NASW/CT quarterly newsletter

CONNECTIONS

April—June 2023

When a flower doesn't bloom, you fix the environment in which it grows, not the flower."

—Alexander Den Heijer

Education Alone Will Not End the Cycle of Poverty for Single Parents

Cheryl Wilson, LCSW, MBA

President, Connecticut Chapter

I remember when I was in graduate school at Fordham University, a professor told us that getting a formal college education for single parents doesn't change their class status. She further went on to explain the institution of marriage and how that was designed to uplift families and better prepare them for a favorable financial experience. In my observation, I've noticed that this information is true, and I also think that the federal poverty guidelines are undervalued and underestimated.

I've seen far too many cases where a single mom has achieved an advanced degree and because there's no additional support, they are not able to pull themselves out of the poverty struggle. The other important thing to consider is that when someone starts to become more self-sufficient the support that they are receiving from the local government which can include food stamps, healthcare coverage, and subsidized housing is reduced, or it's taken away from the family once they reach a certain threshold in their salary and exceed the federal poverty income guidelines.

Because the income is based on the federal poverty guidelines it is an unfair evaluation and it's criminal against single moms. A salary of $45,000 to $55,000 is not enough to sustain housing that is adequate and safe. Oftentimes these families find themselves in low-income housing projects living next to neighbors who are not contributing to society in a productive way and also putting themselves in harm's way for unwarranted gun violence that can occur in these types of living environments. In addition to this, the children are often subjected to poor education in public school systems where the classrooms are overcrowded, and the teachers are spending the majority of their day managing behaviors. These experiences put the entire family at a disadvantage.

It is important to consider the high cost of living in the state of Connecticut where single moms are finding themselves looking elsewhere to relocate, potentially to the southern states where single-parent families can afford the home of their dreams and provide a safe and nourishing environment for their children. There's a lot of opportunity in the state of Connecticut to make housing more affordable and to keep hard-working citizens in the state of Connecticut.

Typically, a single mom with two children who has an advanced degree will still struggle to make ends meet and oftentimes have to work two jobs.

Poverty, continued

Although a master's degree can provide a single mom with an opportunity to earn more income it doesn't provide the economic mobility these families hoped for.

It's important to acknowledge that a post-secondary education alone will not end the cycle of poverty for single-parent families. This is something we need to give more attention to in an effort for these families to realize financial prosperity and their basic right to the pursuit of happiness.

In 2016 the median debt for single mothers was three times higher than for female students without children. Additionally, the debt ratio proportionately affects black student parents who carry more student debt than students of every other racial and ethnic background. And lastly, single parents often juggle many competing priorities. Single parents work more hours, earn less and they have less time and limited resources to advance their own families. Single parents have the responsibility of caring for their children, helping out with homework, running errands, and other tasks that are involved with child-rearing.

In comparison to other developing countries, the United States lacks family-supporting policies that provide basic economic security for single-parent families. As a result, the majority of single mothers in the United States work more hours and have higher poverty rates than single mothers from other high-income countries. This problem has continued for far too long. Single mothers with advanced degrees are a silent majority and I think it's time for us, (the social work profession) to give this population some attention and create policies and practices that will help to provide them with more economic stability. Single parents with advanced degrees deserve to be homeowners and live in desired neighborhoods where children can attend schools of their choice and be a part of a conducive learning environment.

Behavioral Health Ombudsman

Amongst the bills NASW/CT had introduced this legislative session was a bill to create an Office of Behavioral Health Provider Ombudsman and a Retroactive Denial of Payment (claw back) bill. The former was in two bills, one of which has passed in the Children's Committee. The latter died when the Insurance Committee refused to raise the bill for a public hearing.

The concept of a behavioral health providers ombudsman is based on the extremely effective Office of the Health Care Advocate that addresses consumer concerns with health insurers. The initial bill creating a behavioral health providers ombudsman was introduced by Representative Anne Hughes, MSW at the request of NASW/CT. That bill had a public hearing in the Human Services Committee and was well received. The Senate Democratic Caucus than introduced the same ombudsman program based on recommendations of NASW/CT. The Caucus bill is in an omnibus bill (SB 2) that has passed the Children's Committee and now is in the Appropriations Committee. Because SB 2 had the ombudsman language the original bill in Human Services will not be further acted upon.

Senator Rick Lopes, MSW and Representative Gary Turco introduced a bill, again on NASW/CTs request, to regulate insurance claw backs by limiting such retroactive denials to a maximum of one year. Currently, insurers can go back as far as five years! Our suggested bill was based on law in Massachusetts. Unfortunately, the Insurance Committee co-chairs chose not to raise the bill for a public hearing, effectively killing the bill for this year.

Success at the Legislature Means Doing the Work

Steve Wanczyk-Karp, LMSW
Executive Director
Connecticut Chapter

NASW/CT has historically has had a strong track record when it comes to passing bills in the Connecticut Legislature. Each year up to 5,000 bills are introduced and about 150 make it into law. Most groups must reintroduce their bills multiple times before passage, and even then not all cross the finish line. NASW/CT has been an exception, with priority bills often passed on the first or second attempt. Third party reimbursement, confidentiality of records, clinical licensure (LCSW), title protection, language on utilization of social worker by police departments, LMSWs covered in private practice under Medicaid, and a host of children's mental health recommendations all passed in the first year of introduction. Then we had the LMSW statute that took two years and an override of the Governor's veto. It is an enviable track record starting in 1990 right up to last year's session.

This year we issued a set of workforce recommendations for the field of social work. Some of those recommendations have become proposed bills on reducing social work licensure fees and having 2-year renewal, preventative mental health days eligible for sick time if an employer provides sick days, and an office of behavioral health providers advocate to address problems with insurers.

Of course, not all our professional social work bills were successful, or at least not at first. In 2021 we passed legislation to reduce the bed to social worker ratio in nursing homes from 120/1 to 60/1. That was first introduced in 2008! Plus, we spent 25 years working to achieve preference in hiring of BSWs and MSWs for the state's job classification of social worker that finally happened by administrative edict under Governor Malloy's administration. We were never able to get a preference in hiring bill through the legislature.

NASW/CT has another strong track record, stopping bills that would be detrimental to social work practice. Last year we eliminated language that would have required school social workers to make two home visits per school year to each student they worked with. This year we were able to remove language that would have allowed public schools to appoint school social workers to perform the duties of a school resource officer. In the past we have protected the right of social workers to use art in therapy without attaining a license in art therapy, kept a bill from passing that would have licensed non-social workers to become LCSWs in health care settings, and throughout most of the 1990s, stopped health insurers from being able to sell policies without mental health coverage.

Work, continued

So why is it that social work has been so successful at the state legislature? While I cannot speak for legislators, here is what I think:

Legislative success starts with electoral action. CT PACE is our chapter's political action committee. By endorsing candidates, we build support from the get go. Candidates know and appreciate those who helped them to become elected. Several first-time elected legislators offered to introduce bills for us this year. Our licensure fee reduction bill is co-sponsored by legislators we endorsed. Some of the legislators we endorsed from the first time they won have become, or will become committee chairs and other leadership positions. Our electoral program builds relationships and heightens our influence. Our electoral work is an investment in the power of social work.

Social workers are trained in advocacy and political action for the populations we work with as well as our profession. In fact, I think we are better advocates for clients and social justice than we are for ourselves. NASW/CTs legislative agenda is always far deeper in social justice bills than professional ones. This may not always be visible since our social justice work is within coalitions where NASW's name is not forefront, while professional issues are led by and often only promoted by the Chapter. I have always felt that legislators respect our approach and commitment to issues that are not guild bills. When we work on social issues that are dear to a legislator heart, they tend to be more receptive to supporting social work bills that are dear to our hearts. To see the range of bill testimony we have submitted go to https://naswct.org/category/leg-testimonies/ I think you will be impressed!

There is a saying that half of life is just showing up. NASW/CT and schools of social work show up at the Capitol. We testify at hearings, we conduct meetings with legislators, many of our schools have student lobby days, and I have never met a social worker who was uncomfortable sending an email to their legislators. The voice of social work is being heard at the Capitol.

Over the years NASW/CT has developed and refined our legislative program for mobilization of members. I call it the 10-minute lobbyist because our legislative alerts are quick to read and act upon. Plus, on priority bills we conduct phone banking to members that are conducted by staff, interns and members. These calls encourage our members to make those critically important contacts with their legislators. Since the pandemic, we have had fewer members volunteer to make these phone calls, which really are a key component to our success. If you are willing to make 10-20 easy calls to members let me know at skarp.naswct@socialworkers.org If we are going to reduce licensing fees, we will need phone callers this April and May.

Legislators go into elected office to advance the betterment of the communities they represent. Legislators want to hear from constituents and as few as 3-4 emails or calls on a bill can sway a vote. I asked Representative Gary Turco to co-sponsor the license fee reduction bill and he told me one constituent had already asked him so he had already become a co-sponsor.

I ask you to not delay when we send out a legislative alert. Contact your state legislators as requested when requested. The 2023 legislative session ends in early June. We have a lot of work to do before this year's session is over.

NASW/CT is successful at the legislature because you, our members, do the work. We show up, we make our voices heard, and that is how we succeed. Thank you for what you have done and what you will do this year.

36th Annual Conference

June 9, 2023
Wyndham Southbury
1284 Strongtown Road, Southbury

With Keynote Speaker,

Dr. Karen Bullock, PhD, LCSW, FGSA,

Click here for the brochure and to register

Upcoming Chapter Election

Have you thought about taking on a leadership role in your chapter?

Or perhaps you know someone who would make a terrific chapter leader?

If so, now is the time to let us know!

Being an elected leader on the Board of Directors of the NASW/CT Chapter provides you with the opportunity to have a direct say in the chapter's programs, policies, use of resources, and future directions. It's also a terrific way to meet colleagues from throughout the state and to gain a feel for the pulse of social work practice in Connecticut. You will be providing the Association with your expertise and in turn making networking connections that will help in your own career advancement. Truly it is a win, win situation that's enjoyable too!

In developing the ballot, the chapter seeks to successfully meet the chapter's diversity plan, geographic representation, and representation from diverse fields of practice. All nominees are given full consideration and while we may not be able to offer all nominees a place on the ballot these individuals are often considered for other leadership appointments within the Chapter.

NASW/CT is seeking members to serve on the Board of Directors as **Second Vice President for Budget & Finance, BSW student representative, and At-Large Member**. Terms of office for the Board are for three years, except for students who serve one year.

The Board of Directors meets virtually on alternating months on the second Tuesdays of the month from 6 – 8 PM.

If you are interested in being considered for a chapter leadership position, would like to know more about available elected opportunities or would like to recommend a colleague please contact Steve Wanczyk-Karp at the Chapter Office – 860-212-4054 or skarp.naswct@socialworkers.org

Action Needed Now on Licensure

DO YOU WANT YOUR SOCIAL WORK LICENSE FEE REDUCED?
HOW ABOUT A 2-YEAR LICENSE RENEWAL?

WITH YOUR HELP THAT CAN HAPPEN!

HB 6837 IS A BILL IN THE CT LEGISLATURE THAT MAKES THE LICENSE RENEWAL FEE $100 AND THE RENEWAL EVERY 2-YEARS. NASW/CT NEEDS YOUR HELP TO PASS IT.

TELL YOUR STATE REPRESENTATIVE AND STATE SENATOR TO VOTE *YES* ON HB 6837. TELL THEM WHY HAVING A LOWER FEE AND 2-YEAR RENEWAL MATTERS TO YOU.

CT HAS THE HIGHEST SOCIAL WORK LICENSE FEES IN THE NATION.
CT IS ONE OF ONLY SIX STATES WITH ANNUAL RENEWAL.

CONTACT YOUR LEGISLATORS NOW.
NOT SURE WHO REPRESENTS YOU? GO TO WWW.CGA.CT.GOV AND CLICK ON "REPRESENTATION" AT THE TOP LEFT.

TELL YOUR LEGISLATOR YOU ARE A CONSTITUENT AND A SOCIAL WORKER.

ALSO EMAIL HOUSE SPEAKER MATTHEW RITTER Mathew.ritter@cga.ct.gov AND ASK HE BRING THE BILL TO A VOTE.

NASW/CT - THE ORGANIZATION FIGHTING FOR YOU! NOT YET A MEMBER JOIN TODAY TO PROTECT AND ADVANCE YOUR PROFESSION

Members in the News

Karen McLean and **Yvette Tyndale** are running for the position of Region II Director of the National NASW Board of Directors. The position represents the Connecticut and New York City chapters. Both Karen and Yvette are finishing their term on the NASW/CT Board of Directors. The election will be held from May 2-May 31, 2023.

Have news you would like to share? Send it to info.naswct@socialworkers.org

Education and Legislative Action Network (ELAN) Update

In early ELAN strategy meetings at the end of 2022, we discussed the upcoming legislative session. Under consideration were three points: the long session and the budget, the continuing impact of the pandemic, and our social justice focus.

Connecticut has a biennial budget process with the two-year budget defined in the odd-years, known as long sessions, which run for about five months. This legislative session is the long, "working" session where the legislature is required to produce a budget for the subsequent two years. The session also allows individual legislators to introduce bills on any subject and you may see bills submitted at the request of their constituents.

We passed the midway point of the session in late March. All bills have been considered by their appropriate committees or referred as needed, raised for a public hearing based on committee vote, and those that were favorably voted out of committee will await debate on the House or Senate floor.

Similar to last session, ELAN recognized this legislative session would have two distinct paths: advancement and protection of our profession and working with our coalitions on other issues that aligned with our legislative agenda. The chapter would focus efforts on the profession – more can be found about these efforts in this newsletter – while the committee would focus efforts on specific issues, trusting our partners to not only rally their networks but to provide talking points and updates as the session moved forward.

On the issues, ELAN members submitted testimony supporting steps toward creation of full employment trust fund, potentially used for workforce housing, employment opportunities for disadvantaged youth; voting rights protection and voting access expansion; an earned income tax credit, permanent child tax credit, and extending the time limit for temporary family assistance; a ban on child marriage; equitable transit-oriented communities; full expansion of Medicaid regardless of immigration status or age; student -centered education funding; aid in dying; social work consultation on police department crisis intervention training; recommendations of the Juvenile Justice Policy and Oversight Committee, oversight and regulation of health care in correctional facilities; and more. As of this writing, some of these bills are on chamber calendars and while not every bill is guaranteed a debate and vote on both chamber floors, in full our efforts have continued the mission of ELAN and strengthened our networks across the state.

This long session may continue after sine die, the formal adjournment on June 7, as special sessions occur more regularly. No matter, ELAN is ready for the second part of the session – call-to-action emails to memberships, calls to our legislators and leadership, debates and votes in the chambers and the potential of moving this state forward.

Respectfully,

NASW/CT ELAN Committee

Member Editorial: Comments on Current Practice

I have been a social worker in Connecticut since my graduation from UConn School of Social Work in 2004 and a licensed clinical social worker (LCSW) since October of 2006. I have worked in a variety of levels of care, from school social work, private practice, mobile crisis (EMPS), and 11 years as an inpatient clinician at 2 different hospitals. For all of my years, I have worked with children and adolescents.

The mental health crisis for adolescents is very real. That children have struggled during COVID is well documented. Parents increasingly have inappropriate expectations from mental health providers. Parents are often demanding their child be placed in residential treatment without having ever accessed a lower level of care. Parents are far more stressed out and appear perplexed by the current offerings for youth mental health. They seem to believe that there is some magic that we have as clinicians to solve this situation. I struggle to locate services for adolescents to return home. Most of the in-home services, such as IICAPS, MST, and MDFT, are significantly understaffed. Partial hospitalization programs are struggling to have enough clinicians to meet the need. Many PHP/IOPs continue to operate on a virtual or hybrid virtual model. As we have learned with schools, adolescents are not faring well with virtual services.

What I have seen over the past few years has been striking. The work with adolescents and their families is challenging; that is the nature of this work. What has been concerning, in three years of responding to COVID 19, is the tepid response from most all angles to the mental health crisis. We have seen many schools initially flounder to meet the educational needs and some school systems have been quicker than others at meeting the new demands of their field. The Department of Children and Families, though frankly an inefficient, outdated bureaucracy at best, seems to be literally 'phoning it in from home'. I speak with many DCF workers who seem to feel that I should be doing their job for them as well as my own. They can be slow to respond and when they do it is often with planned meetings in which they create more barriers for a youth's treatment. All the while, the intermediate levels of care, from in-home psychiatric services, to partial hospital programs, and to residential treatment facilities, are unable to be fully staffed to meet the needs. The question of where the recent social work graduates are working is an interesting one. Anecdotally, I hear of many new graduates going directly into private practice. Sometimes I hear from PHP coordinators who note the increased referrals to their level of care from private practice clinicians who recognize a client may require more than they are able to provide.

What has happened, with policies of DCF and the CT legislature, has been an exacerbation of the mental health crisis for adolescents. When the Children's Committee pushed forward a temporary non-clinical service, again funded by taxpayers and channeled through DCF to local mental health agencies, they failed to implement something that could address this bottleneck of services between outpatient services and those adolescents needing much more than outpatient clinicians. Many of these new clinicians graduated during COVID-19 with limited direct experience with clients and are now working from home with limited, if any, oversight. I attended a meeting hosted at Manchester Hospital with Rep. Luxenberg with Rep. Anwar and Rep. Linehan from the Children's Commission. They touted all of the great changes to happen and the positive

Editorial, continued

impact that this would have for adolescents. They created a non-clinical team to seek out services for youth and their families, the same programs I attempt to access. Now, a year later, I offer my assessment that the situation is not better.

Clinicians as well are stressed and struggling to manage. I have increasingly had conversations with clinicians in other agencies and we engage in some quick mutual support for each other. These clinicians who work in this intermediate level of care are brave and dedicated warriors to the work. I can only marvel at their ongoing efforts. My conversations with my peers in the field are often brief, stealing away a few moments to support one another. Having been in the field for almost 20 years, I can attest that this is something new. As social workers, we tend to be a hearty bunch and manage fairly well with our own adaptive skills.

With a push to make tele-health permanent, I cannot stress what a fundamental misstep this may prove to be. The shortage for staffing in higher levels of care is directly related to the desire for clinicians to have limited overhead, pick and choose their clients due to an abundance of need, and show up for sessions in casual clothes. I recognize the appeal of this but this occurs while vacancies in higher levels of care remain unfilled. Further, this is complicated by DCF's increasing mandate over the past 10 years to have children remain in the community. If an adolescent is referred for residential care, the wait is often 2-3 months. DCF has increasingly cut all congregate care, including Short term Family Integration Treatment (SFIT) last spring, while funding non-clinical offerings sub-contracted out to mental health agencies as another inefficient offering to ease the crisis. At present many of the in-home providers are 1.5 months wait, residential treatment is often 2-3 months, and partial hospital programs are 1-1.5 months wait. These estimated wait times are for adolescents currently inpatient who have historically been given priority over community based referrals.

As I spoke with my colleagues about his topics, I was given the same feedback, 'I know, what do you think should be done?' Social workers are dramatically underpaid for being master's level clinicians and maintaining a state licensure. With all the discussion about the importance of mental health services, people should agree to pay premium rates for what all tout as a desperately needed service. I would be prioritizing this intermediate level of care. I am in favor of downsizing DCF, diminishing their capacity to solely child protective investigation. This would decrease the tendency for agencies to seek these contracts for state funding. Insurance reimbursements should be aligned with appropriate wages for skilled clinicians. There are currently some bills regarding the cost of licensure that would create some relieve as well.

Best Regards,
Michael Westfall, LCSW
Manchester, CT
860-212-8923

The views expressed here are that of the author and may not reflect the viewpoint of NASW/CT. NASW/CT welcomes editorial comments from members. Submit an editorial for consideration to skarp.naswct@socialworkers.org Editorials should be 1000 words or less though slightly longer submissions may be considered.

Congenital Heart Disease: What social workers need to know

When many people hear the term "heart patient" they generally think about an older adult in need of dietary or lifestyle changes. However, congenital heart disease is completely different from coronary heart disease. Congenital heart disease is an anatomical heart condition which develops in utero. It is often, but not always diagnosed at birth. Congenital heart disease requires specialized care, lifelong care. The Centers for Disease Control estimates that a baby is born with a congenital heart condition (CHD) every 15 minutes in the US, and it is the most common birth defect worldwide. Despite significant medical and surgical advances in the mid to late 20th century, CHDs continue to be the leading cause of birth-related deaths.

It is estimated that there are approximately 2.4 million people living in the US with CHD. About 1 million of them are children under the age of 18 years. According to the non-profit organization Conquering CHD, CHD is 50 times more common than childhood cancer. That means there is a good chance that you or someone you have worked with belongs to this very special medical community. Despite these statistics, however, individuals with CHD continue to be a "hidden population" in need of additional resources and support.

The CHD population is heterogeneous, and it includes individuals with a variety of heart defects, which vary in terms of required treatment, severity, and prognosis. CHD is incurable, leading to a growing number of adults living with a heart condition for their entire lives, from "cradle to grave". As a woman living with a heart condition from birth, I know what it feels like to be a part of this hidden and rapidly growing population.

Many children and adults with CHD have to cope with ongoing physical symptoms (arrhythmia, potential ICD shock, debilitating fatigue), frequent and unexpected hospitalization, repeated surgeries, routine exposure to invasive procedures, and the possible implantation of cardiac devices such as pacemakers or cardioverter defibrillators. For many these experiences can feel relentless, resulting in ongoing or intermittent worry and fear which can sometimes trigger a wide range of responses, including posttraumatic stress, depression and anxiety.

Individuals with CHD deal with typical, "normal" everyday stressors that everyone else does (ie work stress, finances etc), but they also must learn to cope with a layer of medically related challenges from birth. Some of the psychosocial challenges related to CHD can include early separation from primary caregivers while hospitalized, neurodevelopmental delay, excessive scarring, feeling different from peers, bullying, medical trauma, feelings of grief and loss, impact on relationships and self esteem, interrupted education and employment due to hospitalizations, and discrimination. These adverse life experiences can understandably put these individuals at a higher risk of developing mental health issues. Studies have shown that 50% of individuals with CHD had a lifetime prevalence for depression, anxiety or posttraumatic stress, which is more than double the general population. Sadly, it has also been found that there is an enormous lack of mental health resources for this community.

Throughout my life I have experienced a sense of aloneness in my experience, never having my

Heart Disease, continued

medical trauma acknowledged beyond that of physical survival. My medical providers did their best, but back in the early days there just wasn't a lot of awareness around the importance of holistic care. When I attempted on my own to find mental health care, it was extremely difficult to find someone with both the understanding and competency needed.

I have made it my life's work to increase awareness in order to ignite positive change for this growing population. It is crucial for those in the medical field to have an understanding of the emotional, psychological and practical needs of this medical community, and help increase resources and appropriate support for those of us living with a lifelong heart condition. It has been found that individuals with CHD are often interested in receiving mental health support but that there is an enormous gap in resources. Social workers have a real role to play in providing not only evidence-based psychological interventions, but also to empower individuals to take control of their healthcare and help to promote psychologically informed care throughout the wider health care system.

When working with this population it is important to recognize that each individual experience is very different, and not everyone experiences the challenges described above. An individual's style of coping, defense mechanisms and cultural background must be taken into consideration. It is important to be aware of the increased use of denial as a coping mechanism. It is essential that a thorough assessment is conducted, taking into consideration their unique medical history, and that they be encouraged to engage in developing their treatment plan.

Additionally, it is important to not further pathologize what may be a very normal reaction to an unusual and oftentimes traumatic life circumstance. However, given the high prevalence of PTSD, many individuals may benefit from trauma informed interventions which cultivate feelings of safety and stabilization. The use of empathy is important when developing a therapeutic alliance, but an awareness of countertransference is a must in order to avoid relaying pity, over sympathizing.

While research is slowly emerging, evidence-based treatments such as (trauma informed) cognitive behavioral therapy, eye movement desensitization and reprocessing (EMDR), acceptance and commitment therapy (ACT) and mindfulness-based stress reduction treatments have been found to be helpful. Be sure to practice according to your competency level, and seek consultation, if needed. Peer support has been found to be very helpful in this medical community. The Adult Congenital Heart Association https://www.achaheart.org/ has a virtual peer mentorship program (and many resources) specifically designed for those with CHD. Many of the specialized Adult Congenital Heart Centers offer peer support, as well.

Tracy Livecchi, LCSW

Tracy Livecchi, LCSW *has a private practice in Westport, CT and is the Mental Health Consultant for the Adult Congenital Heart Association's Peer Mentorship Program. She is also co-author of the book, "Healing hearts and minds: A holistic guide to coping well with congenital heart disease", published in January by Oxford University Press.*

Licensure Fees, 2 Year Renewal and Future Master Exam All Debated at the Capitol

As many of you know, NASW/CT has been advocating for years to have the license application and annual renewal fee lowered, plus have biennial renewal. Last year the Chapter made a major push to accomplish fee reductions to no avail. Come this year's legislative session, there has been a dramatic change. We have two bills that reduce licensure costs and move to a 2-year license.

Senate bill 2 calls for a reduction in the application fees and 2-year renewal of license. The LCSW fee would go from $315 to $200 and the LMSW fee would drop from $220 to $150. This bill will also make the license renewal every 2-years at the current renewal fee of $195. It appears that some other licensed professions will also go to a 2-year renewal however only the social work licenses are slated for fee reduction. Senate bill 2 is a top priority of the Senate Democratic Caucus.

Senate bill 2 also includes mental health days being eligible for paid sick days when an employer offers sick time and the creation of an Office of Behavioral Health Ombudsman to address mental health providers problems with health insurers. Both of these provisions came from recommendations of NASW/CT.

House bill 6837, introduced by the Public Health Committee, reduces the license renewal fee from $195 to $100 and makes the renewal period every 2-years. This bill also suspends the master exam for the LMSW from October 1, 2023 to April 1, 2026. The reason for the suspension of the license is recognition of the bias in the current exam and the workforce shortage that demands more licensed social workers.

CT has the highest licensure fees of any jurisdiction in the nation and is one of only 6 states to renewal the license annually. In the Chapter's *Recommendations on Workforce Support for Social Workers* we called for a reduction in the renewal fee and biennial renewal.

Having bills that include fee reductions and biennial license renewal is no guarantee of eventual passage. The loss revenue is not in the Governor's budget and will need to included in the budget of the Appropriations Committee and ultimately the final negotiated budget.

This is the first time that we have achieved fee reduction in a bill and a 2-year license renewal. To make it a reality will require a massive lobbying response from the social work community. It is essential that members contact their state legislators in the CT General Assembly and urge them to support lower fees and biennial licensure renewal. Social work has never had the level of support we see currently. We may not get another shot – act now!

Monthly Peer Ethics Support Group

NASW/CT Ethics Committee is proud to announce the first Virtual Monthly Peer Ethics Support Group! This group is free and open to all NASW Members. The purpose of this group is to provide social workers professional, educational, and peer support related to ethical challenges and dilemmas. The first group will occur on January 26, 2023, and all spots are filled! Interested in registering for February? See below for details!

Who can join the Peer Support Group?

-NASW Members from any chapter can join the support group. Social workers who work in a variety of practice settings are welcome to attend!

When does group take place?

-Group will occur the 4th Thursday of each month from 6:30pm-7:30pm (EST); this group started January 26, 2023.

How do I sign up?

-An email can be sent to Yvette Tyndale, Ethics Committee Chair at yvette.tyndale@outlook.com to register. 10 spaces will be available each month.

Is the group open or closed?

-This is an open group. New members are welcome each month!

For additional questions or information, contact Yvette Tyndale at yvette.tyndale@outlook.com.

The next four meetings will be on:

April 27th
May 25th
June 22nd
July 27th

APPLY TODAY

NASW/CT Diversity, Equity, and Inclusion Committee

The NASW/CT's Diversity, Equity, and Inclusion Committee Welcomes New Members!

Our Committee welcomes new members, both current NASW/CT members and those who have yet to join, to our upcoming meetings.

Join us next on Thursday, May 11 from 5 pm to 6 pm on Zoom to network with social workers with diverse experiences and backgrounds, discuss current events, and brainstorm ideas to bring diversity, equity, and inclusion to social workers in CT and beyond!

Email co-chairs Meghan Lauer (Lauer@my.ccsu.edu) and Sherryl Chin (Sgchin09@gmail.com) for Zoom and/or additional information.

CT PACE Endorses in Special Election & Bridgeport Mayoral Race

CT PACE the political action committee of NASW/CT made two wintertime endorsements of social workers running for office. One endorsement was in a special election to fill an open seat for the legislature and the other is for the 2023 Democratic primary for the mayoral race in the City of Bridgeport.

Kai Belton, LMSW ran for the CT House of Representative representing the 100th district in Middletown. The seat became open after the tragic motor vehicle death of Representative Quentin Williams. Ms. Belton was successfully elected on February 28th, becoming the first Black woman to represent Middletown in the state legislature. Representative Belton works for a mobile crisis intervention team. Kai's election is historic for social work as we now have, for the first time, eight social workers elected to the CT General Assembly.

Lamond Daniels, MSW is an announced candidate for mayor of Bridgeport. Currently, he serves as Norwalk's Chief of Community Services where he oversees the city's departments of Health, Human Services, and Library, with a combined budget of $10 million and 100 employees.

"I want to thank my brothers and sisters at NASW for this important - and humbling - endorsement," said Daniels. "I became a social worker to help our community, give people fair opportunity, and provide at-risk families and youth with the support they need to succeed. Since then, I've built a career in government management, overseeing multiple departments with multi-million dollar budgets. Right now, city government needs to do better by Bridgeport families. We need more housing, cleaner and safer streets, real justice, and stronger schools. I believe in Bridgeport and I love our people, but we're never going to get the change we need with the same old faces pushing the same old political agendas."

If elected, Lamond will become both Bridgeport's first Black mayor and first social worker to hold the position. Lamond Daniels is a member of NASW. CT PACE will be mobilizing NASW/CT members in Greater Bridgeport in support of Lamond Daniels.

CT PACE may endorse candidates in municipal elections when a social worker is running for office.

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- Protecting the safety net for Connecticut's most vulnerable citizens;
- Addressing access to comprehensive health and behavioral health;
- Expanding mental health services in schools;
- Extending TANF lifetime cap to 60 months;
- Furthering criminal justice reforms;
- Advancing racial, economic, and environmental justice;
- Adding Medicaid coverage for undocumented immigrant children;
- Passing paid mental health days as sick days eligible;
- Increasing funding for community non-profit providers;
- Banning child marriage;
- Enlarging HUSKY C eligibility limits;
- Promoting progressive revenue sources to pay for human services.
- Passing rules for early voting and absentee balloting.

Social Work Legislation

- Reducing licensing fees and making the license renewal 2-years;
- Creating an Advocate Office for behavioral health providers;
- Making the telehealth statute permanent;
- Acting to support the current social work workforce;
- **Defeating any bills that infringe on social work practice**;

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