify the workforce as well. For SBHCs, there is a particular need for bilingual clinicians and other staff to work effectively with monolingual family members who speak a language other than English. They view this as a higher priority in behavioral health than primary care because they typically offer family therapy. They report it is also hard to find referrals to other levels of care within the system. The focus on pipeline growth presents a strong opportunity to intentionally recruit BIPOC and bilingual individuals into the field. It is also critical that providers work to offer an organizational culture that is inclusive and celebrates diverse and intersecting identities in order to retain a diverse workforce.

In addition to strengthening the pipeline of licensed clinical staff, **there is an opportunity to address portions of the staffing shortage and to diversify the workforce by investing in non-clinical positions, such as peer supports and community health workers.** States such as Maine and Iowa have programs that support entry-level positions through community college and training programs, as well as career pathways for those staff to continue to advance. Indiana found success during the pandemic in recruiting peer supports into the workforce to fill portions of the staff shortages.

Competencies: Strengthening Competencies and Skills Enhances the Workforce's Versatility and Effectiveness

While addressing staffing challenges is critical to ensuring access to timely care, the quality of care must also continue to be a priority. Interview and survey findings highlighted the following opportunities to strengthen workforce competencies:

- ***Expand Training on Evidence-Based Treatments (EBTs).*** Connecticut stands out in its training opportunities, in particular the number of clinicians trained on in-home, clinic- and community-based EBTs, with 54% of children in outpatient clinics reportedly receiving some EBT as part of their treatment. Research from Connecticut found that these EBTs were more effective than usual treatment and also reduced outcome disparities for children of color.[15] The state also supports a range of in-home EBTs, however more access to these high-quality treatments is needed. Many EBTs have been shown to significantly reduce future healthcare, social system, and unemployment costs.[16]
- ***Invest in field placements.*** Providers reported challenges with new graduates having less experience due to virtual field experience that took place in the initial part of the pandemic. Field placement is an important aspect of workforce preparation; however, it necessitates support from provider agencies to allow field placement within their agencies and the costs of supervising students. Incentives for offering child and family-focused field placements could support quality opportunities in the field prior to graduation.
- ***Build Skills to Improve Health Equity.*** Respondents stressed the need for more culturally responsive care and skills to serve LGBTQ+ and gender minority youth. Research has demonstrated differences in outcomes for clients depending on their skills regarding cultural humility.[17,18] One of Connecticut's strengths in its behavioral health system is the dissemination of Culturally and Linguistically Appropriate Service (CLAS) Standards. These national standards have been updated within Connecticut to reflect a racial justice framework and offer a blueprint to organizations to implement racially just and culturally and linguistically appropriate services. Ongoing dissemination of this model will benefit the state.
- ***Strengthen Services to Children with Complex Needs.*** Challenges regarding access to and quality of services for families with children who have intellectual or developmental disabilities were raised within the survey. There is an opportunity for improved services for these populations by strengthening the skills of the workforce. There are existing trainings within the state funded by DCF to address these competencies, as well as efforts to expand the content and audience of these trainings. This can be monitored for any additional gaps to address. Additional complex needs, such as youth involved in the juvenile justice system, those with co-occurring medical needs, and youth with substance use disorder should be addressed as well.
- ***Improve Supervision.*** While formal education provides the skills necessary for roles as clinicians, as staff advance in their careers, training for roles in supervision and leadership is limited. Additionally, there is often inadequate time to provide and receive supervision because of high caseload requirements resulting from inadequate fee for service reimbursement rates. Effective supervision and leadership in children's behavioral health is critical for strengthening recruitment and retention in the field and supporting staff wellness.
- ***Broaden the Audience.*** As appropriate, expand the audience for trainings to include direct care staff (staff providing non-clinical supports to children to supplement clinical services), include school-based behavioral health staff, and the broader child-serving workforce beyond behavioral health (e.g., primary care, juvenile justice, school nurses, etc.)

Recommendations for Building a Sustainable Workforce

Given the focus of this strategic plan, the recommendations presented are specific to the child, youth and family-serving behavioral health workforce. The behavioral health workforce, however, is under tremendous stress across settings, levels of care, and populations served (adults and children). In reviewing workforce development initiatives in other states, most strategies targeting the children's behavioral health workforce were broadened or scaled to impact the behavioral health workforce as a whole (those serving adults as well as children). Connecticut may choose to apply the identified recommendations across the full behavioral health workforce; however, it is critical that the unique needs of the child and youth population and the staff who serve them not be lost in broader workforce efforts, given the unique needs and skills associated with serving children and families.

The need to increase workforce diversity and improve health equity is included within each of the recommended strategies. This approach was taken to promote the intentional integration of diversity and health equity, and strengthen the quality of care and workforce development.

Connecticut has dedicated leaders, providers, and experts with the resourcefulness to repair and strengthen the workforce. For those dedicated to the health and well-being of children and families in this state, **this plan must be read as a *call to action* for a meaningful and long-term state response that reflects the current needs of the children's behavioral health system.** Immediate policy investments and a sustained commitment from policymakers, payers, educators, and behavioral health administrators are needed to help stressed families and providers, now, and in the future. When we support those who are working hard to serve our youngest citizens with behavioral health needs, we ensure a stronger and healthier future for our state.

The following eight recommendations have been developed through extensive engagement with stakeholders and the comprehensive review of best practices and innovative strategies from across the country.

Each recommendation includes implementation action steps, identified leads, timelines, and estimated costs when available. The information below serves as a summary of guidance for coordinating the implementation of the recommendations. Each recommendation has been identified as requiring the state to do one of the following; however, to maximize and sustain their impact on the workforce, the recommendations should be considered interdependent.

Take Legislative Action.

These recommendations should be acted upon by the state legislature in the 2024 legislative session or as soon as possible to avoid additional staffing shortages and longer waitlists.

Make Administrative Changes.

These recommendations can be coordinated through revising state agency policies, practices or contracts.

Convening and Planning.

These recommendations would benefit from additional development through collaborative input from key stakeholders, additional analysis, and identification of best practices in other states. These stakeholders should include those most impacted: members of the workforce and families and youth with lived experience.

RECOMMENDATION 1

Increase reimbursement rates for children's behavioral health services to cover actual costs of high-quality care and establish a transparent and systematic rate-setting process.

Salaries will need to increase to attract and sustain a sufficient workforce to support timely and high-quality services for children, reduce turnover, and attract new staff into the field. ***Providers cannot offer competitive salaries without sufficient increases to public and private reimbursement rates and state grants.***

Building upon past legislation that required a review of reimbursement rates for behavioral health services (and review of parity with medical services), the Department of Social Services should increase reimbursement rates to reflect the actual costs of delivering high-quality services. Other states have made substantial rate increases since the pandemic. In fact, a survey of states by the Kaiser Family Foundation found that 28 of the 44 responding states were increasing Medicaid rates for behavioral health services as a strategy for addressing workforce shortages.[19] In spite of recent increases of Medicaid rates for some services, underfunding of behavioral health services has accumulated over many years resulting in salaries that cannot compete in the current labor market.

The impact of low reimbursement rates not only depresses wages, but disincentivizes providers from accepting some insurance. **Many private practice providers find it unsustainable to accept insurance (or specific insurers as rates vary dramatically from one company to another), and instead only accept clients paying out-of-pocket. This places pressure on other parts of the system and decreases access to care, especially for the most vulnerable.** In a survey of psychologists in Connecticut, many reported dropping at least one insurance panel in the prior year due to low rates.[20] The data on the number of providers accepting insurance is not systematically collected and is complex given that providers choose which insurers to accept. **The impact, however, is a lack of parity with physical health services** (17% of individuals saw out-of-network providers for behavioral health services, vs. 3% for primary care and 4% for specialty care).[21] Therefore, while Connecticut children have high rates of behavioral health care coverage,[22] the proportion with access to fully covered care is unclear. Connecticut has taken legislative action to increase enforcement of parity law. In the last two years, PA22-47 (passed in 2022) required that the Office of Health Strategy, Insurance Commissioner and DSS work to determine if payment parity exists between mental and physical health services; and PA23-101 (passed in 2023) included advocacy for parity as a role for the new Behavioral Health Advocate position. Progress on implementation of this legislation should be tracked to identify any need for additional actions.

States such as Maine and Massachusetts have adopted transparent and systematic Medicaid rate-setting processes to ensure that rates are regularly addressed through a consistent process that accounts for changes due to inflation or other factors impacting the cost of services; these established processes help avoid ad hoc rate adjustments. The process must be clearly documented through legislative action that authorizes the Department of Social Services (DSS) to make such changes, and changes in rates accounted for in the state budgeting process.

STRATEGY IN PRACTICE

OREGON HEALTH AUTHORITY.

In the 2021–23 biennium, the Oregon State Legislature allocated over $1.3 billion in new funding for behavioral health services. This included an increase in Medicaid behavioral health provider rates by an average of 30%, using $42.5 million in state funds, totaling $154.4 million with the federal match. This increase includes a 22%–27% rate bump for providing culturally and linguistically specific services.

MAINECARE RATE SETTING.

The Office of MaineCare Services (OMS), Maine's Medicaid authority, was honored by the National Association of Medicaid Directors for its transformation of its rate-setting system which included adjustments to address immediate workforce needs as well as the development of a systematic process to increase rates based upon inflation and other factors.

ARIZONA'S JAKE'S LAW.

Arizona passed a law in 2020 to increase state agency authority to enforce parity law, require submission of parity compliance reports, prohibit insurance denials of covered services delivered in an educational setting, and created an $8 million fund for behavioral health services for children who are uninsured or underinsured.

States have tended to focus on Medicaid rates because of the direct role they have in the rate-setting process, however private insurance and state grants should also be considered to support the workforce and services. Existing laws on parity and state oversight roles should be employed to the extent available to address private insurers' rates. Note that among the state residents with private insurance, only one quarter are covered by managed care plans that the state has authority to regulate. The others fall under federal regulations. Connecticut is among higher ranking states regarding access to behavioral health care among youth with private insurance,[23] however behavioral health care coverage does not guarantee either approval of a given recommended service for a child or reimbursement reflective of actual cost to the provider. **As appropriate, the Office of Health Strategy, the Connecticut Insurance Department, and/or the new Behavioral Health Advocate position should enforce parity laws that can be enforced and gaps in policies that support coverage and rates.**

Grants from state agencies (e.g., DCF, OEC) support critical services, such as in-home and community-based evidence-based programs. While there were some cost of living increases to state grant-funded programs in the past year, after many years of flat funding, non-profit organizations indicate that the increases were not sufficient to raise salaries to a competitive level. Of note, many of the grant-funded EBTs often have requirements for program staff that are beyond those of typical services, such as availability of 24/7 crisis response, additional training and supervision requirements, extra documentation and data entry, yet reimbursement rates and salaries do not reflect the added demands on the staff delivering these high-quality services. Providers may blend grant funds with reimbursement rates to cover costs, however reimbursement is inconsistent across insurers and services, with only some being reimbursed and often at rates too low to cover actual cost of service delivery. Many important treatments and interventions, such as Wraparound Care Coordination, are not covered at all by any of the commercial plans or by Medicaid.

As reimbursement rates for behavioral health services to children are reassessed, there are important aspects of care for youth and families that may not be traditionally included, or are not sufficiently considered, as a direct cost for services in current fee-for-service payment models. Schools, for example, where many children receive their behavioral health care, are only eligible for reimbursement for a portion of the behavioral health services provided on site. Prevention services, such as those that occur at a classroom level or small group interventions for lower levels of acuity, are not reimbursed. These gaps may also include costs associated with: living wages for entry level direct care staff (care coordinators, peers, etc.), variability in acuity and complexity of both child and family needs, lower caseloads necessary for EBT implementation as well as overall staff wellness and retention, staff training, staff supervision, collaborative care models (e.g., primary and behavioral health care, schools and behavioral health care), data collection, entry and analysis, flexibility in service delivery setting (e.g., home, school, clinic, etc.), and flexibility in use of telehealth and/or phone consultation as appropriate.

DSS and other state agencies are currently engaged in planning efforts related to innovative strategies that support provider payments for some of the additional costs noted above (e.g., collaborative care in primary care settings, billing for school-based behavioral health services, etc.). Alternative payment (or value-based) models are a strategy that can be used to support bundled reimbursement and outcome-based incentives.[24] DSS should continue to explore these opportunities, such as the national Certified Community Behavioral Health Clinic prospective payment model or a look-alike program. However, given the recommended incremental implementation of alternative payment models and continued uncertainty about when such a model would be implemented, it is critical that reimbursement rates immediately be addressed in the interim.

IMPLEMENTATION PLAN

ACTION STEPS:

1. DSS should recommend Medicaid rate increases for behavioral health services that reflect the requirements of the current labor market and costs associated with providing effective, evidence-based and coordinated behavioral health services for children. Submit for review by OPM and approval by the state legislature.

2. In consultation with stakeholders in the state and out-of-state experts, DSS should develop a systematic and transparent Medicaid rate-setting process that is responsive to annual increases in costs. Submit for review by OPM and approval by the state legislature.

3. The Office of the Behavioral Health Advocate or another state entity should track implementation of parity enforcement laws and identify additional opportunities to enforce parity laws between mental and physical health and to mirror Medicaid rate increases among private insurers. Consider opportunities to implement penalties and/or to require more documentation from insurers.

4. State agencies should review grant funding in consideration of actual costs and competitive salaries.

Timeline: Initial rate increases should be prepared for approval during the 2024 legislative session. Rate-setting process and new grant funding should be prepared for the 2025 legislative session.

Cost: Cost of staff or consultant support for developing rate-setting process to be determined by DSS; Cost of increased rates to be determined through approved process and will require bi-annual legislative approval as part of the budgeting process.

RECOMMENDATION 2

Make immediate and significant investments in behavioral health workforce recruitment and retention.

In addition to increases in reimbursement rates, which provide a long-term sustainable approach to increasing salaries for the workforce, Connecticut needs a targeted and time-limited strategy involving grants to agencies to explicitly **address worker recruitment and retention through direct payments to the workforce that can help the state address the immediate staffing shortages and reduce waitlists**. Other states, such as Massachusetts and Oregon, offer a roadmap for this strategy.

The State of Connecticut should make emergency awards available for the next three years to child-serving behavioral health providers. Accepting awards should be contingent on the majority of funds being used directly for recruiting or retaining staff. Priority of funds should be given to providers serving higher proportions of underserved populations, such as BIPOC children and youth and those with more complex needs, such as children with intellectual or developmental disabilities.

The pipeline for non-profit and hospital providers has shifted in recent years with the changes allowing more recent graduates to enter the field directly into private practice through associates licenses (the first in a two-step licensure process required for social workers, professional counselors and marriage and family therapists). These reflect course completion and degree attainment and allow for practice shortly after graduation for new graduates if they are under the supervision of a fully licensed clinician. Social workers and professional counselors with associate licenses can also bill insurance for services. Prior to these changes, new graduates were more likely to enter the field in non-profits while working toward full licensure. Non-profits and other providers offering services that are not easily or appropriately offered through telehealth or private practice (e.g., in-home services, extended day treatment, inpatient, hospitalization, etc.) are particularly challenged in competing with private practice and other settings that allow more flexibility in staff schedules. To fully restore staffing in non-profit and hospital behavioral health programs, it will likely be necessary to prioritize these organizations in the distribution of recruitment and retention grants.

Flexibility in the grants should allow for the variability in need across providers (e.g., some providers may need to hire new staff by offering sign-on bonuses or expanding loan-forgiveness options, while others may need to offer longevity stipends to incentivize retention or offer schedule flexibility or other strategies to improve staff wellness). Funds may also be used to incentivize hiring that will meet specific gaps in available services [e.g, bilingual staff (inclusive of American Sign Language), staff with expertise in serving children with developmental and intellectual disabilities, justice-involved youth, or gender-minority youth].

Following receipt of grants, additional insight on effective recruitment and retention strategies for providers can be gained from the Annapolis Coalition on Behavioral Health Workforce Development. The coalition created an intensive quality improvement intervention for provider organizations to address recruitment and retention challenges. It uses the evidence-based *learning collaborative* approach to change. The collaboratives range from 9 to 18 months in length and have been offered in Connecticut, Delaware, Maryland, Ohio, Pennsylvania, and Washington, D.C.

STRATEGY IN PRACTICE

MASSACHUSETTS.
The state legislature approved two one-time payments to providers calculated as 10% of agency expenditures. Awards were contingent upon use of 90% of the payments toward recruitment and retention.

OREGON.
House Bill 4004 allocated $132 million for Workforce Stability Grants for behavioral health providers serving majority uninsured or publicly insured adults or youth. Grants to providers were contingent upon 75% of the funds being used for employee compensation, and the remainder for other recruitment and retention strategies.

IMPLEMENTATION PLAN

ACTION STEPS:

1. In consultation with providers and OPM, and informed by efforts in other states, DCF should develop a budget for recruitment and retention stipends that will be effective for short-term staffing increases, as well as the requirements and prioritization of recipients associated with the awards.
2. Legislative approval of the emergency funds for distribution in 2024.
3. Prior to the 2025 – 2027 budget cycle, assess the need for additional grants and approve funding as needed during the 2025 legislative session.

Timeline: Develop budget for emergency awards prior to 2024 legislative session; reassess for additional need in preparation for 2025 – 2027 budgeting.

Cost: No cost for planning; Cost of awards to be developed and should be proportional to need.

RECOMMENDATION 3

Develop a children's behavioral health workforce center that can track and respond to trends in supply and demand and sustain workforce development efforts.

The State of Connecticut should fund a Children's Behavioral Health Workforce Development Center (Center) based on similar initiatives in other states, such as Nebraska or Alaska, but tailored to the child-serving workforce. **Dedicating an infrastructure to children's behavioral health workforce efforts would enable Connecticut to address long-term pipeline solutions, implement programs to strengthen recruitment, retention, and diversity of the workforce, and monitor trends in supply and demand** that strengthen the state's capacity to respond to changes in the labor market and/or children's wellbeing before workforce needs reach crisis levels again. The state already has similar models for other fields, e.g., the Connecticut Center for Nursing Workforce. The Center would work closely with higher education and the provider workforce, but ideally be independent and not a member of either to avoid perceived or real conflicts of interest.

Growing and strengthening the children's behavioral health workforce requires a coordinated effort across state agencies. This is particularly critical for children as their behavioral health may be supported across the varying systems in which they or their families are served (school, clinic or hospital, community- and faith-based organizations, juvenile justice, DCF). There are 15 state agencies identified as supporting children's behavioral health per 2022 state legislation (PA22-47) that updated the original list of 12 in the state's Behavioral Health Plan for Children. Those 15 agencies as well as the Office of Workforce Strategy and Connecticut State Colleges and Universities should be included in the proposed Workforce Development Center's planning and coordination efforts, and should be required to develop and submit individual workforce development metrics (the same should be required of providers receiving state grants). A statewide plan, to be updated biannually, should be developed in coordination with, and based upon the metrics collected from, the identified agencies as well as the provider network. Both The Annapolis Framework for Workforce Planning in Behavioral Health as well as the state's Behavioral Health Plan for Children can serve as guiding documents in establishing priorities and goals.

Specific roles of the Center and components of the statewide plan would be finalized during a planning phase. They are likely to include:

- Conducting a workforce needs assessment inclusive of vacancy and turnover rates, staff diversity, strategies for recruitment, retention, and training across state agencies and provider networks.
- Developing a coordinated statewide plan and updating biannually.
- Ongoing collection, monitoring, analyzing, and reporting on children's behavioral health workforce data and metrics (there is not currently systematic collection or reporting of data specific to the child-serving workforce). It will be important that data are inclusive of demographic variables to disaggregate and track diversity trends.
- Planning, implementing, and evaluating culturally and linguistically appropriate training programs.
- Providing feedback to higher education programs to inform curricula as relevant.
- Developing, monitoring, and updating a strategic plan for the children's behavioral health workforce.
- Providing technical assistance to providers and state agencies to strengthen recruitment, retention, and diversity.
- Seeking federal and foundation grants to further expand and leverage its work.

STRATEGY IN PRACTICE

BEHAVIORAL HEALTH EDUCATION CENTER OF NEBRASKA.

BHECN serves as the state's behavioral health workforce development center. It implements initiatives to strengthen the behavioral health workforce in high schools, colleges, residency programs, and the community of practicing providers. Its $5m annual budget was recently supplemented with $25m by the state legislature to fund competitive grants across the state. Nebraska has experienced a growth in their workforce of more than 30% since implementation.

IMPLEMENTATION PLAN

ACTION STEPS:

1. DCF should, in collaboration with members of the CCBHPIAB:
- **a.** Review the infrastructure in place within other states.
- **b.** Identify the Center's specific roles and responsibilities.
- **c.** Develop a 5-year plan and budget

2. The CCBHPIAB (or TCBHPPC) should recommend legislative action including:
- **a.** Requirements of and funding for the Center.
- **b.** Requirement that the identified state agencies have their own workforce development plans, that they submit data to the center, and that they participate in efforts pertaining to the coordinated statewide plan.
- **c.** Requirement that grants pertaining to children's behavioral health services require submission of workforce development plans (if not already included in contract language).

3. Following legislative approval, DCF should procure a lead entity for the Center.

Timeline: Complete planning in advance of 2025–2027 budgeting process.

Cost: Minimal resources for planning phase; cost of the Center to be determined through planning phase.

RECOMMENDATION 4

Grow and diversify the children's behavioral health workforce pipeline.

The high cost of education and the comparably low wages in behavioral health make tuition and loan repayment programs a powerful tool in recruiting, retaining, and diversifying the workforce. The State of Connecticut has made investments in these strategies, including the CT Health Horizons program currently underway to support nurses (inclusive of APRNs) and social workers (though the majority of this funding is dedicated broadly to nursing). In the last legislative session, the state repealed the Health Care Loan Reimbursement Program, which had not yet been funded.

To address both overall pipeline concerns and increase diversity of the workforce, the state should create or expand tuition and loan repayment programs for those preparing to enter, as well as those already working in the child-serving behavioral health field. While Connecticut has invested previously in incentives for child and adolescent psychiatrists (who are in short supply nationally), given the continued challenges with accessing prescribers for children, the state should consider incentives that grow the prescriber pipeline, such as an APRN child psychiatry residency program.

The social work field represents the majority, although not all, of the licensed behavioral health workforce. As data are collected and reported from the CT Health Horizons project, additional needs for tuition stipends, loan repayment, and faculty expansion can be identified and replicated across the broader behavioral health workforce, with specific funding for those hired in child-serving positions. Funding for education and training for entry-level, non-clinical positions, such as care coordinators and peer support specialists, can be supported through these efforts as well. Investments can prioritize BIPOC and bilingual students. In 2022, the CT state legislature approved a new requirement that the Office of Higher Education (OHE) offer $20,000 incentive grants to licensed health care providers accepting adjunct professor positions. The impact of this program should be monitored over the next year.

While increasing salaries can support entry into the field, additional marketing of child-serving behavioral health professions, and related potential career pathways, can support interest in the field and increases to the pipeline. Messaging that combines both career opportunities and the rewarding nature of the work should be emphasized. Targeted marketing can start with the high school students and extend to colleges and the broader community.

STRATEGY IN PRACTICE

HBCU CENTER FOR EXCELLENCE.

SAMHSA funds the Historically Black Colleges and Universities Center of Excellence in Behavioral Health to provide training that prepares individuals for careers in behavioral health or advances their careers.

OREGON BEHAVIORAL HEALTH LOAN REPAYMENT PROGRAM.

Members of the workforce from historically underserved communities can receive up to two years of funding (up to $50,000) to repay loans contingent on two years of service within a program that does not disqualify clients based on insurance.

MAINE COLLABORATIVE.

AdCare Maine and the Co-Occurring Collaborative Serving Maine partnered with the Kennebec Valley Community College to develop and offer a curriculum in high schools. It involves a presentation that covers the varied jobs in this field, inclusive of entry- through doctoral-level positions.

IMPLEMENTATION PLAN

ACTION STEPS:

1. The lead agencies implementing current pipeline-focused initiatives should annually monitor and publicly report findings to identify ongoing needs and align with the implementation of a statewide strategic plan.
2. Utilize data to identify gaps in investments to support the workforce pipeline and develop a responsive plan and associated budget to fill gaps.
3. The Office of Workforce Strategy, SDE, DCF and other agencies as relevant should develop a plan for marketing child-focused behavioral health careers.

Timeline: Monitor reporting of pipeline initiatives in 2024; identify strategies to fill remaining gaps in advance of 2025–2027 budget process.

Cost: Costs to be identified following assessment of existing strategies.

RECOMMENDATION 5

Increase behavioral health training across the child-serving workforce.

Training is well-documented as effective in raising job satisfaction and improving retention.[25,26] The State of Connecticut should identify gaps in training availability and accessibility and increase funding for training of the child-serving behavioral health workforce, including clinicians (psychologists, social workers, marriage and family therapists and professional counselors), prescribers (psychiatrists, APRNs, and pediatricians), paraprofessionals, peer support specialists, and family support/advocates, as well as for other members of the child-serving workforce to strengthen understanding of children's behavioral health (e.g., school staff, primary care, and others). The strategic plan process identified the following training needs as of high priority across the workforce:

- Expansion of child, youth and family-focused evidence-based treatments (EBTs)
- Cultural humility, racial justice, and culturally-responsive care, including organizational training on Culturally and Linguistically Appropriate Services (CLAS)
- Serving LGBTQ+ and gender minority youth
- Serving youth with complex needs especially children with intellectual or developmental disabilities
- Supervisory skills and strategies to support staff wellness
- Identification of behavioral health needs and effective prevention and early intervention strategies for the broader child-serving workforce
- Trauma-informed care and family engagement strategies for both the behavioral health and the child-serving workforce more broadly

While Connecticut has some strong workforce training programs, gaps in training and access to training remain. In addition to identifying what trainings need to be enhanced and/or expanded to additional audiences, it is equally important that funding be added to address: **(1)** the more indirect costs of sending staff to trainings and implementing new practices (e.g., coverage for out-of-office staff, participation in learning collaboratives, additional data entry, maintaining lower caseloads for EBT implementation, etc.); and **(2)** the costs of effective models of training (e.g., learning collaboratives, coaching, etc.) to support sustained implementation. These costs could potentially be included in new reimbursement rates or as part of alternative payment models.

Responses to both the survey associated with this strategic planning process, as well as those conducted specifically with outpatient and intermediate level of care providers, indicate that the workforce desires additional training opportunities and prefers flexible training modalities. Asynchronous training allows for staff to take trainings that work with their own schedules. Not all trainings are appropriate for this approach, as some topics are better suited for interaction between trainer and trainees. However, for those topics that lend themselves to this modality, it should be utilized.

STRATEGY IN PRACTICE

CONNECTICUT WORKFORCE COLLABORATIVE ON BEHAVIORAL HEALTH.

The CWCBH conducted workforce planning, funding, and evaluation of behavioral health workforce initiatives in Connecticut for five years through federal funding before the grant ended. Initiatives successfully strengthened supervision and leadership, improved higher education curriculum, and supported workforce efforts within agencies.

IMPLEMENTATION PLAN

ACTION STEPS:

1. Training opportunities within Connecticut for CYF–serving behavioral health providers should be assessed to identify any gaps and expand trainings as needed.
2. Estimate costs associated with developing and/or expanding training opportunities (costs for covering lost staff time, etc.) as well as costs for implementation.
3. DCF should expand funding to community-based providers to support organizations in the costs associated with training as well as with implementation of trainings.

Timeline: Identify gaps in FY 2024 and begin rollout of additional trainings in FY2025.

Cost: No cost to identifying gaps; Costs associated with trainings to be developed as gaps are identified.

RECOMMENDATION 6

Remove administrative barriers to workforce entry and retention.

There are multiple requirements associated with entering and remaining in the behavioral health field, many of which are designed to ensure quality of care. These are related to education and licensing, documentation of services, and ongoing supervision and training. Some requirements, however, may be excessive to the need for quality control or require significant out-of-pocket costs, and may hamper recruitment and retention efforts and ultimately decrease access to quality care. **Removing unnecessary administrative mandates may help to grow and diversify the pipeline, decrease burnout and turnover, and increase access to care.**

Through PA 23-101 passed by the Connecticut General Assembly in 2023, the state addressed some aspects of the licensing process that were burdensome and hindered diversifying the workforce. Changes included a reduction in fees associated with applying for and maintaining licensure (which were among the highest in the country) and acceptance of out-of-state exams. Costs associated with entering the workforce should be minimized or even eliminated. The state should continue efforts to reduce licensure costs or subsidize applicants through waivers or stipends bundled with tuition assistance for graduate programs. Associate licenses (referenced in Recommendation 2) should be available at no cost to the applicants who are typically new graduates seeking employment to attain clinical hours required for full licensure.

Disparities in pass rates on the Social Worker exams within Connecticut and nationally have raised significant concerns about whether the exams do more harm than good. In Connecticut, there are differences in pass rates by race and ethnicity (Black: 39%; Hispanic/Latinx: 56%; Multiracial: 74%; White: 81%), by primary language (English: 74%; Other Language: 47%;), and by age (18-39 years: 74–80%; 40 and over: 60–64%).[27,28] As providers seek to hire staff representative of the children they serve and with more experience, the exams are presenting a barrier and an undue burden on BIPOC and older graduates who are more likely to pay to take the exam multiple times or even discouraged enough to leave the field entirely. Connecticut should partner with other states to identify an alternative to the national exam that will support quality and license portability but not promulgate continued structural inequities. The state should make efforts to ensure that licensing requirements do not discourage those living out-of-state from moving to Connecticut.

While it appears that inadequate reimbursement rates are the predominant reason that private practice providers do not accept insurance, the administrative requirements associated with accepting insurance for behavioral health services are more complex than for physical health care and vary substantially across insurers. The processes are cumbersome and require both time and technology (many private practice providers still practice without use of an electronic health record program),[29] contributing to the large number of private practices only accepting clients who are able to pay out-of-pocket, reducing access to care. The state should explore opportunities to simplify the process, provide technology and/or technical assistance that supports more providers to accept insurance.

STRATEGY IN PRACTICE

CONSOLIDATED APPROPRIATIONS ACT

Medicaid has identified specific interventions of high need and high impact that benefit from reduced administrative requirements in order to increase their utilization. Among these are prescription medications to treat opioid use disorder. This change in requirements was passed by Congress in 2022.

IMPLEMENTATION PLAN

ACTION STEPS:

1. Stakeholders, including social workers, employers, DPH and professional organizations, should partner with other states to identify an alternative to the current licensing exam that ideally eliminates disparities in access to licensure without compromising safety and quality of care.
2. The state legislature should remove fees for associate licenses and address resulting loss of revenue within the DPH budget to avoid any impact to their staffing.
3. DCF, DSS, and other state agencies as relevant, should work with providers to identify unnecessary requirements to remove from state contracts, such as paperwork, data collection or other administrative requirements that do not add value to the quality of care for children and families.

Timeline: Approximately one year to identify exam alternative and reductions in administrative requirements.

Cost: Up to $75,000 for staff or consultant support.

RECOMMENDATION 7

Expand the youth and family peer support workforce.

Peer support specialists have demonstrated effectiveness in supporting some behavioral health needs and taking on limited roles to complement the masters-level (licensed/license-eligible) workforce, which can alleviate workforce shortages. Peer supports are used regularly (and are Medicaid-reimbursed) for adult services. Their use in children's services has been more limited (and typically not Medicaid-reimbursable), however use of family peer supports in children's services has demonstrated effectiveness in improving family hopefulness, increasing family engagement, and reducing disparities.[31] "Family peers" refer to family members with lived experience as a caregiver for a child (or other dependent) with a mental health and/or substance use condition.[32] "Youth peers" are older teens or are transitional age youth with lived behavioral health experiences who work as peers directly with youth. **The current workforce shortage is an optimal time to expand peer and family services, which if appropriately supported, can both complement treatment by masters-level clinical staff and in some cases even provide low intensity services, enabling clinical staff to use their time for more intensive clinical needs.** Certifying family peers is a much faster process than increasing the pipeline of masters-level clinical staff and can provide a reasonably large and rapid increase in the overall workforce.

While Connecticut has minimal numbers of paid family or youth peers currently employed by the children's behavioral health services, the state has a strong infrastructure to build upon, including existing peer support training programs, such as those provided by FAVOR and others, that conforms to SAMHSA's National Model Standards for training. Connecticut also recently added reimbursement for some peer support services within its Medicaid State Plan Amendment as well as coverage for some services provided by community health workers which offers a starting place for expansion. Additional work is needed to expand training and certification (or licensing if necessary), define paid peer roles, develop an infrastructure for recruitment and retention, develop career pathways, and expand services that are reimbursable by Medicaid and other insurers. The state should also use the opportunity to recruit families with lived experience who are currently underrepresented in the workforce and/or underserved within the children's behavioral health system.

STRATEGY IN PRACTICE

KENTUCKY SYSTEM OF CARE

Kentucky has a certification process for both family and youth peer support specialists. Once certified, the peers work in various settings supporting children's behavioral health in the state and are integral to the state's system of care. Medicaid reimbursement of services is available contingent on certification and ongoing continuing education.

IMPLEMENTATION PLAN

ACTION STEPS:

1. DCF should convene a Connecticut Peer Support Workforce Workgroup to develop an implementation plan for scaling up peer supports. The membership should include youth peer mentors, family advocates, providers, and a representative of DCF. Youth and family members should comprise at least 51% of the membership. The Workgroup should:
   a. Conduct a review of the status of youth and family peer support in Connecticut, as well as national best practices, and identify options for expansion and improvement.
   b. Develop recommendations related to roles, integration with the existing workforce structure, training, certification, diversity, career pathways, and budget implications.
   c. Report recommendations to the CCBHPIAB (or TCBHPPC).
2. CCBHPIAB should include recommendations in their annual report to the state legislature as relevant.
3. Fund expansion of training, certification and employment of family and youth peer supports.

Timeline: Complete report in advance of the 2025–2027 state budget setting process.

Cost: Up to $50,000 for staff or consultant to convene stakeholders and write plan; Cost of plan activities to be determined during planning phase.

RECOMMENDATION 8

Expand the role and capacity of community-based organizations in prevention and early intervention.

As trusted partners to families, others within the community, including primary care practices, faith-based organizations, schools, after-school programs, and others can play a critical role in prevention and early intervention for children's behavioral health needs. **Youth who have strong healthy connections within their family and community are approximately half as likely to have mental health challenges later in life.**[34] Through introductory education for community-based organizations on mental health, trauma, and substance use, these organizations' staff can promote healthy relationships with trusted adults, educate children on positive mental health strategies and the harm of alcohol and drug use, reduce stigma associated with receiving care, screen for substance use, mental health, trauma and other needs, and make referrals.

These low-cost prevention and early intervention strategies can:

1. Identify symptoms early and connect families to behavioral health providers;
2. Prevent the need for treatment by a behavioral health provider for those children whose needs can be prevented or addressed through non-clinical interventions; and
3. Reduce stigma associated with mental health.

Examples of these interventions include "Friendship Benches" at primary care sites where paraprofessional staff can offer a safe space for youth to discuss challenges and experiences, and offer low intensity interventions and referrals as needed; "Faith-Based Navigators" to support positive conversations and reduce mental health stigma; as well as the prevention strategies regularly offered to families by staff working directly with children, youth or families (staff at WIC sites, home visitors, community health workers, early childhood providers, faith-based organizations, and others).

While these strategies cannot replace treatment provided by behavioral health clinical staff for those children who need clinical intervention, they can reduce the need for treatment, reduce stigma, and/or identify needs earlier to prevent the need for higher levels of care, and in the long-term reduce clinical caseloads and costs.

STRATEGY IN PRACTICE

BROTHER, YOU'RE ON MY MIND.

Intended to address the disparity in mental health care access and utilization among African American men, and the rising rate of suicide among 15–24-year-old African Americans, ***Brother, You're On My Mind*** is a collaboration between the Omega Psi Phi Fraternity and the National Institute on Minority Health and Health Disparities. The Omega chapters identify local behavioral health resources, provide education to their members, and promote awareness in their local communities.

IMPLEMENTATION PLAN

ACTION STEPS:

1. DCF should convene a Connecticut stakeholder group with expertise in children's behavioral health prevention and early intervention. The group should be charged to develop a statewide plan for expanding the role of community-based organizations in prevention and early intervention and identify promising practices that improve mental health and reduce drug and alcohol use among youth. The group will:
   - **a.** Conduct a review of statewide community-based prevention and early intervention resources.
   - **b.** Identify any disparities across populations and their access to culturally responsive resources.
   - **c.** Identify effective programs within the state and any gaps that may be addressed by out-of-state promising practices that are culturally responsive.
   - **d.** Develop a plan and accompanying 5-year budget for review by the CCBHPIAB or TCBHPPC.
2. CCBHPIAB should include recommendations in their annual report to the state legislature as relevant.
3. Fund additions and expansions of community-based prevention and early interventions that address behavioral health needs in children and youth.

Timeline: Complete report in advance of the 2025–2027 state budget setting process.

Cost: Up to $50,000 for staff or consultant to convene stakeholders and write plan; Cost of strategies to be developed during planning phase (these are generally low-cost strategies).

ATTACHMENT A:

The Annapolis Framework for Workforce Planning in Behavioral Health[35]

Broadening the Concept of "Workforce"

GOAL 1: Expand the role of families and young adults with lived experience to actively participate in and influence their own care, provide care and supports to others, and educate the workforce.

GOAL 2: Expand the role and capacity of communities to effectively identify their needs and promote behavioral health and wellness.

GOAL 3: Expand the role and capacity of all health and social service providers, through interprofessional collaboration, to meet the needs of children, youth, and families with mental and substance use conditions.

Strengthening the Workforce

GOAL 4: Expand the pipeline of individuals into the field, ensuring broad diversity, successful completion of initial education and training, and entry into the workforce.

GOAL 5: Implement systematic recruitment and retention strategies at the federal, state, and local levels to find and retain a diverse workforce.

GOAL 6: Increase the relevance, effectiveness, and accessibility of training and education.

GOAL 7: Foster the development of supervisors and leaders among all segments of the workforce.

Creating Structures to Support the Workforce

GOAL 8: Establish financing systems that enable competitive employee compensation commensurate with required education and levels of responsibility.

GOAL 9: Implement systems to track key workforce measures and evaluate workforce development practices.

GOAL 10: Build a technical assistance infrastructure that promotes adoption of workforce best practices.

ATTACHMENT B: EXPERT INTERVIEWS

The authors wish to thank the following individuals who lent their time and expertise through interviews and offered insight critical to the development of this plan.

Lisa Amaya-Jackson, MD, MPH, DFAACAP

Professor, Department of Psychiatry & Behavioral Science

Duke University School of Medicine Associate Director, UCLA-

Duke National Center for Child Traumatic Stress

Amy Brinkley

Recovery Support Systems Coordinator

National Association of State Mental Health Program Director

Dean Bugaj

Associate Director of Children's Developmental and Behavioral Health Services

Maine Department of Health and Human Services

Kathy Craft

Associate Vice Provost for Health Program Office of Academic Affair

University of Alaska System Former Director, Alaska Health Workforce Coalition

Marley Doyle, MD

Director Behavioral Health Education Center of Nebraska

University of Nebraska Medical Center

Jessie Eagan, MS, LCSW

Child and Family Behavioral Health Unit Manager

Health Systems Division Oregon Health Authority

Lea Forsman, PhD

Interim Manager, Social Determinants of Health and Behavioral Health

Workforce Initiatives Oregon Health Authority

Robert Franks, PhD

President and Chief Executive Officer The Baker Center for Children and Familie

Ann Gionet

Health Program Supervisor

CT Title V Children and Youth with Special Health Care Needs Director

Connecticut Department of Public Health

State-Level Expert, Act Early Ambassadors, Centers for Disease Control and Prevention

Joy Gould

Healthcare Workforce Development Director

Maine Department of Health and Human Services

Heather Gotham, PhD

Director

National Coordinating Office, Mental Health Technology

Transfer Center Network

William Halsey, LCSW, MBA

Deputy Director of Medicaid and Division of Health Services

Department of Social Services

Brian Hepburn, MD

Executive Director

National Association of State Mental Health Program Directors

Sharon Hoover, PhD

Co-Director, National Center for School Mental Health

Director, Center for Safe Supportive Schools, National Child Traumatic Stress Network

Department of Psychiatry, University of Maryland School of Medicine

Larke Huang, PhD

Director of the Office of Behavioral Health Equity

Substance Abuse and Mental Health Services Administration

Stanley Huey, PhD

Associate Professor of Psychology and American Studies and Ethnicity

University of Southern California

Leticia Huttman

Training and Best Practices Coordinator

Office of Substance Abuse and Adult Mental Health Services

Maine Department of Health and Human Services

Craig Mosbaek, MPH

Behavioral Health Equity Integration & Accountability

Analyst

Equity and Inclusion Division

Oregon Health Authority

Margaret O'Hagan-Lynch, LPC

Director, Office of Workforce Development

Connecticut State Department of Mental Health and Addiction Services

Stephen Phillippi, PhD, LCSW, CCFC

Professor and Chair, Behavioral and Community Health Sciences, School of Public Health, Louisiana State University Health Sciences Center at New Orleans

Director, Institute for Public Health and Justice

Founding Director, Center for Evidence to Practice

Kimberly Sandor, MSN, RN, FNP

Executive Director, CT Nurses Association

Kelli-Marie Vallieres, PhD

Chief Workforce Officer Connecticut State Office of Workforce Strategy

Carl Weems, PhD

Department Chair, Human Development and Family Studies

Iowa State University

Melanie Wilde-Lane

Executive Director

CT Association of School Based Health Centers

REFERENCES

1. Hoge, M. (2022, Mar. 9). *The Behavioral Health Workforce Emergency: National and State Perspectives.* [PowerPoint slides]. Presented to the Connecticut Behavioral Health Partnership Oversight Council.

2. Kelly, A., Lang, J., and Forrester, A. (2022, September 30). *Who Will Do the Work?: Strengthening the Children's Behavioral Health Workforce to Meet Families Increasing Behavioral Health Needs.* Child Health and Development Institute and Clifford Beers Community Health Partners. https://www.chdi.org/index.php/publications/policy-briefs/policy-brief-who-will-do-work-strengthening-childrens-behavioral-health-workforce-meet-families-increasing-behavioral-health-nee.

3. Connecticut Department of Public Health. (n.d.). 2021 *Connecticut School Health Survey (CSHS) Summary Graphs*. [PowerPoint slides]. https://portal.ct.gov/-/media/DPH/CSHS/2021/2021_CSHS_Graphs_Trends_web.pdf.

4. Centers for Disease Control and Prevention. (n.d.). *High School YRBS: Connecticut 2021 and United States 2021 Results.* [Data set]. https://nccd.cdc.gov/Youthonline/App/Results.aspx?TT=G&OUT=0&SID=HS&QID=QQ&LID=CT&YID=2021&LID2=XX&YID2=2021&COL=T&ROW1=N&ROW2=N&HT=QQ&LCT=LL&FS=S1&FR=R1&FG=G1&FA=A1&FI=I1&FP=P1&FSL=S1&FRL=R1&FGL=G1&FAL=A1&FIL=I1&FPL=P1&PV=&TST=True&C1=CT2021&C2=XX2021&QP=G&DP=1&VA=CI&CS=Y&SYID=&EYID=&SC=DEFAULT&SO=ASC.

5. © 2022 The Annapolis Coalition on the Behavioral Health Workforce. Adapted from Hoge, M. A., Morris, J. A., Daniels, A. S., Stuart, G. W., Huey, L. Y., & Adams, N., 2007. An Action Plan for Behavioral Health Workforce Development. Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

6. Vanderploeg, J., & Freeburg, T., Lang. J., Sovronsky, H., MoroySmith, A., Hoffman, P. (2021). *Advancing Equity in Behavioral Health through Telemedicine. Child Health and Development Institute*. https://www.chdi.org/index.php/publications/policy-briefs/policy-brief-advancing-equity-behavioral-health-through-telemedicine.

7. Average salary ranges based upon search of full-time licensed/license-eligible positions, excluding managerial or supervisory positions, using *Indeed* job search website (https://www.indeed.com/). Public agency positions from Connecticut's state employment portal (https://www.jobapscloud.com/CT/). Note that Private Practice positions are less likely to provide benefits (although some do), and non-profit positions are more likely to allow applicants with associate licenses.

8. Estimate from Living Wage Calculator operated by the Massachusetts Institute of Technology Living Wage Calculator – Living Wage Calculation for Connecticut (mit.edu).

9. Substance Abuse and Mental Health Services Administration (SAMHSA). (2018, May 9). *Improving Life Outcomes for Children with History of Mental Health Challenges and Trauma* [Press release]. https://www.samhsa.gov/newsroom/press-announcements/20180509.

10. Colizzi, M., Lasalvia, A. and Ruggeri, M. (2020). Prevention and Early Intervention in Youth Mental Health: Is It Time for a Multidisciplinary and Trans-Diagnostic Model for Care? *International Journal of Mental Health Systems.* 14(23)

11. Cabral, R.R., Smith, T.B. (2011). Racial/Ethnic Matching of Clients and Therapists in Mental Health Services: A Meta-Analytic Review of Preferences, Perceptions, and Outcomes. *Journal of Counseling Psychology*. 58(4): 537–554.

12. Connecticut Department of Public Health (Jan. 10, 2022). Professional Race and Ethnicity Charts. Presented to the Connecticut Behavioral Health Partnership Oversight Council, Child/Adolescent Quality, Access & Policy Committee on July 20, 2022. Professional Race Ethnicity Charts.pdf (ct.gov).

13. US Census Bureau, Population Division. (2022, June). *Annual State Resident Population Estimates for 6 Race Groups (5 Race Alone Groups and Two or More Races) by Age, Sex, and Hispanic Origin: April 1, 2020 to July 1, 2021*.

14. Randall, K., Lang, J., Solak, H., Schleider, J. (2022, Sept. 6). *Issue Brief 86: Making the Most of the Moment: Brief Interventions Can Improve Children's Behavioral Health Services*. Child Health and Development Institute. https://www.chdi.org/index.php/publications/issue-briefs/issue-brief-86-making-most-moment.

15. Lang, J. M., Lee, P., Connell, C. M., Marshall, T., & Vanderploeg, J. J. (2021). Outcomes, evidence-based treatments, and disparities in a statewide outpatient children's behavioral health system. *Children and Youth Services Review, 120*, 1–12.

16. Washington State Institute for Public Policy. (2019). *Benefit-Cost Results: Children's Mental Health*. https://www.wsipp.wa.gov/BenefitCost/Pdf/5/WSIPP_BenefitCost_Childrens-Mental-Health.

17. Larrison, C.R., Schoppelrey, S.L. (2011). Therapist Effects on Disparities Experienced by Minorities Receiving Services for Mental Illness. *Research on Social Work Practice 21*(6): 727–736.

18. Kivlighan, D.M., Hooley, I.W., Bruno, M.G., Ethington, L.L., Keeton, P.M., and Schreier, B.A. (2019). Brief Report: Examining Therapist Effects in Relation to Clients' Race-Ethnicity and Gender: An Intersectionality Approach. *Journal of Counseling Psychology.* 66(1):122–129

19. Saunders, H., Guth, M., and Eckart, G. (2023, Jan. 10). *A Look at Strategies to Address Behavioral Health Workforce Shortages: Findings from a Survey of State Medicaid Programs.* https://www.kff.org/medicaid/issue-brief/a-look-at-strategies-to-address-behavioral-health-workforce-shortages-findings-from-a-survey-of-state-medicaid-programs/#.

20. Souter, C.R. (2020, Feb. 5). *Are More Psychologists Serving Only Self-Pay Patients: Difficulties with Insurance Companies Highlighted.* New England Psychologist. https://www.nepsy.com/articles/leading-stories/are-more-psychologists-serving-only-self-pay-patients-difficulties-with-insurance-companies-highlighted/.

21. Modi, H. Orgera, K., and Grover, A. (2022, Oct. 10). *Issue Brief: Exploring Barriers to Mental Health Care in the U.S. Association of American Medical Colleges.* https://www.aamc.org/advocacy-policy/aamc-research-and-action-institute/barriers-mental-health-care.

22. Reinert, M, Fritze, D. & Nguyen, T. (2022, Oct.). *The State of Mental Health in America 2023*. Mental Health America. https://mhanational.org/sites/default/files/2023-State-of-Mental-Health-in-America-Report.pdf.

23. Reinert, M, Fritze, D. & Nguyen, T. (2022).

24. Child Health and Development Institute. (2021, Dec.). Children's Behavioral Health Plan Implementation: Alternative Payment Methodology and Measurement-Based Care Workgroup. https://plan4children.org/wp-content/uploads/2022/01/APM-Workgroup-Final-Report_12.17.21.pdf.

25. Hutchison, S.L., Herschell, A.D., Hovorka, K., Wasilchak, D.S., & Hurford, M.O. (2021). Payer-Provider Partnership to Identify Successful Retention Strategies for the Behavioral Health Workforce. Progress in Community Health Partnerships: Research, Education and Action. 15(2):151–160.

26. Morse, G. and Dell, N. (2021). The Wellbeing and Perspectives of Community-Based Behavioral Health Staff During the COVID-19 Pandemic. Social Work in Health Care. 60(2):117–130.

27. Association of Social Work Boards. (2022). 2022 ASWB Exam Pass Rate Analysis [Data set]. https://www.aswb.org/exam/contributing-to-the-conversation/aswb-exam-pass-rates-by-state-province/.

28. Note that the listed rates apply to the Licensed Clinical Social Work Exam. Similar disparities exist for the licensed master's in social work exam across race and ethnicity and primary language, but not age.

29. Modi, H. Orgera, K., and Grover, A. (2022).

30. Government Accountability Office. (2018, Nov.). *Mental Health: Leading Practices for State Programs to Certify Peer Support Specialists*. https://www.gao.gov/assets/gao-19-41.pdf.

31. Donnelly, T., Baker, D., Gargan, L. (n.d.). T*he Benefits of Family Peer Support Services: Let's Examine the Evidence* [PowerPoint slides]. Substance Abuse and Mental Health Services Administration. https://www.nasmhpd.org/sites/default/files/Benefits%20of%20Family%20Peer%20Support%20FIC%20SAMSHA%20Updated.pdf.

32. Substance Abuse and Mental Health Services Administration. (2023). *National Model Standards for Peer Support Certification*. Publication No. PEP23-10-01-001. Office of Recovery, Substance Abuse and Mental Health Services Administration. https://store.samhsa.gov/sites/default/files/pep23-10-01-001.pdf.

33. Substance Abuse and Mental Health Services Administration. (2023).

34. The Partnership Center: Center for Faith-Based and Neighborhood Partnerships. U.S. Department of Health and Human Services. (n.d.). *Young Mental Health and Wellbeing in Faith and Community Settings: Practicing Connectedness. A Toolkit of the HHS Partnership Center.* https://www.hhs.gov/sites/default/files/youth-mental-health-and-well-being-in-faith-and-community-settings.pdf.

35. *The Annapolis Framework for Workforce Planning in Behavioral Health* was developed by the Annapolis Coalition to guide behavioral health workforce development efforts. https://annapoliscoalition.org/about-us/framework/. It identifies 10 key goals clustered in three major areas. This slightly modified form addresses the focus on the child, you and family-serving workforce in order to use it as the framework for developing Connecticut's Behavioral Health Workforce Plan for Children, Youth, and Families.

ABOUT CHDI

The **Child Health and Development Institute** provides a bridge to better behavioral health and well-being for children, youth, and families. We collaborate with policymakers, providers, schools, and partners to advance system, practice, and policy solutions that result in equitable and optimal outcomes in Connecticut and beyond.

Child Health and Development Institute | Bridge to Better.™