

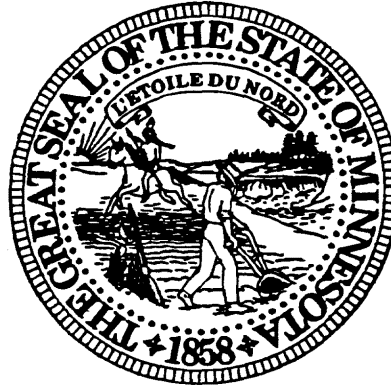
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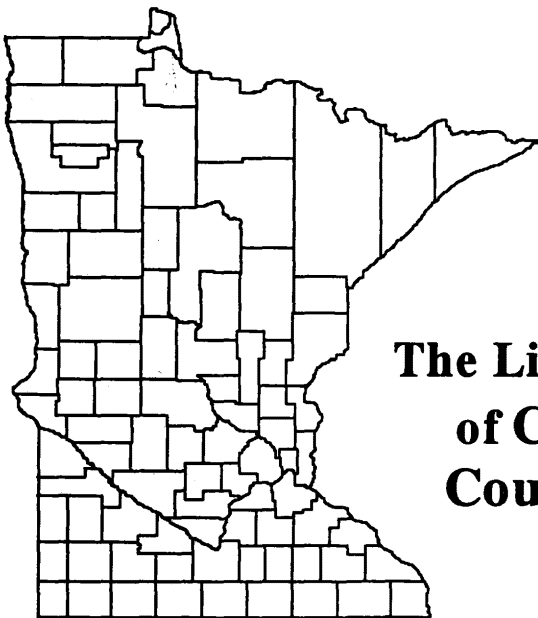


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Minnesota Department of Human Services



Report to the Legislature



The Licensing or Credentialing of Chemical Dependency Counselors in Minnesota

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Chemical Dependency Program Division, January 31, 1992

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Pursuant to 1991 Laws, Chapter 292 —
Article 1, Section 2 Subd 6 Para #8

A REPORT ON THE LICENSING OR CREDENTIALING OF
CHEMICAL DEPENDENCY COUNSELORS IN MINNESOTA

A MANDATED LEGISLATIVE REPORT
as required by
Laws of Minnesota, 1991, Chapter 292
Article 1, Section 2 Subdivision 6, Paragraph #8

MINNESOTA DEPARTMENT of HUMAN SERVICES
CHEMICAL DEPENDENCY PROGRAM DIVISION

January 31, 1992

1992

EXECUTIVE SUMMARY

Minnesota is recognized as a leader in the field of chemical dependency. This recognition has been national and international in scope; yet Minnesota does not have a process established in legislation that establishes standards for chemical dependency counselors.

The State of Minnesota has approximately 3,000 persons who are practicing chemical dependency counselors, who treat nearly 40,000 individuals a year for chemical abuse and dependency at a cost of nearly \$100 million annually. The 1991 legislature asked the Department of Human Services to recommend standards and procedures to be used in the licensing or credentialing of chemical dependency counselors by January 31, 1992 (*Laws of Minnesota 1991, Chapter 292, Article 1, Section 2, Subdivision 6, Paragraph 8*).

Nationally there are 42 certifying bodies for chemical dependency counselors. These bodies consist of 37 State boards, 2 boards from the District of Columbia, the United States Air Force, Navy and Canada and insure that very specific standards are adhered to when individuals are providing chemical abuse and dependency services to a highly vulnerable population. Approximately 75% of the States have State Boards that regulate chemical dependency counselors. Minnesota is not one of these states. Currently Minnesota has a voluntary credentialing process operated by a non-profit agency.

The chemical dependency field has been working to improve the status and credibility for individuals providing treatment since 1973. Most recently the field developed the Chemical Dependency Regulatory Coalition which is an organization concerned with chemical dependency services provided by counselors in Minnesota. The coalition is comprised of 14 associations and organizations, some of which are state-wide and others which represent local or regional groups. This coalition is prepared to pursue a licensing process through the legislature that will establish standards for training, ethics, qualifications, scope of practice, experience and competencies expected of chemical dependency counselors.

Pursuant to Minnesota Statutes 214.13 and 214.141, the Chemical Dependency Regulatory Coalition presented its application for licensure to the Human Services Occupational Advisory Council (HSOAC) in 1990. This council was staffed by the Health Department. The council defeated by one vote a recommendation to license chemical dependency counselors. HSOAC subsequently voted to recommend registration of all chemical dependency practitioners regardless of employment setting or professional titles used.

The Commissioner of Health has not issued a formal opinion on the regulation of chemical dependency counselors, but consistent with legislative policy stated in Minnesota Statutes 214.001, subdivision 1 and 3, believes that the least restrictive form of regulation is most appropriate. Based on the existing statutes the Minnesota Department of Health believes that authority exists only to adopt a registration process.

The Department of Human Services is recommending that the legislature adopt a licensing process for chemical dependency counselors that is similar to the Licensing Boards for Social Workers and Marriage and Family Practitioners. Minnesota needs to continue to protect its vulnerable population and a licensing process would be an effective means of protecting the 40,000 people treated by chemical dependency counselors in Minnesota each year.

The legislature should appropriate \$376,114 to operate the chemical dependency licensing board for the biennium. The board should establish fees, including late fees, and renewal fees for licensing of chemical dependency counselors so that the total fees collected by the board will equal the anticipated expenditures during the fiscal biennium.

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I. Introduction

A. Legislation

The purpose of this report is to respond to legislation passed during the 1991 session. As a rider to the Human Services Budget Bill legislation was passed that stated the following:

"By January 31, 1992, the commissioner of human services shall present to the legislature a report, prepared in cooperation with the commissioner of health, containing recommendations on the standards and procedures to be used in the licensing or credentialing of chemical dependency professionals. In preparing this report, the commissioners shall consult with an advisory group that includes a representative of each of the boards established under Minnesota Statutes, chapter 148B and at least six individuals representing chemical dependency professionals and service providers."

The Department developed an advisory group for this purpose in August of 1991. The Department had meetings in September and December with this group in order to obtain their input and recommendations for the regulation of chemical dependency counselors. In addition to meeting the legislative requirements for the make-up of this committee the commissioner assured that the group included representation from minority communities, existing State Advisory Councils, rural members and the Institute for Chemical Dependency Professionals (See Appendix A for Committee List).

B. Overview of Report

This report, contains a history of the chemical dependency field's efforts to improve their credibility, legislation regarding occupational regulation and the human services occupational advisory council of the health department. The report also gives a description of what the various agencies' and groups' positions are in relation to regulation of chemical dependency counselors. The report provides recommendations to the legislature regarding the regulation of this occupation.

II. History

A. Chemical Dependency Counselors Efforts to Obtain Status and Credibility.

In 1971 the State of Minnesota decriminalized public drunkenness which became the starting point for the growth of the chemical dependency field. In 1973, a group of alcohol and drug abuse workers organized to form the Minnesota Chemical Dependency Association(MCDA). The intent of developing this association was to: 1) unify the alcohol and drug abuse fields in order to promote the exchange of information; 2) enhance the delivery of chemical dependency services; and 3) improve the status of the chemical dependency professional among peers, other professionals and the general public.

In 1971 the State had only three treatment programs. These were Willmar State Hospital, Hazelden and St. Mary's. By 1974, just three years after the repeal of public drunkenness, there were 126 information and referral agencies, 381 detoxification beds, 1,455 primary inpatient treatment slots, 17 outpatient treatment programs, 821 extended care beds and 934 halfway house beds. In the early years of the field of chemical dependency, counselors were primarily recovering persons with varying levels of competency and training.

In 1974 M.C.D.A. established a steering committee in hopes of furthering the legitimacy of the chemical dependency counselor by defining the unique competencies of the worker and seeking certification of professionals. M.C.D.A. developed a working relationship with the Minnesota Department of Health, with the goal of initiating licensure or certification for its professionals. By the end of 1974, the association had developed attitude, skill and knowledge statements that were accepted by the general membership.

In 1976 the chemical dependency professionals of M.C.D.A. sought mandatory regulation from the Health Department for counselors. This request was never acted on and it was suggested that the counselors seek a voluntary process.

In 1978 chemical dependency associations had developed a credentialing process based on competencies and peer review. In 1979 the voluntary credentialing process was implemented and the Institute for Chemical Dependency Professionals of Minnesota was incorporated as a separate 18 member board to manage the

credentialing process. At this time it was also recommended that counselors so certified should be referred to the Department of Health for registration.

By 1982 no decision had been made by the Health Department as to the registration of Chemical Dependency Counselors. In 1984, however, the Department of Health began reviewing applications for regulation again through the Human Services Occupational Advisory Council and the Commissioner of Health.

In 1985 I.C.D.P. joined the National Certification Reciprocity Consortium which allowed Minnesota Chemical Dependency Counselors who sought the voluntary credentialing process through I.C.D.P. to be recognized in other parts of the country.

In 1987 the process for seeking regulation of counselors peaked among the chemical dependency field. I.C.D.P. was approached to submit an application to H.S.O.A.C. It was determined by the CD professionals that I.C.D.P. did not represent fully the interest of the field so in 1989 the Chemical Dependency Regulation Coalition was formed.

B. The Chemical Dependency Regulatory Coalition

The Chemical Dependency Regulatory Coalition is an organization that was formed in 1989 to pursue a licensure process for chemical dependency counselors. This organization was developed in order to form a unified front for regulation. The coalition is made up of 14 associations and organizations that are concerned with chemical dependency services provided by counselors in Minnesota. This coalition most recently sought a licensure process for chemical dependency counselors from the Health Department's Human Services Occupational Advisory Council and the Health Department (in 1990) and the State Legislature (in 1991).

In January of 1990 the Coalition reapplied to H.S.O.A.C. and the Department of Health seeking a Licensure process for the state's Chemical Dependency Counselors. (See section D for results of this process)

During the 1991 Legislative session the Coalition attempted to have a bill introduced that would have developed a licensure process for CD counselors but the bill failed to get out of Committee.

C) Relevant Statutory Provisions and History

Minnesota Statute section 214.001, subdivision 2 states that the legislature declares that no regulation shall be

imposed upon any occupation unless required for the safety and well-being of the citizens of the state. Section 214.13, subdivision 1 states that the commissioner of health shall promote the recognition of human services occupations useful in the effective delivery of human services. Section 214.13, subdivision 5 states that the commissioner of health shall exercise care to prevent the proliferation of unessential registered human services occupations

In 1987 the state legislature passed Minnesota Statute 148B which established a Board of Social Work, a Board of Marriage and Family Therapy and a Board of Unlicensed Mental Health Practitioners. This law identified chemical dependency counselors as mental health providers who would be required to comply with the rules adopted by the Board of Unlicensed Mental Health Practitioners. The law at this time only required that providers file with the board and that it was no endorsement by the state that the individual who filed had met any training requirements, documented any skills or met any standards of conduct. The law at this time did not allow or authorize the board to take any disciplinary action against a registered provider.

As initially passed this section of law, identified as Laws of 1987, chapter 347, article 4, sections 1 to 8, was to be repealed effective July 1, 1991. In the interim the Board of Unlicensed Mental Health Services Providers was required to report to the commissioner of health and the legislature by July 1, 1990 on the activity of the board.

By January 15, 1991 the board was required to report to the legislature with recommendations on whether providers who are not trained should be allowed to continue to practice (See Appendix C).

At the same time the commissioner of health was required to report to the legislature on the need for registration or licensing of mental health service providers and the need to retain the board of unlicensed mental health service providers (See Appendix D).

During the 1991 legislative session the Board of Unlicensed Mental Health Providers was abolished and replaced with the Office of Mental Health Practice, which is to be established within the department of health. This new law establishes a nine member council to advise the commissioner of health in the development of enforcement rules and procedures. Six members of the council are to be mental health professionals, with three public members.

In addition to a council the new office does have the authority to impose disciplinary measures, ranging from limiting practice and filing injunctive relief to investigating other criminal and civil penalties. The new

office will not regulate occupational groups already under the jurisdiction of a state-licensing board. The law does however allow the office to investigate any complaints filed or reported regarding unlicensed mental health practitioner or chemical dependency counselors.

With the new office of mental health there is no formal requirement for chemical dependency professionals to register. The new office does not recognize the need for specialized training or qualification of chemical dependency counselors but in fact will be a policing agency for investigating complaints.

D. Human Services Occupational Advisory Council

Minnesota Statutes 214.141, establishes a human services occupational advisory council to assist the commissioner of health in formulating policies and rules regarding human service occupations. The commissioner has the authority to request the council to review applications for regulations and make a recommendation.

Minnesota Statutes 214.001, subd. 2, states that in evaluating whether an occupation should be regulated the following factors shall be considered:

- 1) whether the unregulated practice of an occupation may harm or endanger the health, safety and welfare of citizens of the state and whether the potential for harm is recognized and not remote;

- 2) whether the practice of an occupation requires specialized skill or training and whether the public needs and will benefit by assurances of initial and continuing occupational ability;

- 3) whether the citizens of this state are or may be effectively protected by other means; and

- 4) whether the overall cost effectiveness and economic impact will be positive for citizens of the state.

HSOAC completed its review and deliberation of the Chemical Dependency Coalition's application for regulation based on the statutory criteria in June 1990. After a motion to recommend licensure was defeated by one vote, HSOAC recommended registration.

A legislative decision to eliminate funding for the occupational review activity became effective June 30, 1990 and resulted in the appointment of Health Department staff to other positions. A written report of HSOAC's review was not produced and a recommendation was not transmitted to the

Commissioner of Health. Consequently, the Commissioner of Health had no basis upon which to make a recommendation to the legislature concerning the need to regulate chemical dependency counselors. Subsequently, the Coalition decided to initiate legislative action.

For the purposes of this report, meeting minutes of May and June 1990 HSOAC deliberations provide documentation of HSOAC's evaluation, findings and conclusions concerning the statutory criteria (See Appendix E).

With regard to criteria #1 listed above the H.S.O.A.C. committee supported the coalition's application and agreed that there is public harm to the public caused by this unregulated occupation. The coalition presented a number of cases where CD counselors harmed their clients. A number of cases of harm were also presented by clients and outside agencies.

The H.S.O.A.C. committee also supported the coalition's application regarding criterion #2. This criterion specifies that specialized training and skills are required to perform the duties of this occupation.

The committee unanimously agreed that the public is not currently protected by other means, as described in criterion #3, above.

The 4th criterion considered by the committee was whether regulation would have an overall positive effect for the citizens of the state. The committee supported the coalition's documentation that regulation would be cost effective and that other means of regulation would not be more effective in protecting the public.

With the above criteria as a measure for the necessity of some sort of regulation the HSOAC committee agreed that the applicant should be monitored in some fashion. In the closest vote of the committee, a motion to regulate the CD counseling profession through a licensing process to permit practice by those recognized by the state and to prohibit practice by unqualified persons ended in a tie. The tie vote of the committee members was broken by the chairperson, who voted against a licensing process.

A second motion voted on by the committee was to implement a registration system to restrict the use of the occupational title of chemical dependency counselor, create an official roster and establish qualifications. This motion was approved by the committee. The committee also approved two other motions which included provisions that would not allow for any exemptions to the registration process based on place of employment and to include any person known as or calling themselves a CD counselor.

The findings, conclusions and recommendations of HSOAC were not documented in a report to the Commissioner because, as noted earlier, the legislature defunded the occupational analysis activity. In the absence of a written report of the policy analysis, the Health Department did not have a basis upon which to make a recommendation to the legislature concerning regulation of chemical dependency counselors.

III. Positions of Other Agencies and Groups

A) Regulation Advisory Committee

The Human Service Department's Counselor Regulation Advisory Committee established pursuant to the current legislation passed a motion on a 5 to 1 vote that the Department of Human Services recommend to the legislature that chemical dependency counselors in the State of Minnesota should be licensed.

B) Health Department

In the absence of a policy analysis report and recommendation concerning regulation of chemical dependency counselors, the Commissioner of Health has not taken a position on the appropriate mode of regulation. In any event, the Health Department believes that legislative policy and definitions stated in Minnesota Statutes 214.001, subdivisions 1 through 3, and Minnesota Rules 4695.0600, subdivision 10, should continue to guide in making the determination. These provisions provide the following:

1) Minnesota rule part 4695.0600, item B, subpart 10, defines Credentialing as: "Credentialing" means licensure or registration and the process by which they are obtained;

2) Minnesota Statutes, Section 214.001, subdivision 3 indicates that after evaluation of the factors to be considered for regulation that it is necessary to regulate an occupation not heretofore credentialed or regulated, then regulation should be implemented consistent with the policy of this section in the following order:

a) Creation or extension of common law or statutory causes of civil action, and the creation or extension of criminal prohibition;

b) Imposition of inspection requirements and the ability to enforce violations by injunctive relief in the courts;

c) Implementation of a system of registration whereby practitioners who will be the only persons permitted to use a designated title are listed on an official roster after having met predetermined qualifications; or

4) Implementation of a system of licensing whereby a practitioner must receive recognition by the state of having met predetermined qualifications, and persons not so licensed are prohibited from practicing.

The intent of this legislation is to regulate an occupation in the most cost-effective, least restrictive manner. For these reasons the health department believes that registration of chemical dependency counselors may be more appropriate than licensure and should be given serious consideration. Registration is less restrictive and therefore would have fewer negative impacts on health care delivery and health care costs.

C) Human Services Department

The chemical dependency program division of the department of human services has long supported the idea of improving the qualifications and insuring quality of services provided by the chemical dependency counselor profession. Even though the department is concerned about over regulation it is supportive of the chemical dependency regulatory coalitions' efforts to improve the qualification of counselors and to assure the adequate protection of clients and have an effective mechanism to discipline counselors' who use unethical practices.

The Human Services Department agrees with the Human Services Occupational Advisory Council that the Chemical Dependency Regulatory Coalition has demonstrated that the unregulated occupation of chemical dependency counselors has caused public harm, requires specialized training and skills, is not adequately regulated by other means and that it would be economically advantages for regulation.

Despite the long history of the chemical dependency field's efforts to self-regulate and to gain professional recognition, the department of human services sees that these efforts have not gone far enough to protect the public from harm.

Many of the systems in place today which regulate the chemical dependency field are facility-based regulations which do not protect the public from abuse by individual chemical dependency practitioners. In a number of cases there are individual counselors working in licensed programs who have lost their counselor or practitioner status from

the Institute for Chemical Dependency Professionals. The reason for the loss of this status for practitioners has ranged from ethical violations to emotional abuse.

It is clear that the chemical dependency field is a regulated profession but the regulations operate in a very patchwork fashion, none of which get at the competency based qualifications which are needed for adequate regulation.

The department also believes that consideration should be given to the fact that the request for a licensure process is being initiated by an occupational group that has recognized that self-regulation has not been sufficient in protecting the public. If a licensing regulation process is adopted it is at the request of the occupational group and not a regulation that is being imposed upon the group by state government.

For these reasons the department is concerned that a registration process may not go far enough and is supportive of a licensing process.

D) Chemical Dependency Regulatory Coalition

The chemical dependency regulatory coalition will pursue through legislation the status of a licensed occupation regardless of any action of the state health or human service departments. The coalition believes it has demonstrated the need for such action in its application to the human services occupational advisory council and the department of health.

E) American Indian Advisory Council

The American Indian Advisory Council which is established in Minnesota Statute 254A.035 to assist the state alcohol and drug authority in formulating policies and procedures relating to chemical dependency issues by American Indians, is on record as supporting a licensing process to improve the status and recognition of the chemical dependency counselor profession. The council is concerned however with how this process will operate, what qualifications will be imposed and what assurances will exist that will promote the use of culturally appropriate counselors.

F) State Alcohol and Other Drug Abuse Advisory Council

The State Alcohol and Other Drug Abuse Advisory Council is, established in Minnesota Statute 254A.04. Section 254A.05, subdivision 1(b) to advise the commissioner of

human services and the director of the state alcohol and drug authority on policies, goals and the operation of the state plan for alcohol and drug program services in the state and other matters as directed by the commissioner and director, is also supportive of seeing that the chemical dependency counselor profession is adequately regulated and is supportive of a licensing process.

IV. Recommendations

The department of human services recommends that the legislature establish a Chemical Dependency Licensing Board similar to the Board of Social Workers and the Board of Marriage and Family Practitioners.

The board should consist of chemical dependency counselors, chemical dependency educators, public members, former consumers of chemical dependency services and at least one member of each minority group including American Indians, African Americans, Hispanics, and Southeast Asians.

Board members should have the opportunity to adopt policies and rules regarding licensure that will standardize the profession of chemical dependency counseling. The board should have the authority to refuse to grant or to revoke licenses upon findings of incompetency or ethical violations. Board members should serve three year terms.

To meet licensing requirements, all new applicants for chemical dependency counselor license should have obtained an associate degree or certificate from an accredited school or educational program approved by the North Central Accreditation Board or similar accrediting body. The degree should include 270 hours of chemical dependency education and 880 hours of practicum. The board should develop a written test as well as require a case presentation for new applicants seeking licensure. Educational exception criteria should be developed by the board for American Indians, African Americans, Hispanic and Southeast Asian applicants.

Five years after the passage of the licensing process, new applicants for licensure should be required to have a bachelor's degree in a human services area, have completed 480 hours of chemical dependency education and 880 hours of chemical dependency practicum. Exception criteria should be developed by the board for American Indians, African Americans, Hispanic and Southeast Asian applicants.

Criteria should be developed to allow for current chemical dependency counselors to be granted a license. This granting procedure should include a two year time frame from the beginning of the process and consideration for extension for minority applicants.

Individuals to be "grandfathered" a license should include counselors currently certified by the Institute for Chemical Dependency Professionals as a Certified Chemical Dependency Counselor or a Certified Chemical Dependency Counselor-Reciprocal; or applicants who pass a written and oral test and who have three years of experience and 270 hours of training and who have completed 300 hours of practicum; or applicants who have five years of experience, 270 hours of chemical dependency training, have passed either a written or oral test, or are certified by the Institute for Chemical Dependency Professionals as a Certified Chemical Dependency Practitioner; or applicants who have seven years of experience and 270 hours of training with 60 hours of training occurring within the past five years.

Consideration should be given to extending the "grandfather" clause to persons of minority ethnic backgrounds for a period of ten years at which time the process should be reviewed for potential modification. The purpose of this provision would be to promote the continuation of culturally-specific available services for American Indians, African Americans, Hispanics and Southeast Asian persons.

Once an applicant has been approved by the board the licensee should be required to complete 40 hours of continuing education over a two year period in order to renew their license.

The process should specifically define what a chemical dependency counselor is and identify the competencies that must be documented before a license could be granted.

The process needs to identify any individuals who would be exempt from chemical dependency licensure. These exemptions should include physicians, nurses, psychologists, marriage and family therapists and social workers who are practicing within their scope of work.

The licensing process should not exempt individuals on the basis of their place of work. This licensing process should not exclude state and county chemical dependency counselors, clergy or licensed mental health or social workers who purport to do chemical dependency counseling.

The process needs to include penalties for individuals who practice or use the title of chemical dependency counselor without the license, including a prohibition to practice without a license.

The legislature should appropriate sufficient funds for the board to operate for two years. It is estimated that it would cost the board \$376,114 to operate during the biennium (see appendix F for budget detail). It should be the board's responsibility to establish fees, including late fees, and renewal fees for licensing of chemical dependency counselors so that the total fees collected by the board will as closely as possible equal the anticipated expenditures during the fiscal biennium. Fees should be credited to accounts in a special revenue fund.

APPENDIX A

Licensing/Credentialing Advisory Board Members

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Nancy Howes
AIAC
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293-5191

James Prokop
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924-5741

Tom McSteen
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623-5185

Phil Brekken
Mn. Depart.of Human Services
444 Lafayette Rd.
St. Paul, MN. 55155
296-4611

Jo Beth Marshall
ICDP
596 S. Osceola Ave.
St. Paul, MN. 55102
227-7584

APPENDIX B

CHEMICAL DEPENDENCY REGULATION COALITION

American Indian Advisory Council
Department of Human Services
Chemical Dependency Division
444 Lafayette Road
St. Paul, MN 55155

Employee Assistance Professionals Association
(formerly Allied Labor & Management
Alcoholism Counselors Association)
2550 University Avenue West
St. Paul, MN 55104

Number of counselors represented: 100

Hennepin County Council of Chemical Dependency Programs
1800 Chicago Avenue
Minneapolis, MN 55404
Number of agencies: 51
Number of counselors employed: 275

Institute for Chemical Dependency Professionals of MN, Inc.
596 South Osceola Avenue
St. Paul, MN 55102
Number of counselors certified: 350
Number of practitioners certified: 1,050

Independent Outpatient Treatment Association
525 Park Street, Suite 310
St. Paul, MN
Number of agencies: 18 corporations
representing 34 outpatient programs
Number of counselors employed: 150

Institute on Black Chemical Abuse
2616 Nicollet Avenue
Minneapolis, MN 55404
Number of counselors employed: 15

Minnesota Alcoholism Counselors Association
P.O. Box 21115
Minneapolis, MN 55421
Number of counselors represented: 210

Minnesota Chemical Dependency Association
P.O. Box 506
Maple Plain, MN
Number of agency members: 47
Number of counselor members: 200

Minnesota Association of Programs Serving Adolescents
4954 Upton Avenue South
Minneapolis, MN 55410
Number of agencies: 15
Number of counselors employed: 85

Minnesota Association of Residential Programs
6612 Lyndale Avenue South, Suite 2
Richfield, MN 55423
Number of agencies: 6
Number of counselors employed: 40

Minnesota Association of Treatment Programs
490 E. County Road B
Maplewood, MN 55117
Number of agencies: 27
Number of counselors employed: 260

Northwest Counselors Association
c/o Ah-Gwah-Ching
Walker, MN
Number of counselors represented: 100

Ramsey County Council of Chemical Dependency Programs
c/o Fairview Granville
10 West Exchange
St. Paul, MN
Number of agencies: 22
Number of counselors employed: 80

Southern Minnesota Association of Alcohol and Drug
Abuse Counselors
203 West Lanesburg
Le Center, MN 56057
Number of counselors represented: 70

APPENDIX C

**Report of the Commissioner of Health
on the Regulation of Unlicensed Mental Health Practitioners**

Minnesota Department of Health

March, 1991

Submitted to the Minnesota Legislature

Pursuant to Minnesota Statutes 1990, 148B.48, Subdivision 1

In accordance with Minnesota Statutes 148B.48, Subdivision 1, this report contains the recommendations of the Department of Health regarding the need for additional regulation of unlicensed mental health practitioners.

This report also makes reference to the report and recommendations of the Interagency Task Force on Mental Health Practitioner Regulation mandated by Laws, 1990 Chapter 568, Article 2, Sections 93 and 94, in which the Department of Health concurs.

HISTORY

In 1987, the Legislature created the Office of Social Work and Mental Health Boards. This structure includes the Social Work Licensing Board, the Marriage and Family Therapy Licensing Board, and the Board of Unlicensed Mental Health Service Providers. The Office was established to provide coordination of administrative support activities to the three regulatory boards, including budget development, staffing, and office space.

The Social Work and Marriage and Family Therapy Boards were modeled on other licensing boards--they are empowered to establish education and training standards for entry into their respective professions, as well as continuing education requirements. These boards also may engage in disciplinary action against license holders, or against those who practice unlawfully, without a license.

The Board of Unlicensed Mental Health Service Providers was a departure from traditional means of professional regulation. Rather than base the board's authority on holders of certain credentials or users of particular titles, the board was charged with regulating all providers of mental health services who were not licensed by another board. While prohibited from establishing education and training standards, the board had the same powers as traditional licensing boards regarding discipline and enforcement.

The legislation provided that all unlicensed providers file with the board, and provide background information on their education and training. This information was intended to inform the state as to the types of practitioners offering mental health services and what levels of degrees were held. As with other regulatory boards, the board of unlicensed mental health service providers was intended to be fee-supported.

Due to the innovative nature of the board of unlicensed mental health providers, the enabling legislation includes a sunset provision, effective June 30, 1991. Prior to the sunset, the board was to report to the legislature on the nature and types of complaints it had received. This report was filed on July 1, 1990. The Department of Health was also required to report, making recommendations on whether or not additional licensure of mental health practitioners was warranted. This document serves as the Department's report.

On July 1, 1990, the Board of Unlicensed Mental Health Service Providers reported that a total of 561 unlicensed mental health practitioners had filed their credentials with the Board.

Of that total, approximately 75% of those filing had obtained a minimum of a bachelors degree. A breakdown of the data indicated that 12 individuals (2%) had obtained a doctorate, 188 (or approximately 34%) had obtained a master's degree, and 218 individuals (39%) held a bachelor's degree.

None of the 70 written complaints received by the Board of Unlicensed Mental Health Service Providers as of July 1, 1990, concerned professional competence. Instead, the complaints alleged transgressions of ethics in practice: inappropriate sexual contact with clients; fraud; breach of confidentiality; dual relationships; misleading advertising; and willful disregard for client safety, among others.

The Board concluded in its July 1, 1990, report that there was little, if any, relationship between the level of education and training obtained by a practitioner and the frequency or degree of seriousness of complaints made against unlicensed practitioners.

However, the Board's findings were unclear on a related issue--whether there was a need to develop some minimum standard of education and training for unlicensed mental health practitioners. The report indicated that most of those who filed credentials with the Board had "...a considerable amount of education and training in the area(s) in which they are practicing" and that most practitioners were involved in some level of additional education or training. In contrast to this conclusion, however, the Board also suggested that there might be a need for some minimum education and training standards because of the wide range of practitioner training and experience, from a seminar or two to advanced degrees.

Pursuant to Minnesota Laws 1990, Chapter 568, Article 2, Sections 93 and 94, the Task Force on Mental Health Regulation was convened in mid-1990 to examine the existing system of regulating and monitoring licensed and unlicensed practitioners who provide a range of mental health services and to make recommendations for administrative improvements in that system. The Task Force was comprised of representatives from the following state entities: the Board of Marriage and Family Therapy, the Board of Social Work, the Board of Medical Examiners, the Board of Nursing, the Board of Psychology, the Board of Unlicensed Mental Health Service Providers, the Department of Health, and the Department of Human Services. The Task Force met twice, in July and November of 1990. The Department of Health provided staff support for the efforts of the Task Force.

The Task Force report, which is enclosed, presents an in-depth analysis of information that was gathered during more than 60 interviews with individuals who were involved in the development of the legislation creating the Office of Social Work and Mental Health Boards, the start-up period and/or the current operation of the Office and the three boards contained therein (i.e. Board of Social Work, Board of Marriage and Family Therapy, and Board of Unlicensed Mental Health Service Providers); experts in the field of occupational regulation; national and local representatives of mental health professional associations; and officials in ten states which regulate various mental health occupations. A review was performed of the statutes and rules for those states.

FINDINGS AND RECOMMENDATIONS

The Task Force reached consensus on a number of findings related to the operation of the Office of Social Work and Mental Health Boards and, specifically, to the continued viability of the Board of Unlicensed Mental Health Service Providers. The Task Force found that most of the problems faced by the Office of Social Work and Mental Health Boards, the Board of Social Work, the Board of Marriage and Family Therapy, and the Board of Unlicensed Mental Health Service Providers can be traced directly to flaws in the enabling statute (Minnesota Statutes Chapter 148B). The statute contains no clear direction about administrative roles and responsibilities of the Office of Social Work and Mental Health Boards.

In addition, the statutes governing the operations of the Office of Social Work and Mental Health Boards (Minn. Stat. 148B, Minn. Stat. 214, Minn. Stat. 13 [Government Data Practices Act], and Minn. Stat. 14 [Administrative Procedures Act]) are in conflict with regard to the legal responsibilities of the Office and the three Boards contained therein. The appropriation of funds is made to the "Office" but the Boards collect fees. The Office appears to have administrative authority and is accountable for the aggregate expenditures of the three Boards but the legal authority and the ability to raise or lower fees rests with Boards.

The Department of Health agrees with the finding of the Interagency Task Force on Mental Health Regulation that the umbrella structure of the Office of Social Work and Mental Health Boards, as defined in current law, is unworkable and that the current system cannot be modified successfully to ensure smooth functioning. The Department recommends that the Office of Social Work and Mental Health Boards be eliminated and the Board of Marriage and Family Therapy and the Board of Social Work be allowed to operate independently.

With regard to the continued viability of the Board of Unlicensed Mental Health Service Providers, for a number of reasons related to the operational difficulties and funding problems faced by the Board, the Department concurs with the Task Force that investigations and disciplinary actions taken against unlicensed providers would be better administered by a state agency. The Department of Health recommends that the Board of Unlicensed Mental Health Service Providers be sunset, as scheduled, in June, 1991.

While the Board should be sunset, the Department of Health agrees with the Task Force that the consumer protection function served by having a means to discipline unlicensed mental health practitioners remains crucial. The Department of Health was the chief proponent of the concept of having unlicensed mental health practitioners file their credentials with the State when the legislation establishing the Board of Unlicensed Mental Health Service Providers was enacted in 1987. It was believed that filing would provide a valuable service by identifying the number and type of non-licensed, and perhaps nontraditional, practitioners in the State. The Department intended the collection of this data to function as a preliminary

sunrise review in determining the potential or need for regulating existing or emerging occupations. With such data, it would be possible to determine whether it would be beneficial to phase-out the unlicensed practice of psychotherapy.

Filing was also envisioned as a means of consumer protection at the front end of a new, experimental process of "regulating the unlicensed" that required no minimum education or training standards. It was believed that requiring all providers to file their credentials with the board might serve as a deterrent to some questionable providers and prevent them from engaging in questionable activities. In the event that a consumer brought a complaint against a provider for ethical violations, the Board would have some background information available on that individual to take action.

Unlicensed practitioners have shown strong resistance to filing their credentials with the Board of Unlicensed Mental Health Service Providers. They are reluctant to pay \$50 for their "acknowledgment" of filing because they believe that this process stigmatizes them. Occupational regulation is undertaken by the State to benefit the public, not professionals, and compliance is generally not in question. However, full compliance with the mandatory filing requirement has been difficult to assess.

One indication that there is not full compliance with the filing requirement is that the majority of complaints that have been brought to the Board of Unlicensed Mental Health Service Providers--**68 complaints or 74%**-- have been brought against people who have not filed with the Board but who are not licensed by other Boards. Of that total, 45 complaints have been brought against individuals who are not exempt from filing with the Board but have not done so. The remainder of complaints have been brought against individuals who are exempt from the Board's jurisdiction.

Failure to file with the Board of Unlicensed Mental Health Service Providers by individuals who are not eligible for licensure by another Board is a violation of Minn. Stat. 148B.42, punishable as a gross misdemeanor. However, enforcement of the filing requirement is not a high priority for County Attorneys, who are responsible for a wide range of criminal prosecutions, and, to date, there have been no prosecutions of unlicensed mental health practitioners for failure to file their credentials.

Another potential benefit of filing that has not been realized, due in part to data privacy concerns, is a prospective check on filing applicants with other Minnesota licensing boards to determine whether an individual has been disciplined, including license revocation, or has been the subject of a malpractice claim. The Board occasionally will check with regulatory bodies in other states for this information but only if the applicant has indicated that he or she has been licensed or certified elsewhere.

The Department of Health concurs with the Task Force that the filing requirement for unlicensed mental health practitioners should be repealed. Repeal of the filing requirement would eliminate the most controversial, and least enforceable, aspect of regulation for this

varied group of providers. To ensure consumer protection and provider accountability, however, the Department joins the Task Force in recommending that the code of conduct for all unlicensed mental health practitioners, found in Minn. Stats. 148B.44, be retained in statute, as should the language of Minn. Stats. 148B.45, describing penalties for prohibited conduct. In addition, the Department concurs with Task Force's recommendation to eliminate all current exemptions from disciplinary action under the code of conduct.

The Department recommends that all unlicensed practitioners, including those who are exempt from licensure and those who are employed by state facilities or programs, be subject to disciplinary action by a newly established "clearinghouse on mental health practice," recommended by the Task Force. Because of this Department's long-standing expertise in the area of occupational regulation, it is recommended that the clearinghouse be placed within the Department of Health.

Minn. Stats. 148B.48, Subdivision 1 directs the Commissioner of Health to make recommendations on the need for registration or licensure of unlicensed mental health service providers. The Department of Health concurs with the Task Force's finding regarding the potential for limiting or phasing out the unlicensed practice of psychotherapy. Concern about the propriety of allowing practice by potentially untrained individuals was one of the original motivations behind the creation of the Board of Unlicensed Mental Health Service Providers.

The July 1, 1990 status report of the Board of Unlicensed Mental Health Service Providers provides no clear evidence of distinguishable occupations which merit regulation at this time. In addition, despite strongly voiced concerns about the education and training of some unlicensed providers, the Task Force has concluded that there is insufficient evidence to justify limiting or phasing out the unlicensed practice of psychotherapy. This finding supports the Department of Health's original contention in 1987 that public harm and training are unrelated.

However, the Department acknowledges that there continues to be significant interest and concern about the identification and regulation of additional mental health specialties. The Human Services Occupations Advisory Council (HSOAC) completed its review of the need to regulate Chemical Dependency Counselors in June, 1990. A determination by the Commissioner of Health is expected shortly. However, because the Legislature failed to provide funding for the HSOAC Council during the 1989-1990 legislative session, the fate of future reviews to determine whether additional occupations should be regulated is uncertain at this time.

Finally, the Task Force is concerned, generally, that data privacy laws inhibit data sharing between the health related Boards. The motivation behind disciplinary action for licensed practitioners is protecting consumers from harm by incompetent or unethical practitioners and preventing practitioners from changing occupational titles in order to continue providing services which have been deemed inappropriate by a licensing board. Under the current regulatory system for mental health practitioners, there exists the possibility that an individual

who has been disciplined by one of Minnesota's existing licensing boards might continue to provide services by filing his or her credentials with the Board of Unlicensed Mental Health Service Providers. Clearly, the inability of regulatory Boards to gain access to necessary data in order to prevent such activity has the potential to put consumers at risk. The Department concurs with the Task Force's suggestion that the Legislature undertake a review of the Government Data Practices Act (Minn. Stats. Chapter 13) and the Administrative Procedures Act (Minn. Stats. Chapter 14), to ensure that Chapter 214 licensing boards and other state regulatory entities have the ability to exchange necessary data and to ensure that there is a balance between the due process rights of mental health practitioners and consumer protection concerns.

SUMMARY OF RECOMMENDATIONS

The Department of Health concurs in the following recommendations of the Interagency Task Force on Mental Health Regulation:

- 1) eliminate the Office of Social Work and Mental Health Boards.
- 2) allow the Board of Social Work and the Board of Marriage and Family Therapy to operate autonomously.
- 3) allow the Board of Unlicensed Mental Health Service Providers to sunset, as scheduled, on June 30, 1991.
- 4) eliminate the filing requirements for unlicensed mental health practitioners and repeal all current exemptions from disciplinary action under the code of conduct. Retain the language of Minnesota Statutes 148B.44, describing prohibited conduct by all unlicensed mental health service providers, and the language of Minn. Stats. 148B.45, describing penalties for prohibited conduct.
- 5) transfer the enforcement of the existing code of conduct laws for unlicensed practitioners to a state agency. These laws would allow the state to fine, censure, reprimand, or enjoin from practice any non-licensed individual who engages in harmful or fraudulent behavior.
- 6) grant the agency explicit cease and desist authority and investigative resources, similar to that provided for in Minn. Stats. 153A.15, which empowers the Commissioner of Health to investigate and take enforcement action against hearing instrument sellers for prohibited conduct.
- 7) establish a "clearinghouse" function in a state agency (referred to in the Task Force report as the "Office of Mental Health Practice") to: perform intake of complaints against unlicensed mental health practitioners and referral of complaints against licensed practitioners to the appropriate

licensing board; administer disciplinary action against unlicensed providers of mental health services (using the definition of "psychotherapist" and "psychotherapy" found in Minn. Stats. 148A.01, Subdivision 5 and 6, regarding criminal violations for sexual contact between psychotherapists and clients); and provide information and public education on mental health practices and practitioners.

- 8) fund the consumer protection function of the "clearinghouse" through the surplus in the Special Revenue Fund. If a surplus does not exist, the cost of the function should be charged as agency indirect cost to all health-related licensing boards. In addition, some baseline percentage of funding for the clearinghouse should be provided via general appropriations to ensure the operation of the public education activities to be undertaken by the "clearinghouse."
- 9) enact legislation to grant cease and desist authority to health professional licensing boards governed by Minn. Stats. 214.
- 10) if any licensing boards are established in the future, ensure that provisions are made in the enabling legislation for "start-up" activities.

APPENDIX D

Interagency Task Force on Mental Health Regulation
Recommendations for Changes in Minnesota's
Mental Health Regulatory System

Report to the Commissioner of Health
and to the Minnesota Legislature

Authority: Laws of Minnesota, 1990
Chapter 568, Article 2, Sections 93 and 94

Minnesota Department of Health
Health Systems Development Division

March, 1991

INTRODUCTION

The 1990 Minnesota Legislature directed the Commissioner of Health to convene an interagency task force to study the existing system of regulating and monitoring licensed and unlicensed individuals who provide a range of mental health services and to make recommendations for administrative improvements in that system. (1990 Minnesota Laws, Chapter 568, Article 2, Sections 93 and 94.)

The Task Force was directed to consider:

- 1) methods of coordinating and improving the monitoring or regulation of unlicensed mental health practitioners and the most efficient venue for administering this function (e.g. autonomous board, state agency, etc.);
- 2) funding sources for the monitoring or regulation of unlicensed mental health practitioners; and
- 3) methods of coordinating complaints and disciplinary actions regarding licensed and unlicensed mental health providers.

The Task Force, which met in July and November of 1990, is comprised of representatives from the following state entities: the Board of Marriage and Family Therapy; the Board of Social Work; the Board of Medical Examiners; the Board of Nursing; the Board of Psychology; the Board of Unlicensed Mental Health Service Providers; the Department of Health; and the Department of Human Services. Staff support for this effort was provided by the Department of Health.

This report provides background on developments in the area of mental health professional regulation since 1987 and reports on the findings and recommendations of the Interagency Task Force on Mental Health Regulation on a number of issues related to the current regulation of mental health practitioners in the State of Minnesota.

EXECUTIVE SUMMARY

Staff conducted more than 60 interviews with individuals who were involved in the development of the legislation creating the Office of Social Work and Mental Health Boards, the start-up period and/or the current operation of the Office and the three boards contained therein (i.e. Board of Social Work, Board of Marriage and Family Therapy, and Board of Unlicensed Mental Health Service Providers); experts in the field of occupational regulation; national and local representatives of several mental health professional associations; and officials in ten states which regulate various mental health occupations. Staff performed a review of the regulatory statutes and rules for those states, as well as the California statute.

In addition, Task Force members reviewed and analyzed eight different cost/benefit policy options which were prepared by staff, ranging from the status quo to the establishment of an omnibus health professionals regulatory agency. These policy options are presented as Appendix B of this report.

The interview process has yielded consensus on a number of issues related to the operation of the Office and, specifically, to the continued viability of the Board of Unlicensed Mental Health Service Providers:

- Minnesota Statutes Chapter 148B, establishing the Office of Social Work and Mental Health Boards, the Board of Social Work, the Board of Marriage and Family Therapy, and the Board of Unlicensed Mental Health Service Providers, contained no clear direction about administrative roles and responsibilities of the Office of Social Work and Mental Health Boards.
- a drafting flaw in the statute provided no clear direction regarding assistance to the "Office" and the three new regulatory boards during their start up phase. The task fell, unfunded, to the Department of Health, which was unable to provide much guidance. This lack of guidance was perceived by the three Boards established in 1987 as a lack of support for occupational regulation on the part of the Department.
- the umbrella structure of the Office of Social Work and Mental Health, as defined in current law, is unworkable. There is little hope that the composite structure can be modified to make it work.
- the statutes governing the operations of the Office of Social Work and Mental Health Boards (Minn. Stats. 148B, Minn. Stats. 214, Minn. Stats. 13 (Government Data Practices Act), and Minn. Stats. 14 (Administrative Procedures Act) are in conflict with regard to the legal responsibilities of the Office and the Boards. The appropriation of funds is made to the "Office" but the Boards collect fees. The Office appears to have

administrative authority and is accountable for the aggregate expenditures of the three Boards but the legal authority and the ability to raise or lower fees rests with Boards.

- there is the potential for conflict with regard to data sharing between Boards. The data sharing problem has particular implications for applicants for dual licensure and for investigations performed by the Attorney General's Office of complaints against individuals who are dual-licensed.
- there is consensus among Task Force members that the consumer protection function served by having a means to discipline unlicensed mental health practitioners remains important. However, the Task Force believes that requiring unlicensed practitioners to file their credentials with the Board of Unlicensed Mental Health Service Providers has not served to identify the "universe" of unlicensed mental health providers, is extremely difficult to enforce, and should be repealed.
- there is consensus on the Task Force that investigations and disciplinary actions taken against unlicensed practitioners would be better administered by a state agency, rather than an autonomous Board. Thus, the Task Force recommends that the Board of Unlicensed Mental Health Service Providers be sunset, as scheduled, in 1991.

In addition, a number of related themes have arisen in the Task Force's examination of the State's mental health professional regulation system. These include: 1) a desire for a consistent, single "point of entry" for information to consumers on the provision of mental health services as well as complaints made against all licensed and unlicensed mental health professionals; 2) concern about conflicts between the implementation of Chapter 148B, the Government Data Practices Act and the Administrative Procedures Act which have implications for the smooth operations of all health professional regulatory Boards; 3) concern that health regulatory boards lack cease and desist authority; 4) concern about issues related to staff and complaints that are in process during the transition period following the sunset of the Board of Unlicensed Mental Health Service Providers; 5) universal concern among health professional regulatory boards about insufficient resources allocated to the Attorney General's Office, which lengthens the time required to adjudicate consumer complaints; and 6) the need for a system to assist in the "birth" of any new licensing boards in the future.

RECOMMENDATIONS

The Interagency Task Force on Mental Health Regulation makes the following recommendations:

- 1) eliminate the Office of Social Work and Mental Health Boards.
- 2) allow the Board of Social Work and the Board of Marriage and Family Therapy to operate independently.
- 3) allow the Board of Unlicensed Mental Health Service Providers to sunset, as scheduled, in June, 1991.
- 4) eliminate the filing requirements for unlicensed mental health practitioners and repeal all current exemptions from disciplinary action under the code of conduct. Retain the language of Minnesota Statutes 148B.44, describing prohibited conduct by all unlicensed mental health service providers, and the language of Minn. Stats. 148B.45, describing penalties for prohibited conduct.
- 5) transfer the enforcement of the existing code of conduct laws for unlicensed practitioners to a state agency. These laws would allow the state to fine, censure, reprimand, or enjoin from practice any non-licensed individual who engages in harmful or fraudulent behavior.
- 6) grant the agency explicit cease and desist authority and investigative resources, similar to that provided for in Minn. Stats. 153A.15, which empowers the Commissioner of Health to investigate and take enforcement action against hearing instrument sellers for prohibited conduct.
- 7) establish a "clearinghouse" function in a state agency (referred to in this report as the "Office of Mental Health Practice") to: perform intake of complaints against unlicensed mental health practitioners and referral of complaints against licensed practitioners to the appropriate licensing board; administer disciplinary action against unlicensed providers of mental health services (using the definition of "psychotherapist" and "psychotherapy" found in Minn. Stats. 148A.01, Subdivision 5 and 6, regarding criminal violations for sexual contact between psychotherapists and clients); and provide information and public education on mental health practices and practitioners.
- 8) fund the consumer protection function of the "clearinghouse" through the surplus in the Special Revenue Fund. If a surplus does not exist, the cost of the function should be charged as agency indirect cost to all health professional licensing boards. In addition, some baseline percentage of funding for the clearinghouse should be provided via general appropriations to ensure the operation of the public education activities to be undertaken by the "clearinghouse."
- 9) enact legislation to grant cease and desist authority to health professional licensing boards governed by Minn. Stats. 214.
- 10) if any licensing boards are established in the future, ensure that provisions are made in the enabling legislation for "start-up" activities.

These recommendations were accepted unanimously by the Task Force.

BACKGROUND INFORMATION

The ultimate goal of occupational regulation, whether through legislative or administrative action, is to protect public safety and well-being. Traditionally, this goal has been designed as a two-part process. Applicants for licensure or registration (as title protection is known in Minnesota) must meet certain entry level criteria, usually based on education and supervised training, and pass an examination. Second, practitioners are held accountable for their actions by a state entity, often a Board, which governs each licensed profession. The Board considers consumer complaints against a practitioner and takes investigatory or disciplinary action, when appropriate.

Under Minnesota Statutes 214.001, Subdivision 2, there are four criteria which are used to evaluate the degree to which the public will benefit from regulation of a human service occupation:

- whether the unregulated practice of an occupation may harm or endanger the health, safety and welfare of citizens of the state and whether the potential for harm is recognizable and not remote.
- whether the practice of an occupation requires specialized skill or training and whether the public needs and will benefit by assurances of initial and continuing occupational ability.
- whether the citizens of this state are or may be effectively protected by other means.
- whether the overall cost effectiveness and economic impact would be positive for the citizens of the state.

The Commissioner of Health has primary responsibility for determining the need for occupational regulation. Under Minn. Stat. 214.13, the Commissioner coordinates the Human Services Occupations Advisory Council (HSOAC), an advisory panel of health and human service professionals who conduct a rigorous "sunrise" review of different occupations to determine whether regulation, or additional regulation, is appropriate. The Council may recommend no additional regulation; registration (title protection), which the Commissioner is empowered to administer by administrative rule; or licensure, which requires the enactment of legislation.¹

¹The HSOAC program is not funded currently but it remains authorized, should the Legislature provide funding in the future.

The State of Minnesota currently licenses practitioners from the five federally-recognized mental health disciplines: psychiatry; psychology; social work, marriage and family therapy; and psychiatric nursing.²

The legislature enacted licensure laws for the occupations of social work and marriage and family therapy in 1987. That same year, the legislature also enacted innovative legislation aimed at regulating unlicensed providers of mental health services. A self-supporting, autonomous Board of Unlicensed Mental Health Service Providers was established to identify providers who were not licensed under existing law and to provide jurisdiction for consumer complaints against unlicensed providers.

These actions arose out of a legislative compromise among the recommendations of three different entities: the Human Services Occupations Advisory Council, the Advisory Task Force on the Regulation of Psychotherapists (a panel appointed by the Commissioner of Health to examine generic regulation of psychotherapists), and the Department of Health. Under this compromise, all three of the Boards created in 1987 were to operate as part of a newly established composite structure, the Office of Social Work and Boards (Minn. Stats. 148B), hereafter referred to as the Office.

METHODOLOGY

In the preparation of this report, staff conducted more than 60 interviews with individuals who were involved in the development of the legislation creating the Office of Social Work and Mental Health Boards, the start-up period and/or the current operation of the Office and the three boards contained therein (i.e. Board of Social Work, Board of Marriage and Family Therapy, and Board of Unlicensed Mental Health Service Providers); experts in the field of occupational regulation; national and local representatives of several mental health professional associations; and officials in ten states which regulate various mental health occupations.³ Staff performed a review of the regulatory statutes and rules for those states, as well as the California statute.

In addition, Task Force members reviewed and analyzed eight different cost/benefit policy options which were prepared by staff, ranging from the status quo to the establishment of an omnibus health professionals regulatory agency. These policy options are presented as Appendix B of this report.

²Public Health Service Act, 42 USC 242a, Section 303.

³Colorado; Florida; Georgia; Massachusetts; Nebraska; Texas; Virginia; Washington; Wisconsin; and Wyoming.

FINDINGS

The interview process has yielded consensus on a number of issues related to the operation of the Office of Social Work and Mental Health Boards and, specifically, to the continued viability of the Board of Unlicensed Mental Health Service Providers:

- Minn. Stats. 148B, establishing the Office of Social Work and Mental Health Boards, the Board of Social Work, the Board of Marriage and Family Therapy, and the Board of Unlicensed Mental Health Service providers, contained no clear direction about administrative roles and responsibilities of the Office of Social Work and Mental Health Boards.

- the statutes governing the operations of the Office of Social Work and Mental Health Boards (Chapter 148B, Chapter 214, Chapter 13 (Government Data Practices Act), and Chapter 14 (Administrative Procedures Act) are in conflict with regard to the legal responsibilities of the Office vs. the Boards. The appropriation of funds is made to the "Office" but the Boards collect fees. The Office appears to have administrative authority and is accountable for the aggregate expenditures of the three Boards but the legal authority and the ability to raise or lower fees rests with boards.

- there is the potential for conflict in the statutes with regard to data sharing between Boards. Chapter 214.10, Subdivision 8(d) requires the exchange of information between boards, agencies or departments within the state. However, under Minn. Stats. 13.41, Subdivision 2, data collected, created or maintained by any licensing agency are classified as private, except for the names and addresses submitted by applicants for licensure. The data sharing problem has particular implications for investigations of complaints against individuals who are dual-licensed, which are performed by the Attorney General's Office, and for applicants for dual-licensure.

- a drafting flaw in the statute provided no clear direction regarding assistance to the "Office" and the three new regulatory boards during their start up phase. The task fell, unfunded, to the Department of Health, which was unable to provide much guidance. This lack of guidance was perceived by the three Boards established in 1987 as a lack of support for occupational regulation on the part of the Department.

- the umbrella structure of the Office of Social Work and Mental Health Boards, as defined in current law, is unworkable. There is little hope that the composite structure can be modified to make it work.

- there is consensus among Task Force members that the consumer protection function served by having a means by which to discipline unlicensed mental health practitioners remains important. However, for a number of reasons that will be discussed later in this report, the Task Force believes that requiring unlicensed practitioners to file their credentials with the Board of Unlicensed Mental Health Service Providers has not served to identify the "universe" of unlicensed mental health providers, is extremely difficult to enforce, and should be repealed.

■ there is also consensus among Task Force members that investigations and disciplinary actions taken against unlicensed providers would be better administered by a state agency, rather than an autonomous Board." Thus the Task Force recommends that the Board of Unlicensed Mental Health Service Providers be sunset, as scheduled, in June, 1991.

EXPLANATION OF FINDINGS

The compromise which created the Office of Social Work and Mental Health Boards and the three new regulatory boards was crafted in the closing days of the 1987 legislative session. Because of time constraints, little attention was given to incorporating an implementation plan into the statute. The creation of the Office itself was clearly intended to increase administrative efficiency by capitalizing on economies of scale (i.e. shared computer systems, shared staff, etc.) The parties involved agreed to this imperfect compromise, fully acknowledging that it had major problems but indicating that they were committed to its implementation. Unfortunately, the operation of these four entities has developed into an administrative quagmire.

The Task Force finds that many or most of the management and policy issues that have arisen in this debate are directly related to the statute which created the "Office" and the three boards. The statute is silent on which entity (the Office vs. the individual Boards) is responsible for which tasks. This lack of statutory direction became apparent immediately upon the start up of these four new entities. In addition, the undefined structure of the "Office" -- not part of a state agency but not a Chapter 214 self-supporting regulatory board -- has made the implementation of the legislation and the smooth operation of the three boards it contains very difficult.

The transition period to full operation of the Office and the three Boards was further complicated by a number of factors: 1) four separate and distinct entities were being started concurrently; 2) little direction was provided to the Office and the Boards due to the absence of funding and structure for start-up; 3) there were complex legal issues to address in the development of rules for each Board; 4) four groups of citizens, most unfamiliar with the legislative process, administrative rulemaking, or state government were immersed immediately in technical and legal matters, a situation which was aggravated by a vague statute; 5) there is no precedent in Minnesota law for structures similar to either the Office of Social Work and Mental Health Boards or the Board of Unlicensed Mental Health Service Providers; and 6) there was no statutory delineation of administrative and legal functions and responsibilities of the Office vs. those of the boards.

It is reasonable to expect a certain amount of confusion in the development of a new regulatory entity. There are complex rulemaking obligations which must be completed under time constraints. Essentially volunteer board members who may or may not be familiar with the political development and the legislative intent of the statute with which they are now charged

with regulating must be trained. Some Board members must also learn to place their obligations to the Board to which they are appointed above the special interests of the regulated profession to which they belong.

Office of Social Work and Mental Health Boards

The creation of a composite Office of Social Work and Mental Health Boards to perform administrative functions for three regulatory Boards with similar interests is understandable. The Legislature's goal in promoting this structure was to discourage the proliferation of licensing boards, to encourage administrative efficiency among similar boards, and for the Office to serve as a single, easily identifiable point of contact for consumers seeking to bring complaints against practitioners.

However, the lack of direction in the statute about the responsibilities of the Office and its Executive Secretary has resulted in major administrative problems for the Office and the three Boards that continue to this day. These problems have reached a critical stage, the consequence being that the Board of Marriage and Family Therapy has moved its operation away from the Office to a different space. Both the Board of Social Work and the Board of Unlicensed Mental Health Service Providers have also considered taking the same action at various times.

The statute established four equal senior staff positions -- an Executive Secretary for the Office and one for each of the Boards -- but it was silent on several crucial administrative issues. Each Board was given the authority to hire only an Executive Secretary. There was no provision for hiring the head of the Office nor was there any indication of who would supervise that individual. By default, an Executive Committee, consisting of the Chairs and Vice-Chairs of each of the Boards was formed to supervise the Executive Secretary of the Office and to make administrative decisions about the operation of the Office. The Chair of the six-member Executive Committee rotates between the three Boards.

This arrangement has resulted in a significant problem. Because the Chair loses the power to vote on issues before the Executive Committee, each of the Boards perceives a negative shift in the balance of power during its tenure as Chair. This imbalance has further exacerbated the confusion already experienced by members of each of the Boards. In addition, the Office staff perceive that their interests are not well represented on the Executive Committee.

Further, while the statute does not delineate a reporting relationship for the head of the Office, Section 148B.02, Subdivision 1 does give that individual sole authority to hire all administrative staff. Staff perform administrative duties for all of the Boards but they serve at the direction of the Executive Secretary of the Office. The Executive Secretary is also responsible for compiling an annual report on the operations of the Office and the three Boards which is submitted to the Legislature.

The administrative arrangements that have been developed in an attempt to address the deficiencies in the statute have been a constant source of concern and irritation to the volunteers

who serve on each of the three Boards and have forced the Boards to focus primarily on administrative matters rather than policy concerns. This administrative focus has competed for time and resources during the crucial start up and rulemaking phases of each of the Boards. The contingency nature of these arrangements has also had an extremely negative impact on the staff employed by the Office of Social Work and Mental Health.

The majority of those interviewed for this report believe that the deficiencies in the statute have contributed to a high level of turnover since 1987 in Executive Secretaries for the Office of Social Work and Mental Health Boards, the Board of Social Work, and the Board of Marriage and Family Therapy (the Office has had three; Social Work has had three; and Marriage and Family Therapy has had two). The working environment has been described by some as chaotic and lacking direction. There are indications of persistent confusion about reporting lines as well as a lack of communication between Office clerical staff, the Executive Directors of the Boards, and members of the Boards.

The existence of the Office also appears to have contributed to the financial problems of each of the three Boards, as each must pay for a percentage of the staff, equipment, and other expenses of the Office. The bitter disputes over equitable allocation of Office resources and staff which occurred almost immediately upon the creation of these four entities are ongoing and continue to be a source of serious concern for all involved. Members of each of the three Boards (Social Work, Marriage and Family Therapy, and Unlicensed Mental Health Providers) see the Office as competitive with their operations and as a financial drain on Board revenues.

A number of states have composite board structures comprised of several licensed or certified mental health occupations. As in Minnesota, most have been developed as part of a political compromise. There are critical differences in the experience in Minnesota and other states, however.

The majority of the composite structures in each of the states reviewed for this report are housed within an agency of state government, e.g. the Office of the Secretary of State (Georgia); the Department of Professional Regulation (Florida); a department of health (Texas and Washington) or a department of commerce (Wyoming and California).

In many states, there is a single Regulatory Board, composed of representatives from several licensed or certified professions. Minimum standards of practice for each of the regulated mental health professions are determined by standards committees for each regulated profession. Checks and balances are built into these structures to ensure equitable allocation of staff and resources between the various regulated professions. Big and small boards do not compete for staff and other resources; each receives services that are appropriate to its needs.

Colorado's regulatory system is slightly different from other states. There are separate licensing boards for psychology, marriage and family therapy, social work and professional counseling under the Mental Health Division of the Department of Regulatory Agencies' Division of Registrations. Licensure is voluntary. However, a composite structure -- the Colorado State

Grievance Board -- is charged with investigating complaints and taking disciplinary action against all persons, licensed and unlicensed, who provide mental health services.

The Grievance Board does not generate revenues. A surcharge is levied on the renewal fees of all licensed mental health professionals for the operation of the Board; unlicensed providers do not file their credentials with the state. The only remedy currently available to the Board for disciplining unlicensed providers is injunctive relief through the courts.

The Colorado State Grievance Board is scheduled to sunset on July 1, 1992, unless continued by the General Assembly. The Colorado Department of Regulatory Agencies is currently conducting a sunset review of the Board. Issues to be raised as part of the review process include additional funding mechanisms, the duty of licensed mental health professionals to report ethical and other violations made by other mental health professionals, the definition of adequate supervision, and the implications of restricting the practice of unlicensed psychotherapy.

Board of Unlicensed Mental Health Service Providers

Every state in the nation currently allows the practice of psychotherapy by individuals who have no formal education or training in a recognized mental health discipline.⁴ In the vast majority of states -- Minnesota, Colorado and Washington being exceptions -- there is little or no protection or formal redress for consumers who have been harmed by unregulated providers.

In 1987, the Minnesota Legislature established the Board of Unlicensed Mental Health Service Providers to serve as a regulatory body for mental health practitioners who were not eligible for licensure by one of the existing regulatory boards. This effort was aimed largely at identifying otherwise unregulated providers. As is the case for all health professional regulatory boards governed by Minn. Stats. Chapter 214, the Board of Unlicensed Mental Health Service Providers was intended to be self-supporting.

There are no minimum education or training standards required for practice. For a \$50 fee, "filers" receive a document, similar to a business permit, which allows them to practice and places them under the jurisdiction of the Board for disciplinary actions. However, this "permit" implies neither State recognition nor an endorsement of the individual's credentials or competence to provide services. Individuals are prohibited from displaying the permit.

There has been concern among individuals who are required to file with the Board that "they don't get anything" for filing and that the fees are too high, relative to what filers receive (i.e.

⁴This is scheduled to change in 1995, when the State of Florida will prohibit the provision of mental health services without a license in one of the mental health occupations that is regulated by the State. Officials in Nebraska and Colorado are also considering restricting the practice of psychotherapy to licensed or certified individuals.

nothing, in their view). However, as noted previously, occupational regulation is undertaken by the State to benefit the public, not professionals.

The Board's primary activity since its establishment has been rulemaking. The Board was prohibited in statute (Minn. Stats. 148B.41, Subdivision 1) from adopting rules that "restrict or prohibit persons from providing mental health services on the basis of education, training, experience, or supervision, or that restrict the use of any title." The Board's role was to identify unregulated providers of mental health services, not to screen their credentials, and to discipline providers who breached ethical and generally accepted professional standards of practice.

As a result, the rules were drawn very broadly to capture a great many aspects of practice and the broadest possible array of professions. This may be a result of the difficulty in defining psychotherapy. However, it also speaks directly to the issue of whether the Legislature intended to "close the loop" on practice, in other words, whether minimum standards should be required for the provision of mental health services.

During the rulemaking process, the Minnesota Legislature exempted chemical dependency counselors and public employees from the Board's jurisdiction. This action severely reduced the expected number of filers. During its deliberations, the Task Force considered whether to recommend regulation for chemical dependency counselors and professional counselors as part of this project. However, a majority of the members of the Task Force agreed that regulation for either group should be decided on its own merits, independent of the work of the Task Force.⁵

The wording of Minn. Stats. Chapters 148B.44 and 148B.45 clearly speaks to the investigation, adjudication, and enforcement of complaints against unlicensed providers. The Board of Unlicensed Mental Health Service Providers has been more active in addressing complaints than in gathering data about the nature and breadth of unlicensed practice in the state. To date, the Board has engaged in little or no public education efforts to advise practitioners who might fall under the Board's jurisdiction of the necessity of filing their credentials.

A total of 100 complaints have been filed with the Board of Unlicensed Mental Health Service Providers since its establishment in 1987. Of that total, 30 cases have been dismissed and 21 have been referred to another Board for action. Twenty-one cases are under formal investigation and 25 others are pending action. (Of the original 35 complaints that were transferred to the Board from other established licensing boards, approximately 20 concerned one facility and two providers. Those cases are still under investigation by the Attorney General's Office.)

⁵The Minnesota Department of Health is nearing the completion of its Chapter 214 review of the regulation of Chemical Dependency Counselors and a final recommendation from the Commissioner of Health is pending. The Department is not currently funded to undertake a new Chapter 214 sunrise review of professional counselors or other occupations.

The Attorney General's Office has categorized 46 of the complaints (46%) as A-1 (Serious) and 20 (20%) as A-2 (Moderately Serious). A partial listing of complaints includes sexual contact with clients (criminal penalties for which are found under Minn. Stats. 148A.01-.06); fraud; breach of confidentiality; misleading advertising; willful disregard of client safety; and prohibited dual relationships. Sexual impropriety is alleged in nearly half of all complaints.

Twelve percent of complaints have been brought against individuals who have actually filed their credentials with the Board. However, the majority of complaints -- **68 complaints or 74%** -- have been brought against people who have not filed with the Board but who are not licensed by other Boards. Of that total, 45 complaints have been brought against individuals who are not exempt from filing with the Board but have not done so and 23 complaints have been brought against individuals who are exempt from filing. Failure to file with the Board of Unlicensed Mental Health Service Providers by individuals who are not eligible for licensure by another Board is a violation of Minn. Stat. 148B.42, punishable as a gross misdemeanor. To date, however, there have been no prosecutions for failure to file.

Some of those interviewed for this report have expressed concern about the sunset date that has been imposed upon the Board. It has been suggested that, because of the difficult transition period to full operation, the Board of Unlicensed Mental Health has not had sufficient time or funding to "work out the bugs" in its operations.

There is some validity to this assertion. An entity to "regulate the unlicensed" was unprecedented and the Board received little guidance during the start up phase in its operations. In addition, like the Board of Social Work and the Board of Marriage and Family Therapy, the Board of Unlicensed Mental Health Service Providers experienced a number of administrative problems in gaining final approval for its rules, a situation which caused a delay in the recovery of Board fees.

Nevertheless, concerns about the continued viability of the Board of Unlicensed Mental Health Service Providers are justified. While Minn. Stats. Chapter 214 requires that regulatory boards be self-supporting, the unlicensed Board has not collected enough in receipts to offset its expenditures or appropriation. In the Fiscal Year 1990-1991 biennium, the Board received a specific exemption from the language requiring them to be self-supporting. (Laws of Minnesota, 1989, Chapter 282, Article 1, Section 10, Subdivision 13)

The Board of Unlicensed Mental Health Service Providers collected \$33,900 in fees in Fiscal Year 1990 with expenditures of \$159,400. The Board requested a \$150,000 general fund appropriation from the Legislature but received a \$75,000 appropriation. Even with this supplement to its FY 1990 receipts, the Board ran a shortfall of \$50,500. This appropriation was granted in anticipation that adequate fees, in addition to the appropriation, would be collected by the end of the FY 1990-91 biennium to offset the Board's operating expenses. However, the Board's expenditures for the current fiscal year (FY 1991) are estimated at \$169,600, and the Board of Unlicensed Mental Health Service Providers estimates fee receipts of only \$40,000, leaving an FY 1991 shortfall of \$129,900.

The total number of "filers" has generally remained steady at just under 600, although this number has fluctuated temporarily to as many as 650. As of late 1990, the Board of Unlicensed Mental Health Service Providers was receiving about 20 to 30 new filing applications each month. Concurrently, some number of "filers" are granted licensure by other boards, leave "the field" or, for other reasons, may not renew with the Board of Unlicensed Providers.

The Board would face strong opposition to an increase in the \$50 fee which many filers now believe is a financial burden, relative to the perceived benefit conferred (i.e. none.) In addition, the Board will not have the opportunity to undertake a fee increase, should it choose to take such action, because of the impending sunset date. Thus, a substantial increase in fee-generated revenues, and a subsequent reconciliation of the two-year deficit, will not occur prior to June, 1991. Clearly, without a substantial yearly general appropriation, the Board of Unlicensed Mental Health Service Providers has not been and cannot be self-supporting.

One additional note of concern related to the Office of Social Work and Mental Health Boards becomes apparent in an examination of the finances of the Board of Unlicensed Mental Health Service Providers. Although the Board collected only \$33,900 in fees in FY 1990, its prorated assessment for the administrative operations of the Office of Social Work and Mental Health Boards was \$45,600, a difference of \$11,700. As discussed previously, the Board has been granted an exemption in the current biennium but the possibility exists that it would be unable to meet its financial obligation to the Office in the future if the sunset date is extended, thereby increasing the financial obligations for the Office from the Board of Social Work and the Board of Marriage and Family Therapy. This is a further indication of the inefficiency and inequity of the current administrative structure.

Others who have been interviewed for this report are concerned about the sunset date because they do not believe that the Board has yet completed its original mission. They assert that the original intent of the Legislature in establishing the Board of Unlicensed Mental Health Service Providers was the collection of information on the practice of psychotherapy, with the ultimate goal of limiting the practice of psychotherapy.

The annual report of the Board of Unlicensed Mental Health Service Providers, which was submitted to the Commissioner of Health on July 1, 1990, expresses the view of the Board that supervisory requirements, which are customary in the helping professions, strongly encourage providers to incorporate ethical boundaries into their practice of psychotherapy. The Board concludes that, "this type of training may not be available to persons with lessor [sic] training. The data on complaints that we have reviewed so far, however, does not justify this conclusion one way or another." However, the report also asserts that "the data collected to date by the Board, both in terms of registrations and complaints, shows no pattern that providers without degrees generate anymore [sic] or any less complaints than do those with a degree. In fact the

data suggest there may be little, if any, relationship between the amount of training, frequency and/or seriousness of complaints."⁶

The Board of Unlicensed Mental Health Service Providers has suggested to the Task Force that the solution to its funding and operations problems is not a sunset of the Board's activities. Instead, they propose that the Board be expanded into a free-standing, composite "superboard," similar to the two-tiered universal registration system implemented by the State of Washington.⁷ This autonomous "oversight" system would operate in addition to the existing licensing boards for psychology, social work, and marriage and family therapy (and any additional mental health-related licensing boards which might be established in the future) and would handle complaints against unlicensed providers.

The State of Washington requires that all persons providing mental health services register initially with the state Department of Health as generic "counselors." (Psychiatrists and psychologists are licensed and are thus exempt from the counselor law.) Once identified by the State, registrants may practice but are prohibited from using a number of protected titles (certified marriage and family therapist or licensed psychologist, for example). All registrants must complete a four hour course in AIDS education, supply personal information and pay a filing fee.⁸

In order to obtain certification, the second tier of regulation, a practitioner must hold a minimum of a master's degree and must have two years of supervised, postgraduate experience, as well as a passing score on a national exam appropriate to one of the three certified occupations (e.g. marriage and family therapy, social work, or mental health counseling). Certification is voluntary and provides title protection only. Investigations and disciplinary actions against all licensed, certified or registered mental health professionals are governed by the Washington Department of Health.

The most significant difference in the Minnesota and Washington regulatory systems concerns funding. In Washington, a fee is required of all persons who "register" their credentials with the Department of Health as well as those who choose to become certified. However, administrative,

⁶Board of Unlicensed Mental [Health] Service Providers, "Report to the Minnesota Commissioner of Health and the Legislature," July 1, 1990.

⁷A similar proposal for a universal generic psychotherapist licensure system was made in 1986 by the Minnesota Advisory Task Force on the Regulation of Psychotherapists. It was one of several proposals which was incorporated into the legislative compromise which resulted in the creation of the Board of Unlicensed Mental Health Service Providers.

⁸In late 1988, the Minnesota Commissioner of Health recommended that all health professional licensing boards in the state incorporate similar training on HIV infection into continuing education requirements for licensed, registered or otherwise regulated professionals. To date, there has been no action on the Commissioner's recommendation.

personnel, and other costs are met by the Washington Department of Health. In Minnesota, all free-standing regulatory boards must be self-supporting under Minn. Stats. Chapter 214. All administrative, personnel, and other costs must be covered by fees. It has been suggested that this composite oversight board be funded out of general revenues.

The Task Force does not support a statutory change that would expand the current Board of Unlicensed Mental Health Service Providers into a free-standing, composite "superboard." This proposal does not have a clear source of funding and would appear to perpetuate the serious funding and administrative problems now facing the Board of Unlicensed Mental Health Service Providers and the Office of Social Work and Mental Health Boards.

It would also appear to be duplicative of the efforts currently undertaken by existing mental health licensing boards. The members of the Task Force do not believe that there is a need to create an entity which would change the manner in which currently licensed professions are governed. Each of the licensed professions has developed entry-level standards of practice and strict ethical guidelines that allow for appropriate self-governance and client protection.

There is strong agreement on the Task Force that the long term goals in the creation of the Board of Unlicensed Mental Health Service Providers -- provider accountability and protection of the public from incompetent, unethical or unqualified practitioners of psychotherapy -- remain valid. Accountability for providers in independent practice -- those who have no supervision nor peer consultation -- is of particular concern. This is not to imply that unprofessional practice or conduct does not occur in public settings or in private practice where supervision is available. Rather, it is believed that mechanisms for accountability exist in those venues, for instance, facility licensure and inspection or direct supervision of practice by other qualified mental health professionals in that setting.

However, it is difficult to state with any certainty whether the Board of Unlicensed Mental Health Service Providers has been successful in achieving the goal of public protection from unscrupulous, exploitative or unqualified providers. The filing and enforcement functions carried out by the Board of Unlicensed Mental Health Service Providers currently are linked in an effort to provide a comprehensive "safety net" for consumers who risk harm from unlicensed practitioners.

Despite the significant operational and funding problems which the Board has experienced, consumers apparently perceive that the Board has authority to take disciplinary action against providers. However, the Task Force believes that the filing process, while well intentioned, has not served to identify the "universe" of unlicensed mental health providers, is extremely difficult to enforce, and should be repealed.

With the repeal of the filing function, the Task Force also recommends that all current exemptions from the code of conduct governed by the Board of Unlicensed Mental Health Service Providers be repealed. It is the clear intention of the Task Force that all unlicensed mental health practitioners be subject to disciplinary action under the existing code of conduct.

There is consensus among those on the Task Force that the State has a primary role in ensuring, to the maximum extent possible, the competent and ethical practice of psychotherapy. Toward that goal, the Task Force recommends that the Board of Unlicensed Mental Health Service Providers be allowed to sunset as scheduled in June, 1991, and that the disciplinary activities currently conducted by the Board be transferred to an existing state agency.

Establishment of "Clearinghouse" on Mental Health Practice

The Task Force further recommends the establishment of a "clearinghouse" on mental health practice (referred to for the remainder of this report as the Office on Mental Health Practice) in an existing state agency, to perform the disciplinary functions now performed by the Board of Unlicensed Mental Health Service Providers. In addition to its disciplinary mission, the Task Force recommends that the Office perform public education and information dissemination activities. It is recommended that this new office have an advisory committee comprised of consumers.

There is a general lack of public understanding about the skills of various mental health professionals and about the services they provide. Consumers often are not familiar with differences in degrees or training between various licensed and/or unlicensed professions. Although each mental health professional regulatory board, including the Board of Unlicensed Mental Health Service Providers, is required by statute to provide public education about the services provided by individuals regulated by that Board, more often than not, greater emphasis is placed on regulatory and disciplinary actions than on the public education function.

The creation of an Office of Mental Health Practice would benefit consumers in a number of ways:

- it would clearly identify the State as the public's source of information regarding mental health practitioners and practices.
- it would assist the consumer by providing "one stop shopping" for information and complaints on the provision of mental health services. Complaints against unlicensed practitioners would be addressed directly by the Office, in consultation with the Attorney General's Office. Complaints against licensed practitioners would be referred to the appropriate Board for further action.
- it would provide public education and disseminate information on the services provided by mental health practitioners. A single phone number could be publicized as part of ongoing public education efforts to raise public awareness of appropriate vs. inappropriate mental health services, thus providing an aspect of public protection. Protection is also offered by ensuring that all unlicensed providers who practice outside of generally-accepted ethical or professional norms of practice can be disciplined.

The Task Force recommends the development of a central data base in the Office, in conjunction with the mental health licensing boards, which would identify the licensees of each of the mental health boards and would note dual-licensure. Because of potential conflicts with the Data Practices Act, data would be limited to the practitioner's name, business address and licensure status.⁹

Another potential advantage of a single intake phone number is consistent access to and from the newly established National Practitioner Data Bank. Through contact with this new federal entity, which began operation in 1990, state regulatory boards and agencies will have access to information regarding malpractice insurance awards, license revocation and other disciplinary actions taken by regulatory entities in other states against specified health professionals. Established under Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1985, the Data Bank currently requires state regulatory authorities to report disciplinary actions taken against physicians and dentists. States may voluntarily report actions against other regulated health personnel to the Bank but such action is not mandatory at this time.

However, in the future, states will be required to report disciplinary actions against additional licensed or otherwise regulated health and mental health professionals, under an amendment to the program found in Section 5 of Public Law 100-93, the Medicare and Medicaid Patient and Program Protection Act of 1987. The U.S. Department of Health and Human Services is in the process of drafting regulations governing the collection of data regarding additional health professionals, and is expected to promulgate final rules as soon as 1992.

The Task Force has reviewed a number of agencies to determine which might be best suited to the required tasks: Department of Health (Office of Health Facilities Complaints and other divisions within the Department); Department of Human Services (Mental Health Division and Licensing Division); Attorney General's Office-Consumer Division, Information and Complaint Line; Commerce Department Enforcement and Licensing Division; and the Office of the Ombudsman for Mental Health and Mental Retardation. (Appendix B, Option 3, provides pros and cons for establishing an Office of Mental Health Practice in all but the last of the listed agencies.) The Task Force has made no recommendation regarding which agency is best suited to perform these functions.

⁹While there is anecdotal evidence to support claims of wide-spread dual licensure, hard data to support the claims is not available as of January, 1991. The Office of Social Work and Mental Health Boards is in the process of creating a new data base to enter basic information on social work licensees and the Board of Marriage and Family Therapy will soon undertake a similar effort for its licensees. The new systems will enable the State to determine the extent of dual licensure between the two boards and, ultimately, with other boards which govern mental health professionals (i.e. Board of Medical Examiners for psychiatrists; Board of Nursing for psychiatric nurses; and Board of Psychology.)

Funding for the Office of Mental Health Practice

There are several sources of revenue available to fund the complaint and disciplinary process for unlicensed mental health providers as well as the public education activities to be performed by the Office of Mental Health Practice. These include: general revenues; a minimal surcharge on mental health professional licensees; a surcharge on all health related boards; a recapture of surplus funds in the Special Revenue fund; or some combination of the above. The level of funding is tied, in part, to the number of complaints which are filed against unlicensed mental health providers.

Given the current volume of complaints pending before the Board of Unlicensed Mental Health Service Providers, the cost of operating the Office of Mental Health Practice is estimated at \$150,000 to \$200,000 per year.

One funding alternative considered by the Task Force is a minimal surcharge on all licensed mental health professionals (to be defined.) The ability to discipline unlicensed providers benefits the consumer by providing an avenue of redress and increased understanding about mental health services and providers. Some assert that benefits also accrue to licensed providers in the form of positive public image. Following that logic, a minimal surcharge is a small price for licensed professionals to pay to enhance consumer protection and to receive a real or perceived benefit related to professional image.

However, in recognition of the budget constraints facing the State, the Task Force recommends that the consumer protection and public education activities to be performed by the Office of Mental Health Practice be funded through the surplus in the Special Revenue Fund. If a surplus does not exist, the cost of the function should be charged as agency indirect cost to all health professional licensing boards. In addition, to ensure some consistent baseline level of funding, the Task Force recommends that some baseline percentage of the funding be provided through general fund appropriations.

RELATED ISSUES

Cease and Desist Authority

There is a great deal of support among Task Force members for explicit cease and desist authority for the health professional licensing boards governed by Minn. Stats. Chapter 214 and for the agency which houses the recommended Office of Mental Health Practice.

There is precedent in existing law for such action. The Commissioner of Health has the power to obtain similar injunctive relief through the courts with regard to state-licensed nursing homes, under Minn. Stats. Chapter 144A.12, and state-licensed Health Maintenance Organizations (HMOs), under Minn. Stats. Chapter 62D.17, Subdivisions 4 and 5.

The use of cease and desist authority has a number of checks and balances. First, the decision to proceed with a cease and desist order requires the consultation and approval of the Minnesota

Office of the Attorney General. Second, a cease and desist order can be drawn narrowly to address a particular issue, and, thus, may not shut down a business. For instance, an order can be drawn to prohibit a male therapist from seeing female clients or to prohibit a particular type of behavior or the use of a particular type of technique.

Some have expressed concern about the wisdom of granting a powerful tool of this sort to volunteer boards. No matter how narrowly it is drawn, a cease and desist order can have serious repercussions for a practitioner's business. It can harm a person's reputation such that, even though they remain open for business, they may suffer a partial or complete loss of clients. These concerns have merit. Nevertheless, cease and desist authority offers a licensing board or other state entity the ability to address egregious conduct by a provider in a timely manner without the heavy burden of taking the situation to a court for an injunction.

Cease and desist authority is no panacea. It is an additional administrative tool that should be used very sparingly and only in the most egregious cases, and even then, with appropriate checks and balances on power. In order to ensure the due process rights of the provider, cease and desist action may be taken only in close consultation with the Office of the Attorney General. The Attorney General has ultimate responsibility for carrying out a cease and desist order.

The Task Force recommends that all health professional licensing boards under Minn. Stats. Chapter 214 be granted explicit cease and desist authority. The Task Force recommends that, because there are no minimum standards for practice of psychotherapy by unlicensed providers, and because there is no license to revoke, cease and desist authority should also be granted to the agency in which the Office of Mental Health Practice is housed. It is further recommended that the agency be granted authority similar to that provided for in Minn. Stats. 153A.15, which empowers the Commissioner of Health to investigate and take enforcement action against hearing instrument sellers for prohibited conduct.

Adjudication Time for Complaints

There is almost universal concern among Task Force members about insufficient resources allocated to the Attorney General's Office, which lengthens the time required to adjudicate consumer complaints made against licensed and unlicensed mental health providers. From a practical standpoint, the length of time required to process a complaint may constitute significant harm to the public during the processing time.

This is not to assert that the complaints process should be hurried or incomplete. Under the Administrative Procedures Act (Minn. Stats. Chapter 14), there are stringent due process concerns which must be addressed. However, some on the Task Force believe that balance may have tipped too far in favor of the practitioner and away from protection of the consumer who may have suffered harm.

The length of time required to process complaints can be tied directly to an increase in the volume of complaints. In Fiscal Year 1982, the Office of the Attorney General received a total

of 250 complaints from ten health professional licensing Boards. The same ten boards generated 647 complaints in fiscal year 1986, an increase of 397 cases or 159%. By FY 1990, the number of complaints brought to the Attorney General rose to 1452 complaints (827 major and 625 minor), a 480% increase since FY 1982.

The increased caseload may be due to a number of factors. In this age of consumerism, individuals are more aware that they can file complaints and there is more support and encouragement to take such action; this is especially true in the area of sexual impropriety. In addition, the State of Minnesota has enacted legislation in recent years which requires reporting of improper conduct or other problems concerning vulnerable adults and children and issues related to insurance. Mental health practitioners and Chapter 214 licensing boards are required to report allegations regarding other professionals who have engaged in questionable or prohibited activities.

The Attorney General's Office has taken several actions to try to address the growing caseload and the resulting backlog of complaints. In fiscal year 1987, the Attorney General's Office began to prioritize complaints, categorizing them as "significant" or "minor." Health regulatory boards have been given authority to adjudicate "minor" complaints (e.g. false or misleading advertising), with the option of a review by the Attorney General's office, while the Attorney General concentrates on complaints that are judged to be serious or significant.

RECOMMENDATIONS

The Task Force on Mental Health Regulation makes the following recommendations:

- 1) eliminate the Office of Social Work and Mental Health Boards.
- 2) allow the Board of Social Work and the Board of Marriage and Family Therapy to operate independently.
- 3) allow the Board of Unlicensed Mental Health Service Providers to sunset as scheduled in June, 1991.
- 4) eliminate the filing requirements for unlicensed mental health practitioners and repeal all current exemptions from filing and disciplinary action under the code of conduct. Retain the language of Minnesota Statutes 148B.44, describing prohibited conduct by all unlicensed mental health service providers, and the language of Minn. Stats. 148B.45, describing penalties for prohibited conduct.
- 5) Transfer the enforcement of the existing code of conduct laws for unlicensed providers to a state agency. These laws would allow the state to fine, censure,

reprimand, or enjoin from practice any non-licensed individual who engages in harmful or fraudulent behavior.

- 6) grant the agency explicit cease and desist authority and investigative resources, similar to that provided for in Minn. Stats. 153.A.14, which empowers the Commissioner of Health to investigate and take enforcement action against hearing instrument sellers for prohibited conduct.
- 7) establish a "clearinghouse" function in a state agency (referred to in this report as the "Office of Mental Health Practice") to: perform intake of complaints against unlicensed mental health practitioners and referral of complaints against licensed practitioners to the appropriate licensing board; administer disciplinary action against unlicensed providers of mental health services (using the definition of "psychotherapist" and "psychotherapy" found in Minn. Stats. 148A.01, Subdivision 5 and 6, regarding criminal violations for sexual contact between psychotherapists and clients); and provide information and public education on mental health practices and practitioners.
- 8) fund the consumer protection function of the "clearinghouse" through the surplus in the Special Revenue Fund. If a surplus does not exist, the cost of the function should be charged as agency indirect cost to all health professional licensing boards. In addition, some baseline percentage of funding for the "clearinghouse" should be provided via general fund appropriations to ensure the operation of the public education activities to be undertaken by the "clearinghouse."
- 9) enact legislation to grant cease and desist authority to health professional licensing boards governed by Minn. Stats. 214.
- 10) if any licensing boards are established in the future, ensure that provisions are made in the enabling legislation for "start-up" activities.

These recommendations were accepted unanimously by the Task Force.

TRANSITION ISSUES

The members of the Task Force have expressed concern about several issues which will arise as a result of the recommended sunset of the Board of Unlicensed Mental Health Service Providers in June, 1991, and during the period of transition to the establishment and start up of operations of the new Office of Mental Health Practice.

The Task Force is concerned that classified employees of the Office of Social Work and Mental Health Boards be provided with ample opportunity to gain new classified employment in other

state agencies after the legislation authorizing the operation of the Office is repealed. Under the layoff provisions of the appropriate collective bargaining agreements for state employees (e.g. American Federal of State, County, and Municipal Employees for clerical employees, Middle Management Association for supervisory employees, and Minnesota Association of Professional Employees for professional employees), certain rights are provided to employees whose jobs are abolished.

It is also crucial that the Legislature clearly delineate the point of decisionmaking authority for complaint and disciplinary activities related to unlicensed mental health providers, both during the period of transition and once the Office of Mental Health Practice has been established. The majority of the problems currently affecting the operation of the Office of Social Work and Mental Health Boards, the Board of Unlicensed Mental Health Service Providers, the Board of Marriage and Family Therapy and the Board of Social Work originated during the transition period after their establishment. There is strong consensus on the Task Force that close attention be paid to planning for the transition period and during the initial start up phase of the Office of Mental Health Practice.

Further the Task Force suggests that the Legislature undertake a review of the Government Data Practices Act (Minn. Stats. Chapter 13) and the Administrative Procedures Act (Minn. Stats. Chapter 14), to ensure that Chapter 214 licensing boards and other state regulatory entities have the ability to exchange necessary data and to ensure that there is a balance between the due process rights of mental health practitioners and consumer protection concerns.

Sec. 93. REPORT ON METHODS OF COORDINATING SOCIAL WORK AND MENTAL HEALTH BOARDS.

(a) The commissioner of health shall convene an interagency task force consisting of health department staff and representatives from the commissioner of human services and the boards of social work, marriage and family therapy, unlicensed mental health service providers, medical examiners, nursing, and psychology to study the current system of monitoring and regulating both licensed and unlicensed individuals who practice mental health counseling, psychotherapy, psychiatry, psychiatric nursing, social work, professional counseling, chemical dependency counseling, and similar activities. The task force shall make recommendations for improving coordination, administrative efficiency, and effectiveness of the activities of the department of health and the boards that monitor and regulate these social work and mental health occupations and professions. The task force shall solicit and consider the comments and recommendations of affected individuals, associations, and government agencies. In developing its recommendations, the task force shall consider:

(1) methods of monitoring or regulating unlicensed practitioners and whether this activity should be administered by the health department, an independent administrative agency, a board, or another entity;

(2) a surcharge on license fees of all social work and mental health boards to finance the monitoring or regulation of unlicensed practitioners;

(3) methods of coordinating the various systems for accepting and investigating complaints;

(4) coordinated information systems to identify individuals who have been denied a license or have been subject to disciplinary action by another licensing board or agency; and

(5) other relevant issues identified by the task force.

(b) The commissioner of health shall report to the legislature by December 1, 1990, with the results of the study and the recommendations of the task force.

Sec. 94. EXEMPTION.

For the biennium ending June 30, 1991, the board of unlicensed mental health service providers is exempt from Minnesota Statutes, sections 16A.128, subdivision 1, and 214.06, subdivision 1.

New language is indicated by underline, deletions by ~~strikeout~~.

INTERAGENCY TASK FORCE ON MENTAL HEALTH REGULATION

OPTIONS PAPER

The 1990 Minnesota Legislature directed the Commissioner of Health to convene an interagency task force to study the current system of regulating and monitoring licensed and unlicensed individuals who provide a range of mental health services. The Task Force is responsible for making recommendations for administrative improvements in the existing regulatory structure. 1990 Minnesota Laws, Chapter 568, Article 2, Sections 93 and 94.

The Task Force must consider the following:

- 1) methods of coordinating and improving the monitoring or regulation of unlicensed mental health providers and the most efficient venue for administering this function (e.g. autonomous board, state agency, etc.);
- 2) funding sources for the monitoring or regulation of unlicensed mental health providers; and
- 3) methods of coordinating complaints and disciplinary actions regarding licensed and unlicensed mental health providers.

Due to staff constraints, the scope of the options presented in this study are limited to existing regulatory boards and structures.

Staff acknowledges that significant interest and concern exists about the identification and regulation of additional mental health specialties. The Human Services Occupations Advisory Council (HSOAC) completed its review of the need to regulate Chemical Dependency Counselors in June, 1990. A determination by the Commissioner of Health is expected by December, 1990.

That determination will influence, and be influenced by, issues discussed in this study. Therefore, Options 5 and 6, which consider the regulation of additional mental health specialties, are included for discussion purposes only. Additional regulation would require a review of criteria under Minnesota Statutes, Chapter 214.

1) Status quo. Retain current structure (i.e. Office of Social Work and Mental Health, containing Board of Social Work, Board of Marriage and Family Therapy, and Board of Unlicensed Mental Health Providers) but rename Board of Unlicensed Mental Health Service Providers to Board of Mental Health Practice.

Pros:

- system already in place
- no new State expenditures
- public protection function still valid, as evidenced by new complaints being brought to board by public.
- New name may provide benefit to public by clarifying purpose or function of Board as place to bring complaints or seek information on providers
- removes stigma to both public and "filers" implied by current name (i.e. Board of Unlicensed Mental Health Service Providers)

Cons:

- pairing of licensed and unlicensed providers in one composite structure creates confusion
- lack of direction in statute makes administrative "overlay" of Office of Social Work and Mental Health Boards cumbersome and confusing; source of great tension to three separate Boards contained therein
- Board of Unlicensed Mental Health Service Providers is not currently self-supporting in FY 1991, as required under Minn. Stats. 214, and likely will not be in FY 1992
- no clear constituency in support of continuation of separate "board" for unlicensed providers
- insufficient statutory authority to enforce penalties against a) persons who practice without filing credentials or b) filers who practice outside of generally-accepted norms of ethical and/or professional practice (e.g. false or misleading advertising, dual relationships, sexual contact with clients, etc.)
- no incentive for individuals to file credentials with unlicensed board (i.e. no perceived benefit to filers)

2) Office of Social Work and Mental Health is dismantled. Board of Social Work, Board of Marriage and Family Therapy, and Board of Unlicensed Mental Health Service Providers operate as autonomous boards.

Pros:

- dismantling "Office" removes source of severe tension from operations of three Boards, resulting from lack of statutory definition of scope of "Office" (e.g. legal responsibilities of Office vs. those of Boards, reporting lines, etc.)

- dismantling "Office" allows Boards to concentrate on regulatory policy matters instead of current heavy emphasis on administrative details, reporting lines, etc.
- dismantling "Office" may result, to some degree, in lower expenditures to each Board
- inequitable allocation (or perception of inequitable allocation) of resources from Office to each Board ceases to be an issue
- restores direct control over Board operations and expenditures to boards
- clear precedent in Minnesota law for autonomous, health-related Boards, free of composite structure

Cons:

- volunteer boards may not have sufficient expertise to complete prospective budgets and fee reviews and other administrative functions (e.g. personnel matters, purchasing) now performed by "Office" staff
- Board of Unlicensed Mental Health Service Providers is not currently self-supporting in FY 1991, as required under Minn. Stats. 214, and likely will not be in FY 1992.
- questions exist regarding Board of Marriage and Family Therapy's ability to be self-supporting
- autonomy of Board which "regulates the unlicensed" is problematic; regulatory responsibility may be better placed in State agency
- opportunity for coordination of functions is reduced

3) Board of Unlicensed Mental Health Service Providers sunsets in June, 1991. Office of Social Work and Mental Health is dismantled. Board of Social Work and Board of Marriage and Family Therapy become autonomous. Existing state agency administers current system of filing of credentials of unlicensed mental health service providers and complaints against filers. (Different agency scenarios are provided below.) Filing function is supported via filing fees and minimal charge on and all mental health licensees (i.e. psychologists, social workers, and marriage and family therapists).

NOTE: None of the agencies discussed in Option 3 has been asked for comment on their willingness to assume responsibility for the function outlined in this option. Agency scenarios are provided for discussion only.

Pros:

- public protection function still valid, as evidenced by new complaints being brought currently by public to Board of Unlicensed Mental Health Service Providers

- dismantling Office of Social Work and Mental Health Boards allows Board of Social Work and Board of Marriage and Family Therapy to concentrate on regulatory policy matters instead of current heavy emphasis on administrative details, resulting from lack of statutory definition of scope of "Office" responsibilities vs. Board responsibilities
- dismantling of "Office" may result, to some degree, in lower expenditures to Board of Social Work and Board of Marriage and Family Therapy
- broadening fee support to include all licensed mental health providers is considered a "public service," i.e. licensed providers contribute to ensure that appropriate action can be taken against unlicensed providers who practice outside of generally-accepted ethical or professional norms of practice
- broadening fee support to licensed mental health providers recognizes benefit to all practitioners from "safety net" function

Cons:

- less professional autonomy if regulation (i.e. monitoring) is done by state agency instead of separate Board
- no incentive for individuals to file credentials with State (i.e. no perceived benefit to filers)
- insufficient statutory authority to enforce existing penalties against:
 - a) persons who practice but do not file or
 - b) filers who practice outside of generally-accepted norms of ethical and/or professional practice (e.g. false or misleading advertising, dual relationships, sexual contact with clients, etc.)
- lack of full range of enforcement options (e.g. no cease and desist authority or other administrative remedies) is problematic

OPTION 3A: DEPARTMENT OF HEALTH,
REGULATION BY DIVISION

Pros:

- Department of Health has long-standing expertise with regulation of allied health occupations
- Department has substantive knowledge of provision of mental health services and development of Board of Unlicensed Mental Health Service Providers
- Department currently provides some degree of administrative support to Boards contained under Office of Social Work and Mental Health

Cons:

- Department of Health has not had a role in mental health regulation

OPTION 3B: DEPARTMENT OF HEALTH,
OFFICE OF HEALTH FACILITY COMPLAINTS

Pros:

- Office of Health Facility Complaints has regulatory expertise related to health-care facilities (e.g. hospitals, nursing homes, board and care facilities and supervised living facilities)

Cons:

- Office has no expertise in regulation of individual health or mental health providers in private practice. Complaints about individuals employed in licensed health care facilities are referred to county social services, Department of Human Services or other relevant agencies, as well as County Attorney.

OPTION 3C: DEPARTMENT OF HUMAN SERVICES
MENTAL HEALTH DIVISION

Pros:

- Department of Human Services Mental Health Division has substantive knowledge of mental health facilities and provision of mental health services.

Cons:

- Department of Human Services Mental Health Division has no regulatory jurisdiction over individuals.
- Department of Human Services Licensing Division does not regulate individuals who provide mental health or chemical dependency services; Licensing Division does have regulatory jurisdiction over and processes complaints against various types of facilities in which mental health and chemical dependency services are provided.

OPTION 3D: ATTORNEY GENERAL'S OFFICE CONSUMER DIVISION
INFORMATION AND COMPLAINT LINE

Pros:

- Consumer Division has expertise in investigating and mediating and/or adjudicating consumer complaints against individuals in a variety of non-health related occupations who violate various consumer laws

Cons:

- AG's Consumer Division has no expertise in occupational regulation or in mental health practice.
- Consumer Division Information and Complaint Line refers all complaints to agencies of jurisdiction, where such jurisdiction exists. Consumer Division keeps only those complaints for which no such jurisdiction exists.
- Information and Complaint Line gets few mental health-related calls; refers those calls to appropriate boards.
- potential for complaints against unlicensed mental health service providers being lost in "queue" of a wide variety of consumer complaints against a wide variety of professionals

OPTION 3E: COMMERCE DEPARTMENT
ENFORCEMENT AND LICENSING DIVISION

Pros:

- Licensing Section of Enforcement and Licensing Division has expertise in regulation of a variety of individuals in non-health related industries. Separate Enforcement Section investigates complaints against licensees for alleged violation of consumer laws.
- Some complaints against unlicensed mental health service providers might best be addressed under consumer laws (e.g. false or misleading advertising of services)

Cons:

- Commerce Department has no expertise in provision of health or mental health services.

4) Board of Unlicensed Mental Health Service Providers sunsets in June, 1991. Office of Social Work and Mental Health is dismantled. Board of Social Work and Board of Marriage and Family Therapy become autonomous. Unregulated mental health service providers are no longer required to file credentials in order to practice.

Pros:

- sunset of Board of Unlicensed Mental Health Service Providers resolves numerous jurisdictional and operational conflicts
- dismantling Office of Social Work and Mental Health Boards allows Board of Social Work and Board of Marriage and Family Therapy to concentrate on regulatory policy matters instead of current heavy emphasis on administrative details, resulting from lack of statutory definition of scope of "Office" responsibilities vs. Board responsibilities

- dismantling of "Office" may result, to some degree, in lower expenditures to Board of Social Work and Board of Marriage and Family Therapy
- option will have support from providers who must now file with Board of Unlicensed Mental Health Service Providers

Cons:

- original intent of BUMP board (i.e. protection of public from unregulated providers) is abandoned
- consumer complaints against subsequently unregulated providers will not be investigated or enforced
- workload of remaining regulatory boards and Attorney General's office may increase as new complaints against unregulated providers must be investigated for jurisdiction

5) Board of Unlicensed Mental Health Service Providers sunsets in June, 1991. Office of Social Work and Mental Health is dismantled. Board of Social Work and Board of Marriage and Family Therapy become autonomous. Additional mental health specialties are regulated; minimum standards for practice are developed for independent and supervised practice of counseling.

Legislature establishes Clearinghouse on Mental Health Practice in state agency which:

- a) administers filing of credentials/complaints for small number of remaining unregulated mental health service providers for defined period of time, then practice by unregulated individuals is phased-out (i.e. closes "loop");
- b) provides public education on mental health practices;
- c) refers complaints/questions on licensed or otherwise regulated mental health providers to appropriate venue. Clearinghouse is supported via minimal fee on all regulated and unregulated mental health providers.

(NOTE: The Clearinghouse structure would work with or without additional regulation, and regardless of the degree of regulation: no additional regulation, registration, or licensing.)

Pros:

- clearly identifies State as public's source of information regarding mental health service providers and practices
- provides public with "one stop shopping" for information and complaints on provision of mental health services
- ongoing public education efforts raise public awareness of appropriate vs. inappropriate mental health services
- provides public protection
- meets original intent of Board of Unlicensed Mental Health Service Providers

- Clearinghouse may have support of licensed mental health occupations
- public protection function still valid, as evidenced by new complaints being brought currently by public to Board of Unlicensed Mental Health Service Providers
- dismantling Office of Social Work and Mental Health Boards allows Board of Social Work and Board of Marriage and Family Therapy to concentrate on regulatory policy matters instead of current heavy emphasis on administrative details, resulting from lack of statutory definition of scope of "Office" (e.g. legal responsibilities of Office vs. those of Boards, reporting lines, etc.);
- dismantling of "Office" may result, to some degree, in lower expenditures to Board of Social Work and Board of Marriage and Family Therapy
- broadening fee support to include all licensed and unlicensed mental health providers recognizes benefit to consumers from "safety net" function
- broadening fee support for "safety net" function to include all licensed and unlicensed mental health providers recognizes benefit to providers, i.e. to ensure that appropriate action can be taken against unregulated providers who practice outside of generally-accepted ethical or professional norms of practice

Cons:

- Professional Counselors/Chemical Dependency Counselors/ other unregulated groups likely to continue to push for licensure in legislature
- no incentive for individuals to file credentials with State in interim period (i.e. no perceived benefit to filers)
- Clearinghouse may experience problems re: Data Practices Act
- insufficient statutory authority to enforce existing penalties against:
 - a) persons who practice but do not file or
 - b) filers who practice outside of generally-accepted norms of ethical and/or professional practice (e.g. false or misleading advertising, dual relationships, sexual contact with clients, etc.)
- lack of full range of enforcement options (e.g. no cease and desist authority or other administrative remedies) is problematic.

CLARIFICATION: The primary difference in Options 5 and 6 can be found in subdivision (c). In Option 5, the Clearinghouse serves a referral function. In Option 6, the Clearinghouse serves an investigatory function.

6) Board of Unlicensed Mental Health Service providers sunsets in June, 1991. Office of Social Work and Mental Health is dismantled. Board of Social Work and Board of Marriage and Family Therapy become autonomous. Additional mental health specialties are regulated; minimum standards for practice are developed for independent and supervised practice of counseling.

Legislature establishes Mental Health Information and Grievance Office in Department of Health which:

- a) administers filing of credentials/complaints for small number of remaining unregulated mental health service providers for defined period of time, then practice by unregulated individuals is phased-out;
- b) provides public education on mental health practices;
- c) investigates complaints against all licensed or otherwise regulated mental health providers (i.e. physicians, nurses, social workers, psychologists, marriage and family therapists, and others.) Complaints are addressed by composite advisory board with augmenting panel from each of the licensed/registered professions. Office is supported via minimal fee on all regulated/unregulated mental health providers.

(NOTE: The Clearinghouse structure would work with or without additional regulation, and regardless of the degree of regulation: no additional regulation; registration; or licensing.)

Pros:

- clearly identifies State as public's source of information regarding unlicensed mental health service providers
- provides public with "one stop shopping" for information and complaints on provision of mental health services
- meets original intent of Board of Unlicensed Mental Health Service Providers
- reduces duplication/lowers costs of Attorney General's investigations of dual-licensed providers
- decreases Attorney General's workload and provides for more timely investigations
- central contact point for communications to and from National Practitioner Data Bank (Note: Reporting to Data Bank is now mandatory for actions taken by State entities against doctors, dentists, and nurses. Reporting for other health and mental health providers will become mandatory when regulations are finalized in the next two years.)
- ongoing public education efforts raise public awareness of appropriate vs. inappropriate mental health services provides public protection
- Clearinghouse may have support of licensed mental health occupations

- public protection function still valid, as evidenced by new complaints being brought currently by public to Board of Unlicensed Mental Health Service Providers
- dismantling Office of Social Work and Mental Health Boards allows Board of Social Work and Board of Marriage and Family Therapy to concentrate on regulatory policy matters instead of current heavy emphasis on administrative details resulting from lack of statutory definition of scope of "Office" (e.g. legal responsibilities of Office vs. those of Boards, reporting lines, etc.);
- dismantling of "Office" may result, to some degree, in lower expenditures to Board of Social Work and Board of Marriage and Family Therapy
- broadening fee support to include all licensed and unlicensed mental health providers recognizes benefit to consumers from "safety net" function
- broadening fee support for "safety net" function to include all licensed and unlicensed mental health providers recognizes benefit to providers, i.e. to ensure that appropriate action can be taken against unregulated providers who practice outside of generally-accepted ethical or professional norms of practice

Cons:

- Existing licensure boards may not want to relinquish authority over complaints against licensees
- Professional Counselors/CD Counselors/other unregulated groups likely to continue to push for licensure in legislature
- no incentive for individuals to file credentials with State in interim period
- Clearinghouse may experience problems re: Data Practices Act
- lack of minimum standards for filing weakens enforcement and potentially weakens public protection
- insufficient statutory authority to enforce existing penalties against:
 - a) persons who practice but do not file or
 - b) filers who practice outside of generally-accepted norms of ethical and/or professional practice (e.g. false or misleading advertising, dual relationships, sexual contact with clients, etc.)
- lack of full range of enforcement options (e.g. no cease and desist authority or other administrative remedies) is problematic

7) Legislature shifts control for regulation of all health professions from autonomous boards to existing state agency. Individual boards for each occupation operate semi-autonomously but agency provides administrative, investigative, personnel and other services.

Pros:

- reorganization of existing activities which may provide some degree of policy coordination and administrative efficiency to existing regulatory activities
- provides "one stop shopping" for consumers seeking information or seeking to file a complaint
- regulatory activities continue to be financed through fees on regulated individuals; expenditures from general revenues are low
- potential cost savings to state in terms of personnel, overhead, equipment, materials, and other resources now purchased by individual boards
- to some degree, centralization already exists for finances of health-related boards; all board fees are deposited into the same account
- provides additional degree of state oversight for those who perceive "capture" of boards by professions
- consistent point for communications on disciplinary actions to and from the National Practitioner Data Bank
- precedent in other states: approximately 30 states centralize occupational regulation functions, to varying degree

Cons:

- regulatory boards and corresponding professional associations may oppose loss of autonomy, depending on degree of centralization
- efficiency varies depending on type of centralization (i.e. is professional staff hired to serve individual Boards or to serve functions?)
- who appoint Board members - Governor or Commissioner of Department?

8) Legislature establishes omnibus regulatory agency for health professions with individual, semi-autonomous regulatory boards for each regulated occupation.

Pros:

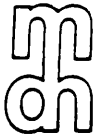
- reorganization of existing activities which may provide some degree of policy coordination and administrative efficiency to existing regulatory activities
- provides "one stop shopping" for consumers seeking information or seeking to file a complaint

- regulatory activities continue to be financed through fees on regulated individuals; expenditures from general revenues are low
- potential cost savings to state in terms of personnel, overhead, equipment, materials, and other resources now purchased by individual boards
- to some degree, centralization already exists for finances of health-related boards; all board fees are deposited into the same account.
- provides additional degree of state oversight for those who perceive "capture" of boards by professions
- consistent point for communications on disciplinary actions to and from the National Practitioner Data Bank
- potential for support in legislature
- precedent in other states: approximately 30 states centralize occupational regulation functions, to varying degree

Cons:

- unknown costs to State of consolidation process
- efficiency varies depending on type of centralization (i.e. is professional staff hired to serve individual Boards or to serve functions?)
- regulatory boards and corresponding professional associations may oppose loss of autonomy, depending on degree of centralization
- who appoints Board members - Governor or Commissioner of Department?

APPENDIX E



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AGENDA

Human Services Occupations Advisory Council
Friday, May 11, 1990
1:00 - 4:30 p.m.
Minnesota Department of Health
Room #105

- I. Call to Order
- II. Approval of Minutes
- III. Program Update
- IV. Chemical Dependency Regulation Coalition:
 - A. Other Means of Protection
 - B. Cost Effectiveness of Regulating
- V. HSOAC:
 - A. Statutory Review Criteria
- VI. Other HSOAC/CDRC Business
- VII. Adjournment

more to do with the fact that chemical dependency counseling is less expensive here than anywhere else.

Dr. Gates asked if the CDRC knew the percentage of the clients coming from out of state for what percentage of the programs. Ms. Teel responded by saying that she was aware of Hazelden, St. Mary's, and Twin Coventry. It was only a small number of programs involved.

Chair Madsen asked if there were other questions for Ms. Teel. Hearing none, he asked for a motion to approve the minutes. Ms. Rose Hamerlink moved that the minutes be approved as written and Ms. Domning seconded. Motion carried. Council then began discussion of the review criteria.

V. Statutory Review Criteria

Dr. Gates moved that the unregulated practice of chemical dependency counseling may harm the health, safety or welfare of Minnesotans. Ms. Domning seconded.

Dr. Gates stated that the harm appeared to be emotional, mental and potentially physical and financial. It appeared to be due to people getting care from unknowledgable individuals who may not be cognizant of the complications of the chemical dependency as well as those practitioners suggesting inappropriate treatment modalities that can result in harm.

Mr. Hiendlmayr asked if there were any particular functions that Council viewed as being more involved in harm?

Ms. Satre responded by saying that she felt that the chemical dependency counselor was involved in counseling a wide variety of problems. She felt it would be too difficult to isolate and treat the chemical dependency problem without looking at the rest of the client's life.

Dr. Gates stated that there was harm in inappropriate diagnosis. There was harm in terms of inappropriate treatment modalities.

Mr. Brekken stated that he thought emotional and mental harm were the two biggest areas of potential harm.

Ms. Bruesehoff stated that she felt that social complexities such as property, gender, battering, of both adults and children, and nationalities were not being considered or taken into account.

Chair Madsen stated that he would not be voting unless there was a tie situation.

Chair Madsen asked if there was any other discussion. Hearing none, he asked the Council to vote. The motion carried: 6 voted yes; 0 no; 0 abstained.

Dr. Gates moved that the potential for harm is recognizable. Ms. Domning seconded.

Dr. Gates stated that he felt the client testimony heard at the public forum and the expert testimony presented was the most convincing evidence.

Ms. Satre stated that she found Mr. Gary Schoener from the Walk-In Counseling Center to be very convincing. (Mr. Schoener was the man who ran the facility that investigated practitioners that were not doing their job appropriately.)

Ms. Bruesehoff stated that there was evidence of inappropriate philosophy also. Chair Madsen asked Ms. Bruesehoff to elaborate on that. Ms. Bruesehoff stated she was referring to appropriate care and appropriate treatment; brutality was shown to be an accepted part of the industry.

Mr. Brekken stated that when there is a closed system and the entire facility has a warped or bent philosophy, that modality is perpetuated and continues to exist. It may be a very inappropriate treatment modality.

Chair Madsen asked Ms. Bruesehoff if she was talking about abusive, harsh, disrespectful types of treatment. Ms. Bruesehoff replied that that was correct.

Mr. Hiendlmayr added that it was important to note that harm arose not from the dangerous nature of the functions or only from the performing of those functions, but primarily from the fact that practitioners operated independently and had a lot discretion in terms of what did or did not happen in a counseling session.

Ms. Satre stated that she felt that rather than say that it was the devices or substances that were used, it was the dangerous nature of some of the procedures that would be mentally or emotionally harmful.

Mr. Brekken stated that he would have to include dangerous substances as well. He stated that he knew of three or four cases where counselors instructed their clients to discontinue taking medication prescribed by their physician.

Chair Madsen asked if there was any other discussion. Hearing none, he asked the Council to vote. The motion carried: 6 voted yes; 0 no; 0 abstained.

Dr. Gates moved that the potential for harm is proximate. Ms. Domning seconded.

Dr. Gates stated that he felt that the expert and client testimony heard was significant. There were specific cases where clients were subjected to mental, emotional, financial and/or physical harm. The impairment resulting from the inappropriate treatment strategies was significant. How do you define major? When an individual modifies their lifestyle as a result of the substantial emotional damage by inappropriate treatment, that is a major issue and it would certainly appear to be a direct effect of the occupational function.

Mr. Hiendlmayr asked if the Council would discuss a function performed and how directly related that might be to harm that occurs. The term proximate

suggests relatedness between a source and a result. For example, one of the cases of harm talked about an individual who came in, had a session, something wasn't done right and the individual was later arrested for robbing a convenience store to get money so they could go out and buy drugs.

Dr. Gates responded by saying that he felt that was an excellent example of proximate.

Ms. Satre stated that she was concerned about the examples of harm where a counselor stripped a client of their dignity. There are immediate and long lasting effects from that. Most client's are on the edge to begin with and the potential for pushing that client over the edge to the realm of no recovery is very great.

Chair Madsen stated that his understanding was that one very important factors was for the client to become aware of and/or admit that they had a problem. To get people to admit they have a problem leads to the possibility for abuse in terms of the harsh and confrontational sorts of things for which the field of chemical dependency counseling is famous or infamous.

Mr. Brekken added that when dealing with adolescents it was an even more important factor.

Dr. Gates felt that another area of very important concern was the issue of recognition of a client suffering withdrawal and other medical complications. A client who was started in a therapeutic relationship without full cognizance of the those concomitant complications can result in very significant harm. A specific example would be of an individual who had been abusing alcohol to such an extent that they had depleted their thiamine reserves. If that client was not given an appropriate medical consultation and was simply started on a detoxification program, that client could suffer great physical harm. Just eating a regular diet when the body is thiamine depleted can create an acute confusional state, and things of that nature. There's tremendous importance for knowing the concomitant complications, and without that people can be severely injured, physically.

Chair Madsen asked if there was any other discussion. Hearing none, he asked the Council to vote. The motion carried: 6 voted yes; 0 no; 0 abstained.

Dr. Gates moved that the practice of chemical dependency counseling requires specialized skill or training. Ms. Domning seconded.

Dr. Gates stated that the application was replete with curricular evidence of the specialized training that is required for this particular occupation. He felt that Dr. Anderson's comment that most general physicians are incapable of dealing adequately with chemical dependency was quite accurate. They do not look for, ask for, do not know what to do about chemical dependency, and have very negative attitudes of addicts. There is clearly a scope of practice that exists and it had been well presented by the applicant group.

Mr. Hiendlmayr asked Dr. Gates if his inquiry about the training the counselors

received, so they would be able to recognize other medical complications, had been adequately answered.

Dr. Gates stated that he did not feel that his inquiry was adequately answered. He stated that the practice did require specialized skill, but whether the applicant group adequately identified the training for that specialized skill was another matter. His concern was more related to the training for the independent practitioner which would have implications in terms of modality.

Mr. Adams felt that the entry level requirements were too low when compared to other psychotherapy types of occupations. He stated that the other applicant groups had entry level requirements that were bachelor's degree or master's degree levels.

Dr. Gates agreed with Mr. Adams. He would like to see at least a bachelor degree for entry level. There were specific concerns about physical and diagnostic issues as well as the other things that Dr. Anderson mentioned in his letter, other psychological or psychiatric issues.

Mr. Brekken stated his understanding and agreed with Dr. Gates and Mr. Adams. While the capability of the practitioners coming out of the training programs cannot be known, it must be remembered that every facility must be licensed by DHS and/or MDH and those facilities are required to have a consulting physician and psychiatrist on contract at all times.

Dr. Gates stated that fell under the category of other means of protection. Mr. Brekken agreed that it was.

Chair Madsen asked if there was any other discussion. Hearing none, he asked the Council to vote. The motion carried: 6 voted yes; 0 no; 0 abstained.

Dr. Gates moved that the public needs and will benefit by assurances of initial and continuing occupational ability. Ms. Domning seconded.

Dr. Gates stated that evidence had been given that the occupation had evolved quickly and was still active. There had been some very specific statements about specialized group needs, for example, adolescents and females. There clearly was evidence of skilled knowledge and technique that was evolving very actively.

Ms. Satre felt that the chemicals that people are addicted to has changed. If one were to look at the last 10 years and the implications there, that also implies that that will continue to change. That would require further continuing education.

Chair Madsen asked if there was any other discussion. Hearing none, he asked the Council to vote. The motion carried: 6 voted yes; 0 no; 0 abstained.

Chair Madsen had a procedural question for the Council. He asked the Council if anyone had any objection to proceeding onto the criterion that deals with cost and economic impact. He had the thought that there would be a great deal

of discussion involved with the other means of protection issue.

Ms. Satre stated that she thought that was a good idea.

Mr. Adams asked if it would be possible to finish the criteria review today.

Chair Madsen thought it might be possible.

Dr. Gates thought that the absent members would probably like to have some say in the matter.

Chair Madsen stated that while they could probably finish today, he did not feel that it would be done in the most effective and efficient way possible. He stated that he would exercise whatever perogatives necessary to be certain that the review criteria was not finished today.

Dr. Gates moved that the overall cost effectiveness and economic impact of any type of regulation, or the type of regulation sought by the applicant group, would be positive for Minnesotans. Ms. Domning seconded.

Mr. Hiendlmayr refreshed the Council's memory about research that has been done regarding regulation. There is a cost to any form of regulation and it is a given that licensure has a greater cost than less restrictive types of regulation. The amount of the greater cost has never been documented.

Ms. Domning stated that while she agreed that there would be costs involved with any regulation, she felt that licensure would be a greater and more prohibitive cost.

Dr. Gates stated that the Council Members needed to determine who would end up bearing most of the cost. The cost to public versus the cost to the occupation. If licensure is the recommended mode of regulation, it is presumed that the cost of for running that is borne by the profession. But the cost to the public might be restricted access and that would therefore, increase fees because there would be less practitioners and they could charge more.

Ms. Domning asked how it would be positive to Minnesotans.

Dr. Gates stated it would be less expensive and it would cost very little to see a chemical dependency counselor.

Chair Madsen asked that if there were additional costs, would the benefits outweigh those costs?

Mr. Brekken stated that one of the examples given by Ms. Teel showed that when a client received chemical dependency counseling, the other medical costs seemed to be reduced by 40%. Not only for that client but also for the rest of that client's family. That would be a significant cost savings.

Chair Madsen stated that was true, except the discussion was about regulation and would that have an effect on cost, not if the service itself would have any

effect.

Dr. Gates stated that one must follow a logical paradigm. If more effective treatment was a consequence of enhanced regulatory modes, and there would then be a decreased rate of recidivism, that would translate to less work time lost and less complicated medical conditions which would in turn cost less in that respect. There have been some studies that have demonstrated that.

Ms. Satre asked what the studies had demonstrated.

Dr. Gates responded by saying that the studies had shown that more effective intervention had resulted in less worktime lost and less utilization of medical resources.

Ms. Bruesehoff stated that while it was understood that regulation would cost more, it certainly would be worth it to decrease the instances of and potential for harm.

Chair Madsen suggested that the Council look at it from the point of view as to who would be denied access to the field of chemical dependency counseling if it were regulated. Consider the impact it would have on minorities or protected classes. Are there people out there who would like to be chemical dependency counselors who would not be able to get into that field because the entry level requirements were too stringent?

Ms. Satre felt that there were very few occupations that could be done without more formal training; a high school diploma just would not be enough anymore.

Ms. Bruesehoff thought that the issue of cultural relevancy was very very important here. She also asked if there could be a stipulation that required that funds be made available, or something, for people of other cultures to acquire the education. There has been a lot of damage done by not recognizing the particular needs of different cultures, and the needs for people of those cultures to be providing treatment.

Chair Madsen agreed that while it had to be addressed socially, he did not know of any way that could be done through a regulatory scheme.

Dr. Gates mentioned that there had been some excellent studies done on the Native American population. The studies have shown that the life expectancy for a Native American male in the city of Minneapolis was 48 years and chemical dependency was the predominant reason for that. He asked Mr. Brekken if there were any numbers available concerning the percentage of chemical dependency counselors in the Metropolitan area.

Mr. Brekken stated that there were no specific numbers available but he did know that there are about three or four programs in the state that specialize in providing services to the American Indian population. Dr. Gates asked if any of the Native Americans were receiving training to do that for their own culture? Mr. Brekken replied that they were. Dr. Gates responded by saying that there was a system already in place so that those people were getting the

appropriate credentials and they would not be precluded.

Mr. Brekken stated that those people would meet the existing standards and rules because those agencies were currently licensed. With the standards that have been laid out for grandpersoning, those people would meet the licensure requirements. It then would go back to the question of whether or not those people could afford the two years of college, and if they are economically poor, that answer would be unknown.

Ms. Satre felt there was no reason why Native American people should have lesser quality programs. There should be an across the board attempt to get minorities into any occupation.

Dr. Gates stated that while there may a significant impact on minorities, the data to make that statement was not available. But there was a potential impact there that the Council must be cognizant of.

Mr. John DuCane informed the Council that the American Indian Advisory Council studied the CDRC application quite closely and they were not opposed to any of these educational requirements for counselors. They are encouraging their Indian counselors to get this kind of training by attending summer school and they encouraged their people to get certified. There was generally no opposition to this kind of development in the Native American community.

Mr. Adams stated that he would like to voice his agreement with something that Ms. Bruesehoff had said and that was that there was no doubt that regulation was going to exclude some people. Some of the best counselors were usually the ones who had been chemically dependent themselves, recovered and then gone on to get further, more formalized training. Whenever educational requirements are enacted, someone is going to be excluded. Efforts to provide funding or specialized programs to help those people meet the requirements was really important.

Dr. Gates stated that the basic thesis was that by getting appropriate training counselors became more effective in the delivery of their services. It would appear to be appropriate to require that regardless of minority status.

Chair Madsen voiced his concern about the lack of evidence that there would be measurable improvements to the quality of care in terms of educational requirements and the possible desparate impact on minorities.

Ms. Satre stated that the Council did vote that it required specialized skills and knowledge and it logically follows that people should acquire those skills and knowledge in order to practice. The vote should have to been to say no, it does not have require specialized skills or knowledge, in order to say it does not really matter if they know it or not.

Dr. Gates asked Mr. Brekken if he had any information on the estimated costs to state and local governments? Mr. Brekken replied that he did not see that there would be a significant increase in the cost to the state.

Ms. Satre added that a 10% increase in the salaries on the list handed out by Ms. Teel is not a very large increase.

Dr. Gates asked if chemical dependency counselors would be able to bill third party payors directly? Mr. Brekken reiterated that it was very unlikely. As the CDRC had indicated, if insurance companies were to start reimbursing licensed chemical dependency counselors directly then there would be some cost increase there.

Dr. Gates reminded Mr. Brekken that bachelor level social workers will be able to do some direct billing of third party payors as of July, 1990. If one were to follow the argument that licensure leads to mandated reimbursement, there could be some third party payor issues here.

Chair Madsen stated that he felt very strongly that in about 5 to 10 years, there would be an attempt to begin direct third party billing and incremental increases in educational requirements for entry level positions. It is refreshing to have the CDRC admit that they will probably do that, instead of sitting here and saying "No, we would never do that."

Dr. Gates added that if a licensed psychologist did an assessment and billed Medicare, which is signed off on by a physician, the reimbursement would be X. But if an LCP, a licensed clinical psychologist, did it, the reimbursement would be 2X. So the impact of licensure on costs for that particular activity is also related to the sophistication of the licensing scheme.

Ms. Bruesehoff stated that she felt that chemical abuse was at least as serious as some of the problems people go to psychologists for, and, if the counselors can provide effective care, let them be paid.

Ms. Satre agreed with Ms. Bruesehoff, and added that 15 or 20 years ago there was no place a person could go and get help.

Chair Madsen stated that he felt that third party reimbursement for chemical dependency counselors would be a good thing, regardless of regulation.

Mr. Brekken stated that the current statute only reimburses facilities that are currently licensed by DHS, so a person licensed as a chemical dependency practitioner would not be eligible for reimbursement; at least the insurance company would not be mandated to reimburse the practitioner. Insurance companies may "choose" to reimburse but they would be under no obligation under state law to reimburse for services rendered.

Dr. Gates stated he wanted to discuss the distribution of practitioners. He wanted to know if there would be a problem in greater Minnesota in terms of a maldistribution of practitioners. Ms. Satre responded by saying that the Council was given some information that said that would not be a real problem.

Ms. Teel was asked to respond and said that Dr. Cynthia Turnure had handed out maps of Minnesota at the HSOAC meeting in January which showed the distribution of chemical dependency treatment centers throughout the state. There was a

good distribution throughout the state and no areas of great concern were foreseen.

Dr. Gates asked if licensure would change that?

Ms. Bruesehoff said she felt that they were well distributed.

Mr. Hiendlmayr reminded the Council Members that the MHA commentor indicated that she would expect that since hospital members complain about the lack of practitioners in a number of other specialty areas in terms of their availability in rural Minnesota, there might be the same kind of problem with chemical dependency practitioners. She did state that it was only an assumption and that it was not based on any evidence that any particular hospital or any particular area of the state had already declared a shortage of such practitioners.

Dr. Gates stated that it may cause a maldistribution. Ms. Bruesehoff stated that she did not think it would.

Ms. Domning stated that she felt that either the facts would be available, or there would be strong opposition by the MHA or the Minnesota Medical Association (MMA) when the licensure bill got to the Legislature.

Mr. Adams added that if chemical dependency counselors were able to do direct third party billing, they would no longer be so dependent on physicians, supervisor, nurses, buildings. They would be able to set up a private practice.

Mr. Brekken stated that currently if they wanted any type of reimbursement through the public system or insurance companies, they would not be able to set up a private practice. They would have to meet all the state regulations and licensing requirements for a chemical dependency program. They could go out and open up a program in their backyard and work with less than five people, but how they would receive payment is the question.

Chair Madsen stated that was with the current reimbursement system, but there is currently no occupational licensure in the system.

Mr. Brekken responded by saying that if licensure were in effect today, he did not see that anything would change. As long as a practitioner were seeing five or more people they would have to be licensed through DHS and MDH to operate that facility.

Ms. Domning asked if Mr. Brekken was referring to the facility that is a general medical facility, but if a person had a chemical dependency facility, are there regulations that said within that chemical dependency facility you have to have these individuals. Mr. Brekken said that was correct. Ms. Satre stated that it would be pretty hard to get around that.

Mr. Brekken added that he felt that the CDRC did indicate that they did not know how many independent practitioners were out there now. The state does not

know either because it does not pay for those services.

Ms. Satre asked if she was correct in understanding that as far as the state was concerned, no one serving more than five people could be on their own and licensure would not really change in the way it did for social workers.

Dr. Gates stated he wanted to be sure that licensure would not facilitate a subsequent movement towards independent practice.

Ms. Satre stated that she felt that the regulations were geared more towards buildings and they are harder to change.

Mr. Brekken added that the building regulations are within MDH and the DHS regulations deal more with program qualifications, the staff and what can be done to improve the program and operations.

Chair Madsen added that it would be a regulation in the absence of other regulations. There have been a lot of arguments that say, in essence, get DHS and MDH out of the business. Let DHS and MDH concentrate on the buildings, the budgeting and the administrative problems. If granted licensure, a board would be created, and that board would take care of the scope of practice and individual practitioner issues.

Dr. Gates stated that he thought licensure would facilitate the move toward more independent practice, relying upon those existing statutes with the presence of licensure might be erroneous.

Chair Madsen reminded Council Members that a yes vote meant they thought that there would be an overall positive economic benefit; a no vote would mean that there would not be an overall positive economic benefit; and an abstention would mean that you did not know.

Chair Madsen asked if there was any other discussion. Hearing none, he asked the Council to vote. The motion carried: 3 voted yes; 0 no; 3 abstained.

Chair Madsen asked what 3 yes votes, 0 no votes and 3 abstentions did to the motion.

Mr. Hiendlmayr asked if the abstention votes were counted as negatives to defeat the motion because the motion did not have a majority of those voting.

Dr. Gates stated that in the case of ties the Chair had to vote.

Ms. Satre, said that there was not a tie because abstaining members did not vote no. She argued that there is only a tie if votes say no. Once one abstains, then you change the number of people voting. On the previous motion there were only three people voting. A quorum has to be present, and the majority of the voters have to say yes.

Mr. Hiendlmayr asked if it would be a correct understanding if the Commissioner were to read the abstentions as "I do not know" votes. Chair Madsen answered

in the affirmative. He had wanted to clarify that before the vote.

VI. Other HSOAC/CDRC Business

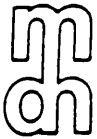
Chair Madsen stressed the importance of everyone attending the June meeting. It would be the last official meeting for the HSOAC and he asked that members make a great effort to be on time so that they could discuss and vote on criteria 3.

VI. ADJOURNMENT

The HSOAC meeting adjourned at 4:00 pm.

Respectfully Submitted,

Kimberly Phipps



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MEETING AGENDA

HUMAN SERVICES OCCUPATIONS ADVISORY COUNCIL

June 1, 1990

1:00 - 4:30 P.M.

Minnesota Department of Health

Room #105

- I. Call to Order and Approval of Minutes
(Minutes will be distributed at the meeting.)
- II. Sister Mary Madonna Ashton, Commissioner of Health
- III. Program Update
- IV. HSOAC Deliberation: Criterion 3 - Other Means of Protection
- V. HSOAC Deliberation: Recommendations Concerning Regulation
- VI. Other Business
- VII. Adjournment



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Date:

To: Members of the Human Services Occupations Advisory Council and Interested Parties

From: Health Occupations Staff

Subject: June 1, 1990 HSOAC Minutes

Members Present

Bill Madsen, Chair
Alex Adams
Phil Brekken
Marianne Bruesehoff
Judy Domning
John Gates, M.D.
Paul Hammonds
Rose Hamerlink
Gretchen Musicant
Marjorie Ross
Anne Satre
Linda Sutherland

Members Absent

Marsha Studer
Judy Walker

Staff Present

Kathleen Burek
Tom Hiendlmayr
Kay Markling
Kim Phipps

I. CALL TO ORDER AND APPROVAL OF MINUTES

Chair Madsen called the Human Services Occupations Advisory Council to order at 1:05 p.m..

Chair Madsen asked for approval of the May 11, 1990 minutes. Mr. Hiendlmayr indicated that there was one correction. On Page 13, paragraph 3, line 5, the phrase "... has a client information system called a unique client identifier." The word called should be changed to the word "with ...". The minutes were approved with that change.

II. Sister Mary Madonna Ashton, Commissioner of Health

Chair Madsen introduced Commissioner Sister Mary Madonna Ashton.

Commissioner Ashton said she wanted to come before the Council to thank them for the contribution they had made to this particular activity in the department. As the Council members all knew, this was the last meeting and everyone in the Executive Office of the Minnesota Department of Health (MDH) was saddened about that because they felt the Council conducted an important function within the department.

Commissioner Ashton stated that she felt the Human Services Occupations Advisory Council (HSOAC) would be reactivated again as it was in the past. She went on to say that when it was reactivated in 1985, some improvements were made in terms of the process. She was impressed with the accomplishments made since 1985 when compared to what the previous Council had accomplished.

Commissioner listed all the reviews the Council had done since 1985. They were: Social Workers; Marriage and Family Therapists; Mental Health Counselors; Acupuncturists; Speech-Language Pathologists & Audiologists; Hearing Instrument Dispensers and Sellers; Spectacle Dispensers; Contact Lens Technicians; Respiratory Therapists; Occupational Therapists; Naturopathic Physicians, Dietitians/Nutritionists; and Chemical Dependency Counselors. She said she had the understanding that the Council would finish chemical dependency counselors and thus put that particular group to rest. She stated that there were three groups that the Council would not review, and they would be held over in the hopes that the HSOAC would be refunded. Those occupations were: the Board of Unlicensed Mental Health Practitioners, Lay Midwives, and Radiologic Technologists. She stated some concerns about the Radiologic Technologists. There was not much MDH could do about that.

Commissioner Ashton told the Council that the Legislature did not repeal Minn. Stat. 214, and when funding was available the HSOAC would be reactivated. As has happened in the past, the Legislature will have occupational groups asking to be regulated by the State. Not being able to withstand the pressure, the Legislature may refund the HSOAC.

Commissioner Ashton stated that she knew from reading the minutes and talking with staff within MDH, that HSOAC put a lot of thought, time and concern into the evaluation of the occupations. That hard work had been extremely helpful in her decision-making. She felt that because she received such good advice from both the Council and Staff, she felt she was in a much better position to decide for the good of the people of the State of Minnesota.

Commissioner Ashton said she especially wanted to thank Mr. Bill Madsen as he had been Chair since the HSOAC started in 1985. She knew it had not been an easy job keeping people on the track and she really appreciated the time and effort he put into this. She wanted to publically thank the Staff, especially Tom and Kathy, who she knew spent a lot of time and energy on the research.

Commissioner Ashton conveyed hope that if or when the HSOAC was reactivated that some would be willing and able to serve again.

III. PROGRAM UPDATE

Mr. Hiendlmayr stated that Ms. Judy Walker called to indicate that she would not be able to attend today.

Mr. Hiendlmayr told Council members that a representative of the Chemical Dependency Regulation Coalition (CDRC) informed staff that the National Certification Reciprocity Consortium of Chemical Dependency Counselors has contracted with the Educational Testing Service to develop a national exam. That exam would be based on a job analysis conducted according to accepted

standards for developing certification examinations.

Mr. Hiendlmayr then informed the Council that Staff had received material from an organization called Narconon. They are an international substance abuse treatment program with a Minnesota chapter. Mr. Hiendlmayr stated that he called a representative of the Minnesota chapter and informed them that while the information was received too late for the Council to review it, Staff would review it.

Ms. Gretchen Musicant asked Mr. Hiendlmayr if he would inform them of the basic contents of the Narconon material. Mr. Hiendlmayr responded by saying that most of the material received was general and descriptive. It was treatment processes based on a philosophy by Ron L. Hubbard, whose is the leader of the Church of Scientology. The primary point that Narconon wished to make was that they were not represented by the CDRC. They constitute a different treatment approach and they are opposed to licensure for that reason.

Ms. Musicant asked if those people would be subject to the licensing. Mr. Hiendlmayr stated that if licensure were adopted as the mode of regulation, those practitioners would be required to be licensed and meet the minimum entry level requirements.

Mr. Brekken asked if Mr. Hiendlmayr knew if Narconon operated any licensed facilities within the state of minn. Mr. Hiendlmayr replied that he was not aware of any currently operating facilities, but thought that they were in the process of trying to develop one or set one up. He stated that the material did not provide a lot of detail.

Mr. Delbert Cory representing Narconon, informed the Council that he was attending the meeting so that if anyone had any questions, he would answer them. Mr. Brekken asked Mr. Cory if Narconon had a licensed facility in Minnesota. Mr. Cory stated that they did not have one presently, but they were in the process of setting one up.

IV. HSOAC Deliberation: Criterion 3 - Other Means of Protection

Chair Madsen gave a quick review of the May meeting. The Council voted 6-0 in favor of public harm and specialized skills and training. Cost effectiveness and economic impact, had 3 voting yes and 4 abstentions. The last Criterion left to be reviewed was number 3.

Dr. John Gates moved that Minnesotans are effectively protected by other means. Mr. Phil Brekken seconded.

Dr. Gates stated that they had already discussed the fact that facilities were licensed by DHS and MDH and that presumably through that licensing process there were effective means for addressing the delivery of services.

Chair Madsen asked Dr. Gates if he had an opinion as to whether or not those were sufficient. Dr. Gates said that in his opinion the current modalities were not sufficient. His main concern was with the independent practitioners;

no one was regulating their practice.

Mr. Phil Brekken indicated that the facility license very rarely reached the individual practitioners within that facility. The only time that an individual may be affected by the facility license would be the initial qualifications set forth in the personnel office. Mr. Brekken gave an example of the lack of authority DHS has regarding individuals. A probation officer had called Mr. Brekken to find out why a chemical dependency facility in his community was still operating with a license. The director of the facility had been arrested on a felony charge, convicted, and given probation. He was allowed to continue as the director of that facility and a judge had ordered a juvenile to go to that facility for treatment. Mr. Brekken asked the probation officer to write up a complaint and submit it for investigation. The probation officer replied that he had already done that and nothing had been done about it.

Ms. Satre felt that there was a lack of education. That had not been addressed by any means that were currently in place.

Chair Madsen said that there may be some deterrents as far as sexual contact with clients because of the laws regarding that.

Mr. Hiendlmayr asked Council members to what extent did Members perceive that chemical dependency counselors were supervised by other regulated practitioners or a service delivery scheme? Mr. Hammonds stated that he felt there were several other existing boards that could regulate chemical dependency counselors. Dr. Gates indicated that he felt that this was a profession that had a scope of practice that was clear and no other professions had that scope of practice. He said it would be like asking an electrician to supervise a carpenter, it would not be appropriate. He went on to say that in the area of diagnosis of medical maladies, there are knowledgeable experts in other professions.

Mr. Hammonds asked if that would be addressed under this particular motion or under the rules? Mr. Hiendlmayr replied that the question was trying to determine if Minnesotans were currently and effectively protected by other means; it was asking are chemical dependency counselors supervised by practitioners who are already regulated.

Chair Madsen stated that some were and some were not. He asked Mr. Hammonds who supervised chemical dependency counselors at Group Health. Mr. Hammonds replied that they were supervised by psychiatrists. Ms. Satre said that she felt that psychiatrists might not have sufficient chemical dependency knowledge. Mr. Hammonds stated that in Group Health patients were usually referred by their primary physicians who followed along. Dr. Gates said that was called collegial interface.

Ms. Marianne Bruesehoff stated that she thought the Council had heard ample testimony that current rules and regulations were not working. She went on to say that part of the problem was that chemical dependency counseling was a new field.

Mr. Alex Adams reiterated that the Council did agree that there was public harm, and that the occupation did require specialized skills and training.

Dr. Gates stated that he wanted to verify that a vote of yes meant that one agreed with the motion. Chair Madsen said that was correct.

Chair Madsen asked if there was any other discussion. Hearing none, he asked the Council to vote. The motion was defeated: 0 voted yes, 11 voted no, 0 abstained.

Dr. Gates moved that Minnesotans may be (more effectively and efficiently) protected by other means. Seconded by Mr. Brekken.

Mr. Hiendlmayr stated that under this motion two discussion issues had been set out, one was were there other statutes or rules which appear to apply to the functions performed by the applicant group. He felt that the Council should discuss the regulation of other mental health practitioners, the licensing rules regulating programs, etc. The other was what issues or questions needed clarification or resolution to determine whether Minnesotans were effectively protected by other means. The Council should try to identify unresolved issues in existing regulatory schemes that needed to be addressed in order to say, Minnesotans were effectively protected.

Dr. Gates stated that the only regulatory scheme he felt applied was the generic Board of Unlicensed Mental Health Practitioners (BUMP) and those rules say, basically, that if they do not abuse patients, everything will be fine.

Ms. Satre said that the problem she had with BUMP was that most chemical dependency counselors were exempt because their place of employment was exempted in the BUMP rules. If the Council recommended that the BUMP oversee the chemical dependency counselors, they were automatically exempt.

Mr. Brekken stated that even if chemical dependency counselors were listed with BUMP it was only a registration system and the public harm would continue.

Dr. Gates stated that other than sexual abuse, the chemical dependency counselor could get into trouble.

Chair Madsen stated that the BUMP regulation included things other than sexual abuse.

Ms. Satre said that Dr. Gates was referring to the sexual abuse laws.

Dr. Gates asked how effective would that be, it was a new law.

Mr. Hiendlmayr clarified for the Council that BUMP issued a permit and there were no minimum entry requirements in terms of training and education that were necessary in order to obtain that permit. It was called a regulatory scheme that was not credential based.

Ms. Domning said that it was functional.

Chair Madsen stated that it did have the possibility of revoking someone's permit for improper conduct.

Mr. Hiendlmayr stated there was an extensive code of ethics and a patient bill of rights that was far more extensive than anything that existed for any other human service delivery practitioner included in that statute.

Chair Madsen stated that was an existing mechanism that could be recommended in lieu of the exemption.

Mr. Brekken reiterated that it did not address educational requirements, it did not set forth any minimum standards.

Dr. Gates added that it did not address anything regarding scope of practice.

Mr. Hiendlmayr said that it did not attempt to make delineations or distinctions in scope of practice it merely defined mental health service functions in a general way and said that if someone was performing those functions they were required to apply for a permit from the BUMP unless they were exempted under the statute or rule.

Chair Madsen stated that that was the type of regulation that he would like for mental health fields across the board. He felt that the evidence⁴³³ that the educational credentials did not have a significant effect on practical competence. There has been a lot of research that clearly said no, those educational requirements were not valid predictors of competent practice. Therefore, a system that was more restrictive in terms of credential basis in this field seemed to him to be unwarranted, and interfered with rights to employment.

Ms. Satre asked anyone to name a job that did not require training beyond high school. She stated that other than working in a store as a cashier, stocker, etc, they just did not exist anymore.

Ms. Bruesehoff stated that she agreed with Chair Madsen. She felt that the primary characteristics that made up a good mental health counselor could not be learned out of a book. Characteristics such as ethics, personality, character. The second part of her statement was if no one was educated, how were standards of performance assessed: by a whole bunch of no-no's?

Dr. Gates stated that he felt that there were skills that had to be learned. It was not intuitively obvious when an individual was developing Wernicke's encephalopathy or developing a significant polymyopathy.

Mr. Adams asked if BUMP was not the answer, why couldn't the facility rules be rewritten in such a way as to require the counselors to have certain educational requirements, and to give the facilities the power to dismiss persons that were in violation of ethical practice.

Mr. Brekken stated that that was easier said than done. He said it would probably be just as fast and efficient to develop a new, separate regulatory process for the chemical dependency counselors as it would be to revise

existing regulations. .

Chair Madsen said another issue was funding, it is statutory requirement that the occupational regulatory schemes be self-supporting.

Dr. Gates pointed out that the licensure and registration regulatory modalities had a peer review process that actively involves the professionals. The permit system, however, did not necessarily involve peers in a review process. That was another important issue.

Mr. Adams stated that the Council felt that this occupation could be, may be regulated by other means, but to upgrade the current regulations would be lengthy, expensive and difficult.

Ms. Satre pointed out that the motion reads "more effectively and efficiently" which implies that it was to be compared with licensure or registration.

Chair Madsen stated that he read that motion to say that it was a good possibility that the other protection might work.

Mr. Hammonds asked how the clinical side of the issue would be addressed. Dr. Gates stated that it would be addressed in registration. A board would be set up and practitioners registered through that board would be required to show evidence of training.

A Council member asked how the exemptions were listed in the BUMP rules. Chair Madsen stated that persons working for the government, hospitals, nursing homes, or certified by ICDP were exempt.

Ms. Bruesehoff asked if that could be repealed.

Mr. Hiendlmayr stated that one of the reasons for creating the task force that would review the BUMP was that the number of individuals supposed to be covered by that statute had been greatly reduced. The decreased number of applicants created a resource problem for that board in terms of funding in order to investigate complaints. The complaints pertain to mental health practitioners of all types.

Ms. Linda Sutherland stated that in order to repeal the exemptions one would have to go back to the Legislature and ask them to change the law.

Ms. Bruesehoff asked how effective a registration system would be if it was not based on credentials, education, etc. Mr. Hiendlmayr responded by saying that registration could be restrictive (even though it was voluntary) in its impact if the titles protected were great in number and expansive in their meaning.

Chair Madsen stated that the question really referred to the BUMP permit system.

Ms. Bruesehoff stated that the state and counties were opposed to having their employees included.

Ms. Sutherland reminded Council members about the strange process by which the BUMP was created. The Legislature was looking at the regulation of several occupations that seemed alike. Finally, three separate boards were created and set up, Social Workers, Marriage and Family Therapists, and the rest were put under the umbrella board of BUMP. Lobbying to get certain public employees and practitioners who worked under certain kinds of supervision began early and was loud. Registration of public employees would not have a great economic impact.

Chair Madsen asked if there was any other discussion. Hearing none, he asked the Council to Vote. The motion was defeated: 1 yes; 7 no; 2 abstained.

V. HSOAC Deliberation: Recommendations Concerning Regulation

Mr. Hiendlmayr explained the modes of regulation.

Mr. Adams asked if any of the regulations were any more expensive to implement and administer than the others? Mr. Hiendlmayr responded by saying that studies that had been done indicated that there was a cost to any regulation, and there was a presumption that the more restrictive the regulation, the greater the cost. But there were no studies to indicate what the differences were between the cost of licensure vs. the cost of registration.

Chair Madsen stated that most of those studies had been done in terms of an existing regulation becoming more restrictive over time.

Ms. Bruesehoff stated that she was confused about exemptions. She asked if there were exemptions within the Marriage and Family Therapy Rules/Statutes and if so, what names did they use. Mr. Hiendlmayr responded by saying that he would have to check the statutes for the exact language, but if someone called themselves a marriage and family therapist they had to be licensed by the Board of Marriage and Family Therapy. Individuals who are waived from the requirement to be licensed who perform marriage and family therapy services included psychologists and social workers who were licensed by their respective boards. The licensure law for marriage and family therapy had exempted other licensed practitioners of similar mental health services who practiced within the scope of practice for their respective occupations.

Ms. Bruesehoff asked if there was any way that the exemptions could be restricted no matter what mode of regulation the Council recommended. Chair Madsen stated that the HSOAC could make recommendations, but the Legislature would do what it wanted.

Ms. Satre asked if Hennepin County could choose to require that their social workers be licensed, or did that statute forbid that. Ms. Sutherland responded by saying that it could be made a part of employment conditions. It would be written in the contract (union). It would be up to the Administration, if they wanted to make the licensure a requirement for employment they could do so.

Ms. Bruesehoff asked if a person were currently employed by someone, and the requirements changed, from registration to licensure or from no regulation to whatever, would it be the responsibility of the employer to make sure that the

employee was educated enough to meet the requirements?

Mr. Brekken stated that the representative of the Minnesota Department of Employee Relations expressed concern about the people at the regional treatment centers and state hospitals being able to meet the requirements. Mr. Brekken was of the belief that they would meet the qualifications that had been established by the CDRC.

Ms. Sutherland stated that Ms. Bruesehoff was asking if the employer would be responsible for upgrading their employees credentials/training to meet the new requirements. She did not think that was a general practice, some unions may bargain for it.

Chair Madsen stated that the Council was in between motions. He wanted to review what the different modes of regulation were prior to proceeding to voting on what mode might be most appropriate.

Mr. Hiendlmayr stated that as a concept, licensure envisioned applicability to everyone who performed the defined functions. Political realities are such that that gets cut away at by the use of exemptions or waivers to reduce the applicability of that mandatory or universal application and certain individuals or groups are then not required to have a license.

Ms. Sutherland stated that in the case of the social worker's, it was in their own best interests for all social worker's, including the county, state, etc., even exempted ones, to become licensed during the grandfathering period. The message that relays later on to the individual that would be competing in future jobs is that persons who are licensed may have the advantage over them. It could be a requirement for employment. Even if a social worker applied with a county, if all the other applicants had their license the chances of getting the job would be narrowed down quite a bit.

Dr. Gates moved that it is necessary to regulate the heretofor uncredentialed or unregulated practice of chemical dependency counseling by implementing a licensing system to permit practice by those recognized by the state and to prohibit practice by unqualified persons. Mr. Brekken seconded.

Chair Madsen asked for discussion.

Ms. Bruesehoff asked at what point a person could add an amendment that said essentially there be almost no exemptions to licensure. Chair Madsen stated that amendments could be added at any time.

Ms. Bruesehoff moved that there be no exemptions.

Mr. Brekken stated that he could not agree with that motion because he felt there may be some appropriate exemptions somewhere. He would not like to add that motion at this point in the process. He preferred to have it later as a recommendation.

Dr. Gates stated that he felt it might sabotage the motion and there were enough vehicles to do that.

Ms. Bruesehoff stated that she would see currently licensed persons as being exempt. She stated that she was trying to get at the state, county and licensed facility employees.

Mr. Brekken stated that the issue of exemption would be debatable even with licensed psychologists who had one or two years of chemical dependency training or services and may not be up to established requirements.

Mr. Hiendlmayr asked if the amendment was meant to restrict exemptions that apply to individuals in work settings but not to individuals that were currently registered or licensed by other boards. Ms. Bruesehoff stated that was her intention.

Chair Madsen asked for a second. Hearing none, the motion died. He added that the tone of the Council made it sound as though that motion may be supported at a future point of time.

Dr. Gates stated that he would basically like to endeavor to champion the perspective that this group had indeed identified the scope of practice and public harm issues. He went on to say that licensure was a double-edged sword: the aegis of autonomy that is afforded by it must be balanced against the protection potential. He felt that registration was appropriate and that licensure would be a step too strong. As had been shown by previous occupations, as they grew they developed into a more professional group as opposed to the Coalition that constitutes this particular group. He stated that he was totally unimpressed with the curriculum that he was shown in terms of the medical diagnoses, and affording the chemical dependency counselors the aegis of credibility through licensure made him uncomfortable. The registration system can be effective if appropriately applied. He cited as an example the physician assistants, they were registered in the State of Minnesota and that registration system was overseen by the Board of Medical Examiners.

Mr. Hammonds asked if he heard correctly that the registration system for physicians assistants was under the board of medical examiners? Chair Madsen stated, yes they were, he added that a registration system need not be under a licensing board.

Mr. Hammonds stated that there was no assurance that if registration were the mode of regulation that it would be under one of the boards. Dr. Gates stated the Council could certainly make that recommendation.

Ms. Satre disagreed. She felt it was unfair to compare the kind of registration that chemical dependency counselors would have to the physicians assistants. She stated that the name physicians assistant implied that that person was going to be working almost one on one, very close with, or supervised by a physician. She stated that felt that the scope of practice needed to be protected as well. It had been defined as a body of skills and knowledge that was required.

Ms. Domning asked if the Council could change their vote on licensure. Chair

Madsen stated that they could make changes in that. Dr. Gates said that what the Commissioner and Legislature did was their business.

Mr. Hammonds asked Ms. Satre if she was satisfied with the education requirements? Ms. Satre said she was not. She felt that they should have a four year degree. The problem was that the schools that currently have some chemical dependency counselor training were not ready to go to a four year degree. She stated she would much rather have two years as opposed to no training whatsoever. She has talked to the public, regular people. Everyone she had talked with did not realize that chemical dependency counselors were not already regulated in some way by someone.

Mr. Brekken stated that he had not seen any evidence that registration was going to be anymore effective than all the other modes of regulation currently in existence. Dr. Gates stated that he disagreed with that.

Chair Madsen stated that the permit system had more clout in it than registration did. With the permit system the permit could be revoked and the person would not be able to practice. With a registration system, the registration would be revoked and the person could continue to practice, the only restriction is that they would not be allowed to use the protected titles anymore. Mr. Hiendlmayr stated that was why he put permit next to licensure in terms of its mandatory character and its restrictiveness. Dr. Gates added that the problem with a permit was that it did not require any education.

Mr. Hammonds stated that chemical dependency counselors had only an associate degree, and nurses were required to have more education than that.

Ms. Satre stated that it had to start somewhere. The Council could also recommend a four year degree.

Ms. Bruesehoff stated that revoking someone's license required a lot of legal maneuvers. She then asked if the revocation of a permit required the same sort of legal maneuvers. Mr. Hiendlmayr stated that when a license or permit was revoked, and the person's right to pursue their livelihood was denied, that denial was impacting a person's constitutional right.

Ms. Bruesehoff asked if the removal of either the license or permit had to go through the Attorney General's Office? Mr. Hiendlmayr replied that the answer was a complicated one. When a licensing board is created, they use the Attorney General's Office to do the investigating, prosecution and enforcement. MDH, in legislation, had been given the authority to do those things regarding hearing instrument sellers who had been issued permits by the Commissioner of Health. It would depend on how the law was written.

Chair Madsen stated that the Attorney General's Office did not operate independently. They provided the service on a contract basis.

Mr. Adams said the problem with permits was that someone could claim that the violations they committed had nothing to do with the permit system, therefore, the permit could not be revoked.

Ms. Bruesehoff asked what powers the boards would have then.

Mr. Hiendlmayr said that Boards in Minnesota are administrative mechanisms for receiving applications, verifying qualifications, issuing a license, and receiving complaints. The Boards then refer the complaints to a complaint committee of the Board who then passes it on to the Attorney General's Office for review. If a review by the attorney general according to their priority system results in any kind of investigation or enforcement action, then a report is sent back to the board and they make some sort of determination as to whether or not a sanction is necessary and what that sanction should be. Then they essentially enter into negotiations with the licensee as to what the outcome would be. That would be a quick description of the procedure followed for a licensee. For someone who is performing the function and is not a licensee, and a complaint is received about them, the board would refer it to the attorney general's office and essentially, the attorney general would have to decide whether there is a violation of criminal law and refer it to the county attorney for prosecution and work with the county attorney in that prosecution, or alternatively, determine the extent to which the public is at risk of harm and there might be a basis for obtaining an injunction against that individual and getting a district court to issue a cease and desist order.

Chair Madsen said that he would like to add that, in psychology, that occurrence was very very rare. Unless the person was doing something that was highly outlandish, that is to say, if the board of psychology gets a complaint about somebody doing psychology and doing bad things who was not licensed, then a referral would go to a county attorney who would look around and say, how important is this given my caseload of stuff to prosecute. In most cases it was not a primary concern. Case in point would be the use of psychological tests by a variety of people. In particular is the Myers-Briggs, which everyone in the world uses like astrology. A lot of psychologists think that it is atrocious that everyone is doing that, but what county attorney is going to prosecute somebody who is in essence doing astrology stuff with Myers-Briggs. The answer is none.

Ms. Bruesehoff asked if there was any clout in these regulatory schemes.

Mr. Hiendlmayr stated that there certainly was. The record has been that in most cases individuals who are subject to administrative proceedings make changes in their conduct. A notice from the administrative agency or the attorney general is sent and it states that, number one there has been a violation of law; number two these facts have been found and number three here is what you (the practitioner) have to do or here is what we (the Board) will do. In 90 - 95% of the cases, an agreement is reached between the party and the Board as represented by the Attorney General's office, for discontinuance of illegal conduct.

Dr. Gates said another perspective of licensure is that it affords independence of practice, a less supervised practice setting for less qualified individuals. The Council stated that it was uncomfortable with the degree of education afforded this group.

Ms. Musicant asked whether in an elaborate registration system there was the

ability to apply some sanctions, or mechanisms used by the licensing boards could be used here.

Mr. Hiendlmayr stated yes. Another way to think about that would be, licensure was a permit plus registration. Registration was a license without the permit feature, and a permit was a license without the registration feature of being credentially based.

Ms. Satre asked if her understanding was correct in that the permit described the functions, registration described the names used, and licensure described both. Mr. Hiendlmayr said yes, that was correct. The legislation that was done for hearing instrument sellers was both a permit and a registration system. The permit and registration systems were separate, but they apply to the same group of practitioners. Every hearing instrument seller was required to have a permit, but registration was voluntary and one of the titles to be protected was hearing instrument dispenser, and there are others. The regulatory schemes were separated, but they work together, one was mandatory, one was voluntary. When BUMP was created the intent was to have a permit system that would apply to everyone, and over time, specific groups of practitioners who should be registered or licensed would be identified.

Chair Madsen asked if there was any other discussion. Hearing none, he asked the Council to vote. The result was: 5 yes, 5 no, 1 abstention. The Chair voted against licensure to break the tie. The tally then was 5 yes, 6 no, 1 abstention.

Dr. Gates moved that it is necessary to regulate the heretofor uncredentialed or unregulated practice of chemical dependency counseling by implementing a registration system to restrict the use of occupational title, create an official roster and establish qualifications. Mr. Brekken seconded.

Mr. Adams stated that the Council had heard very convincing arguments over the last several months in all four criteria areas. He felt that the applicant group proved that there was just cause to require some sort of regulation. The applicant group sought licensure. The Council felt that was a little too strong considering the amount of education and autonomy of practice. The Council felt strongly that the needs of the group could be met by registration. He said that he agreed with Ms. Bruesehoff that exemptions should be kept to a bare minimum.

Chair Madsen said that he felt the reason for all of the exemptions was that the permit was a new mode of regulation. He went on to say that the Legislature was not pleased with MDH's proposal about the Social Workers, etc. The Legislature was aggravated that MDH suggested a regulation (permits) that did not exist in statute. The Legislature then turned around and adopted that permit system.

Ms. Musicant asked if they could define registration so that it was more like the permit system. Mr. Hiendlmayr stated that because registration was defined in law it could not be changed. Permit was not defined in law, but there was authority in law to create that system because of the theory that if you have authority to do a greater thing you have authority to do the lesser.

Chair Madsen stated that one variation in terms of combinations of each of these things was that there could be registration combined with permit but without the restrictiveness of licensure.

Ms. Bruesehoff asked Chair Madsen to say it again.

Chair Madsen reiterated that with licensure, only persons holding a license in chemical dependency counseling could work in that occupation. However, with the combination of registration and permit, only persons holding a permit or registration could call themselves a chemical dependency counselor. Someone could call themselves a guru and practice in the field of chemical dependency counseling.

Chair Madsen asked if there was any other discussion. Hearing none, he asked the Council to vote. The motion carried: 8 yes, 1 no, 2 abstained.

Chair Madsen asked if Ms. Bruesehoff wanted to make a motion in regards to exemptions.

Ms. Bruesehoff moved that there be no exemptions based on place of employment or employer. Seconded by Dr. Gates.

Mr. Hiendlmayr stated that he wanted to clarify something. He asked if the motion was essentially a recommendation to apply to the permit requirement, or was the motion to apply to the registration scheme that had just been recommended?

Dr. Gates stated that they did not want people exempted from the registration system.

Mr. Hiendlmayr stated that registration was voluntary as defined in law, so people could choose to not be registered and they would be within the law.

Chair Madsen added that those people would not be able to call themselves chemical dependency counselors.

Dr. Gates stated that in the setting up of the registration process there should be no waivers, exemptions, etc for people to be excluded and still be able to call themselves chemical dependency counselors.

Mr. Hiendlmayr asked if the Council wanted no exemptions to restrictions on the use of title. Dr. Gates replied that was correct. The Council did not want someone to be exempt just because someone worked for the state; and they would not be able call themselves a chemical dependency consultant, if that was one of the aka's for example, and not be registered.

Chair Madsen stated that all persons would have to have the educational requirements, pass the exam, etc, in order to be registered.

Ms. Bruesehoff asked if Mr. Hiendlmayr was saying that under a registration system, people could choose to not be registered, that it was a totally

voluntary regulation system.

Mr. Hiendlmayr said yes, that was correct, but he added that those choosing not to register could not use a title that was protected by that registration system.

Dr. Gates said that the state was not likely to not use the titles. That is to their convenience not to do that. For example, the state is not likely to call them substance abuse counselors, simply because they do not have to be registered. They will call them chemical dependency counselors. He thought the argument was circular.

Ms. Musicant said it did raise an interesting question though. She asked if the Council wanted to make a comment on the BUMP exemption as well? Dr. Gates stated that they could certainly comment that it stinks. He then said that the Council would like to recommend that the exemptions in the BUMP laws be given careful examination.

Mr. Hiendlmayr stated that in all fairness to the applicant group and the occupational group, the Council should make all recommendations they deemed appropriate, and what other bodies, entities, task forces, etc., did with it, so be it.

Chair Madsen asked Ms. Bruesehoff if she wanted to leave the motion as clarified, that she was speaking about the registration process, or did she want to extend it to the BUMP? Ms. Bruesehoff stated that the registration system was her primary concern at present.

Chair Madsen asked if there was any other discussion. Hearing none, he asked the Council to vote. The motion carried: 9 yes; 1 no; 1 abstained.

Mr. Adams moved that if aka's could be included, that they would encompass persons calling themselves chemical dependency counselors. Seconded by Dr. Gates.

Dr. Gates said they should probably mention as many aka's as they could.

Chair Madsen said it could be worded to read "including but not limited to."

Mr. Hiendlmayr said it needed to convey the Council's intent to cover as many titles as possible.

Mr. Adams stated that was his concern.

Various Council members offered the following titles: Substance abuse counselor, drug counselor, codependency counselors, addiction counselor, chemical health, etc.

Chair Madsen asked if Mr. Adams, being the motion maker, accepted that amendment with the intent and rationale. With particular concern about the codependency piece.

Mr. Brekken asked Mr. Adams if he was referring to the people who purported to be codependency counselors? Mr. Adams stated it was people who were doing chemical dependency counseling and after being investigated were calling themselves codependency counselors, and therefore, dodging the current regulatory system.

Chair Madsen added those that might try to dodge the registration system by calling themselves codependency counselors, which would give them some credibility then, conceivably, in that title.

Chair Madsen asked if there was any other discussion. Hearing none, he asked the Council to vote. The motion carried: 10 yes; 0 no; 1 abstention.

VI. Other Business

Chair Madsen stated that procedure required that the Council approve the document that the Staff wrote up regarding the Council recommendation. In the past the report had been sent to the Council members and any changes desired were communicated to the Staff; they made a decision as to whether or not the change was substantive enough to contact the rest of the Council. If it was not, the report would be approved as written.

Chair Madsen asked Mr. Hiendlmayr if the Council would be given a deadline for reporting any changes? Mr. Hiendlmayr responded in the affirmative.

Chair Madsen asked if there were any objections to that method of operation? Hearing none, he asked if there was any other business.

Dr. Gates stated that he would like to read a quote from Alice in Wonderland, by Lewis Carroll. He felt that there was some marvelous material in Alice in Wonderland to cover the proceedings conducted by this Council over the years.

The quote he wanted to end with was from Tweedle Dum and Tweedle Dee, as follows:

The time has come the walrus said
to talk of many things,
of shoes and ships and sealing wax,
of cabbages and kings.
Why the sea is boiling hot,
and whether pigs have wings.

VII. ADJOURNMENT

The HSOAC meeting adjourned at approximately 3:20 pm.

Respectfully Submitted,

Kimberly Phipps

APPENDIX F

BUDGET PROJECTIONS

A. Assumptions, rationale, computations of estimated costs and revenues.

COST ITEMS	FY 92	FY93	FY94	FY95
Personnel ¹ :				
Exec. Director	42,000	43,680	45,427	47,244
Executive 1	29,520	30,700	31,929	33,206
Clerk Typist 3 ²			27,256	28,347
Clerk Typist 2	<u>24,000</u>	<u>24,960</u>	<u>25,958</u>	<u>26,997</u>
Personnel Subtotal	95,520	99,340	130,570	135,794
Supplies and Expenses				
Rent	10,327	10,327	10,327	10,327
Office Equipment	32,000	1,000	1,000	1,000
Computer Equipment	16,000	1,000	1,000	1,000
Repairs/Maintenance	500	500	500	500
Printing	2,000	1,000	1,000	1,000
Consultant Services ³	5,000	5,000	2,500	1,000
Data/Systems Svcs.	3,000	5,000	1,000	1,000
Professional Svcs. ⁴	11,000	15,000	8,000	8,000
Mail/Phone System	6,000	6,200	6,400	6,600
In-state Travel	7,500	8,000	8,500	9,000
Out-state Travel	3,500	4,000	4,500	5,000
Fees ⁵	8,500	8,500	8,500	4,250
Supplies	2,500	2,700	2,900	3,100
Misc. Expenses	<u>2,500</u>	<u>2,700</u>	<u>2,900</u>	<u>3,100</u>
Supply & Expense Subtotal	<u>110,327</u>	<u>70,927</u>	<u>59,027</u>	<u>54,877</u>
TOTAL COSTS	\$205,847	\$170,267	\$189,597	\$190,671

¹. Salary estimates are based on FY 91 compensation agreements, include 20% fringe benefits and assume 4% wage increases each fiscal year.

²Licensing administration, application and renewal.

³Licensing examination development and administration.

⁴Rulemaking costs in first two years; Attorney General costs in each year of operation for investigation of complaints and enforcement actions.

⁵Board member per diems, assuming monthly meetings in first three years of operation and bimonthly meetings thereafter.