Information Summary and Recommendations

Mental Health Counselors Sunrise Review

January 2001

Health Systems Quality Assurance

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For more information or additional copies of this report contact:

Office of the Assistant Secretary
PO Box 47850
Olympia, Washington 98504-7850

Phone: (360) 236-4605
Fax: (360) 236-4626

Mary Selecky
Secretary of Health

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THE SUNRISE REVIEW PROCESS

It is the Legislature's intent that all qualified individuals should be permitted to provide health services unless there is an overwhelming need for the state to protect the interests of the public by restricting entry into the profession.

The Sunrise Act, RCW 18.120.010, states that a health care profession should be regulated only when:

- Unregulated practice can clearly harm or endanger the health, safety or welfare of the public, and the potential for the harm is easily recognizable and not remote or dependent upon tenuous argument;

- The public needs and can reasonably be expected to benefit from an assurance of initial and continuing professional ability; and

- The public cannot be effectively protected by other means in a more cost-beneficial manner.

After evaluating the criteria, if the Legislature finds that it is necessary to regulate a health profession not previously regulated by law, the least restrictive alternative method of regulation should be implemented, consistent with the public interest. There are five types of regulation to be considered:

1. *Stricter civil actions and criminal prosecutions*. To be used when existing common law, statutory civil actions and criminal prohibitions are not sufficient to eradicate existing harm.

2. *Inspection requirements.* A process enabling an appropriate state agency to enforce violations by injunctive relief in court, including, but not limited to, regulation of the business activity providing the service rather than the employees of the business when a service being performed for individuals involves a hazard to the public health, safety or welfare.

3. *Registration.* A process by which the state maintains an official roster of names and addresses of the practitioners in a given profession. The roster contains the location, nature and operation of the health care activity practices and, if required, a description of the service provided. A registrant is subject to the Uniform Disciplinary Act, Chapter 18.130 RCW.

4. *Certification.* A voluntary process by which the state grants recognition to an individual who has met certain qualifications. Non-certified persons may perform the same tasks, but may not use "certified" in the title. A certified person is subject to the Uniform Disciplinary Act, Chapter 18.130 RCW.

5. *Licensure.* A method of regulation by which the state grants permission to engage in a health care profession only to persons who meet predetermined qualifications. Licensure

OVERVIEW OF PROCEEDINGS

The Department of Health notified the applicant group, all professional associations, interested parties and staff of the sunrise review. Meetings and discussions were held and documents were circulated. A review panel, including staff from the Department of Health was created.

Regulatory agencies in other states were requested to provide sunrise reviews, regulatory standards, or other information that would be useful in evaluating the proposal. Literature and Internet reviews were conducted. Staff and the review panel reviewed all information received.

The review panel conducted a public hearing on September 27, 2000. Interested persons were allowed to present testimony. There was an additional ten-day written comment period following the public hearing.

A recommendation was made based upon all information received. The proposed final draft was reviewed and approved by the Health Systems Quality Assurance Assistant Secretary and the Department of Health Secretary. The final report was transmitted to the Legislature via the Office of Financial Management.

EXECUTIVE SUMMARY

Background

Senate Bill 5218 was introduced in the 2000 Legislative Session and referred to the Department of Health under the sunrise review process. At the beginning of the review process, the senate provided a fifth draft to the department (see Appendix A). A public hearing was held on September 27, 2000. A 10-day written comment period followed.

Several organizations worked together to serve as the applicant in this review. Those groups are: Washington Mental Health Counselors Association, the National Association of Social Workers (Washington Chapter), the Washington State Society for Clinical Social Work, and the Washington Association for Marriage and Family Therapy.

CURRENT REGULATION

Mental health counseling is currently regulated at the level of certification. The more general "counseling" is regulated at the level of registration. Certification is a voluntary process, and provides protection of the title "state certified" for those who certify with the state. Once registered or certified, a provider is subject to the Uniform Disciplinary Act. Anyone providing services that meet the definition of counseling (RCW 18.19.020) must either be registered or

certified in one of the more specialized categories. Therefore, persons may not perform mental health counseling (including social work, and marriage and family therapy) without being regulated by the state.

RECOMMENDATIONS TO THE LEGISLATURE

1. The legislation proposed by the applicant group should be not be enacted.

2. Further investigation needs to be done to ensure that there are no reimbursement problems for mental health counselors based on their category of regulation. Specifically, the department recommends that the applicant, the Office of the Insurance Commissioner and health plans meet to review the current situation and design any remedies, if needed.

3. Changes proposed by the applicant for privileged communication requirements make sense and should be enacted, along with extending the privilege to registered counselors as well.

FINDINGS

1. The first sunrise criteria says that a profession should be regulated if unregulated practice can clearly harm or endanger the health, safety or welfare of the public, and the potential for the harm is easily recognizable and not remote or dependent upon tenuous argument. This question has generally been interpreted to mean a profession should be more tightly regulated (i.e., at a higher level) if it already is, but only if the current level of regulation is endangering the public.

2. The applicant indicated that the current disciplinary process for mental health counselors was inadequate because it did not properly use expert participation. In fact, the Department contracts with expert witnesses or uses expertise within its advisory council as needed for disciplinary cases. The Department can handle any possible problems through its routine quality assurance mechanisms.

3. Requirements for state certification that currently exist and the proposed licensing requirements, based on national standards, are essentially the same. Licensing would create a monopoly profession, potentially increasing costs, without increasing the level of professional competence of the practitioners as required by the sunrise criteria.

4. Washington is only one of a small handful of states that does not license the provider groups. This creates some disruption to mobility of people moving from Washington to other states, but this does not appear to be a harm to the public under sunrise criteria. Because of the similarities between Washington's certification standards and other states' licensing standards, the Department did not conclude that our state is a "magnet" for poorer quality providers.

5. The National Association of Social Work Boards has issued a report[1] that concludes that from "the perspective of a governmental entity authorizing an individual to practice a profession, licensure and certification are synonymous." It further states that the professional credentials offered by organizations such as the National Association of Social Workers are "usually for advanced practitioners and certify competence above the minimal level necessary for public protection. They do not have a bearing on licensing decisions.

6. The idea of creating a commission to regulate these professions does not require a move to licensure.

7. While there may be some benefit, in terms of inter-professional cooperation and understanding, of creating a mental health practitioner commission, the costs would seem to outweigh the benefits. Specifically, there is no evidence that the current regulatory structure is not working, and the cost to licensees would be increased. Furthermore, both the Governor and legislature have a policy against the creation of any new board or commissions without at least one other board being eliminated.

8. The applicant made some excellent points concerning privileged communication. These changes do not require a move to licensure, however.

9. The Department did not find any evidence to confirm a problem with reimbursement. In fact, Group Health Cooperative reported to the Department that "Group Health contracts with certified mental health practitioners as well as licensed" ones. There does not seem to be a real, widespread problem with certified mental health counselors in Washington State not being reimbursed because of their credential category.

SUMMARY OF INFORMATION

The applicant supplied the required report along with a statewide survey of the public concerning issues relating to licensing of mental health providers. The report outlines the thinking behind their proposal:

1. Licensing would eliminate harm to the public by raising educational and professional standards to a national standard, providing privileged communication status for clients; and eliminating public confusion about qualifications of counselors.
2. Licensing would provide a benefit to the public by defining scopes of practice and by qualifying clients for Medicare and Medicaid coverage, and by providing a clearer distinction among different types of providers.
3. The proposal would provide for more effective professional oversight through the formation of a commission to regulate the professions.

[1] "Social Work Laws and Board Regulations: A comparison guide," American Association of State Social Work Boards, Culpeper, VA, 1998.

Evans/McDonough Research Company in Seattle conducted the survey on behalf of the applicant. The survey revealed that 61% of respondents assume counselors were licensed, and that 90% favored licensing when informed that a license was not required to practice. The applicant stresses that this confusion can lead to harm when, as a result of the confusion, access and choice are limited.

In addition, supporters of the applicant's proposal sent approximately 48 emails to the department. (More emails would have been forwarded; the department requested that repetitive emails be halted.) The emails generally covered three main points. First, that Washington is one of just a few states that does not license one or more of the three mental health counselor groups. Second, that the public (as demonstrated by the survey) is confused and concerned that counselors are not licensed. Third, licensure would force adoption of "national standards" which mean the public is better protected.

DETAILED RECOMMENDATIONS TO THE LEGISLATURE

1. The legislation proposed by the applicants should be not be enacted. Applicants did not show that lack of licensure for mental health counselors "clearly harms or endangers the health, safety or welfare of the public."

Rationale:

- While there is some concern about the confusion among the public as to what credentialing by the state signifies, as represented by the applicant's survey, this was insufficient to create a clear picture of "harm."
- It was not clearly demonstrated that certified counselors are not being reimbursed because of their status of "certified" versus licensed. There were a few instances given, but they involved out of state insurance plans. (See Recommendation #2) In addition, Department records indicate that insurance companies use the automated license verification system to check on the status of certified mental health practitioners.
- State and national requirements for certification and licensure (respectively) are substantially equivalent. Therefore, moving to licensing does not further protect the public.

2. Further investigation needs to be done to ensure that there are no reimbursement problems for mental health counselors based on their category of regulation. Specifically, the department recommends that the applicant, the Office of the Insurance Commissioner and health plans meet to review the current situation and design any remedies, if needed.

Rationale:

- The information provided to the department on this issue was inconclusive at best. However, the issue is serious enough, because it has an impact on access to care that further investigation is justified.
- It is appropriately an issue for the Office of Insurance Commissioner to pursue.

3. Changes proposed by the applicant for privileged communication requirements make sense and should be enacted, along with extending the privilege to registered counselors and psychiatric nurse practitioners as well.

Rationale:

- Privileged communication provisions assure clients that information they discuss with their mental health provider will be held confidential (subject to other provisions of law). Whether a client seeks help from a psychologist or a marriage and family therapist for a given problem, they should be given the same assurance that their discussions will be held confidential.
- Registered counselors, while perhaps having less training than certified counselors, should also be given this under the same logic extended by the applicants. That is, a client seeking help for a serious, personal problem should be confident their discussions will not show up in a legal proceeding, for example, unless otherwise required by law.
- The Department supported legislation in the 2000 Legislative Session that would have extended the privileged communication provisions in the psychology statute to registered and certified counselors.

APPENDIX: A

SENATE BILL 5218

Brief Description: Providing licensing standards for mental health practitioners. To be reviewed by the Department of Health under a sunrise review, September 2000.

Page and line numbering may vary depending on the printer used.

ELECTRONIC TRANSMITTAL

AN ACT Relating to licensed mental health practitioners; amending RCW 18.19.010, 18.19.020, 18.19.030, 18.19.040, 18.19.050, 18.19.060, 18.19.080, 18.19.180, 18.19.190, 18.120.020, 18.130.040, 5.60.060, 18.100.050, 18.205.090, 25.05.510, 25.15.045, and 48.43.087; reenacting and amending RCW 9A.44.010; adding a new section to chapter 70.02 RCW; adding a new chapter to Title 18 RCW; and repealing RCW 18.19.070, 18.19.110, 18.19.120, 18.19.130, 18.19.140, 18.19.150, 18.19.160, and 18.19.170.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. **Sec. 1.** The legislature recognizes the real risk of harm and danger to the public from inadequate regulation of mental health practitioners who routinely work with vulnerable adults, families, and children who are in crisis and in need of competent services. Initial and continuing professional accountability through licensing of the profession would reasonably protect the public. The public cannot be effectively protected by other means in a more cost-beneficial manner. After consideration of the governmental and societal costs and benefits, the legislature finds that public health, safety, and welfare requires protection through licensing of mental health practitioners. The legislature intends to require state licensure for any person acting as a mental health practitioner.

NEW SECTION. **Sec. 2.** Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter.

(1) "Applicant" means a person who completes the required application, pays the required fee, is at least eighteen years of age, and meets any background check requirements and uniform disciplinary act requirements.

(2) "Clinical social work" means social work and the application of principles of human development to the diagnosis and psychotherapeutic treatment of mental, cognitive, and emotional disorders. Treatment modalitites include but are not limited to work with children, adolescents, and/or adults as individuals, or in couples, families, groups, and organizations.

(3) "Commission" means the Washington state mental health practitioners quality assurance commission.

(4) "Department" means the department of health.

(5) "Disciplining authority" means the commission.

(6) "Marriage and family therapy" means the diagnosis and treatment of mental and emotional disorders, whether cognitive, affective, or behavioral, within the context of marriage and family systems through the professional application of psychotherapeutic and family systems theories and techniques in the delivery of services to individuals, couples, and families for the purpose of treating such diagnosed nervous and mental disorders.

(7) "Mental health counseling" means the application of principles of human development, learning theory, psychotherapy, group dynamics, and etiology of mental illness and dysfunctional behavior to individuals, couples, families, groups, and organizations, for the purpose of treatment of mental disorders and promoting optimal mental health and functionality. Mental health counseling also includes, but is not limited to, the assessment, diagnosis, and treatment of mental and emotional disorders, as well as the application of a wellness model of mental health.

(8) "Mental health practitioner" means a person licensed under this chapter as a social worker, marriage and family therapist, or mental health counselor.

(9) "Secretary" means the secretary of health or the secretary's designee.

(10) "Social work" means knowledge and ability to apply social work theory, methods, and ethics that include emotional and biopsychosocial assessment, case management, consultation, advocacy, counseling, and community organization.

NEW SECTION. **Sec. 3.** A person must not represent himself or herself as a licensed mental health practitioner, or use any title, including the terms social worker, advanced social worker, independent clinical social worker, mental health counselor, and marriage and family therapist, without

applying for licensure, meeting the required qualifications, and being licensed by the department, unless otherwise exempted by this chapter.

The title social worker shall not be used by any state employee who is not licensed under this chapter.

NEW SECTION. **Sec. 4.** Nothing in this chapter shall be construed to prohibit or restrict:

(1) The practice of marriage and family therapy, mental health counseling, and social work by an individual licensed, certified, or registered under the laws of this state and performing services within the authorized scope of practice;

(2) The practice of marriage and family therapy, mental health counseling, and social work by an individual employed by the government of the United States while engaged in the performance of duties prescribed by the laws of the United States;

(3) The practice of marriage and family therapy, mental health counseling, and social work by a person who is a regular student in an educational program approved by the commission, and whose performance of services is pursuant to a regular course of instruction or assignments from an instructor and under the general supervision of the instructor;

(4) The practice of marriage and family therapy, mental health counseling, and social work by a person issued a temporary permit by the commission;

(5) The practice of marriage and family therapy, mental health counseling, and social work under the auspices of a religious denomination, church, or religious organization;

(6) Marriage and family therapists, mental health counselors, and social workers whose residency is not Washington state from providing up to ten days per quarter of training or workshops in the state as long as they do not hold themselves out to be licensed in Washington state.

NEW SECTION. **Sec. 5.** In addition to any other authority provided by law, the secretary has the authority to:

(1) Adopt rules under chapter 34.05 RCW necessary to implement this chapter;

(2) Establish all licensing, examination, and renewal fees in accordance with RCW 43.70.250;

(3) Establish forms and procedures necessary to administer this chapter;

(4) Issue licenses to applicants who have met the education, training, and examination requirements for licensure and to deny a license to applicants who do not meet the minimum qualifications, except that proceedings concerning the denial of licensure based upon unprofessional conduct or impairment shall be governed by the commission and by the uniform disciplinary act, chapter 18.130 RCW;

(5) Hire clerical, administrative, investigative, and other staff as needed to implement this chapter, and hire individuals licensed under this chapter to serve as examiners for any practical examinations;

(6) Administer and supervise the grading and taking of examinations for applicants for licensure;

(7) Determine which states have credentialing requirements equivalent to those of this state, and issue licenses to individuals credentialed in those states without examinations;

(8) Implement and administer a program for consumer education in consultation with the commission;

(9) Adopt rules implementing a continuing competency program;

(10) Maintain the official record of all applicants and licensees; and

(11) Establish by rule the procedures for an appeal of an examination failure.

NEW SECTION. **Sec. 6.** The secretary shall keep an official record of all proceedings. A part of the record shall consist of a register of all applicants for licensing under this chapter and the results of each application.

NEW SECTION. **Sec. 7.** The Washington state mental health practitioner's quality assurance commission is established.

(1) The commission shall be comprised of nine members. Two members shall be licensed mental health counselors. Two members shall be licensed marriage and family therapists. One member shall be a licensed independent clinical social worker, and one member shall be a licensed advanced social worker. Three members shall represent the public.

(2) Three members shall be appointed for a term of one year, three members shall be appointed for a term of two years, and three members shall be appointed for a term of three years. Subsequent members shall be appointed for terms of three years. A person must not serve as a member for more than two consecutive terms.

(3)(a) Each member must be a resident of the state of Washington.

(b) Each member must not hold an office in a professional association for mental health, social work, or marriage and family therapy.

(c) Each nonpublic member must have been actively engaged as a mental health practitioner for five years immediately preceding appointment.

(d) The public members must represent the general public and be unaffiliated directly or indirectly with the professions licensed under this chapter.

(4) The governor shall appoint the commission members. The governor shall fill any vacancy for the unexpired term by appointment.

(5) A majority vote of the commission members is required for purposes of transacting business. A quorum is five members.

(6) Commissioners are immune from suit in an action, civil or criminal, based on its disciplinary proceedings or other official acts performed in good faith.

(7) Commissioners shall be compensated in accordance with RCW 43.03.240, including travel expenses in carrying out his or her authorized duties in accordance with RCW 43.03.050 and 43.03.060.

(8) The commission shall elect a chair and vice-chair.

NEW SECTION. **Sec. 8.** The disciplining authority has the following authority:

(1) To adopt, amend, and rescind such rules as are deemed necessary to carry out this chapter;

(2) To investigate all complaints or reports of unprofessional conduct as defined in this chapter and to hold hearings as provided in this chapter;

(3) To issue subpoenas and administer oaths in connection with any investigation, hearing, or proceeding held under this chapter;

(4) To take or cause depositions to be taken and use other discovery procedures as needed in any investigation, hearing, or proceeding held under this chapter;

(5) To compel attendance of witnesses at hearings;

(6) In the course of investigating a complaint or report of unprofessional conduct, to conduct practice reviews;

(7) To take emergency action ordering summary suspension of a license, or restriction or limitation of the licensee's practice pending proceedings by the disciplining authority;

(8) To use a presiding officer as authorized in RCW 18.130.095(3) or the office of administrative hearings as authorized in chapter 34.12 RCW to conduct hearings. The disciplining authority shall make the final decision regarding disposition of the license unless the disciplining authority elects to delegate in writing the final decision to the presiding officer;

(9) To use individual members of the commission to direct investigations. However, the member of the commission shall not subsequently participate in the hearing of the case;

(10) To enter into contracts for professional services determined to be necessary for adequate enforcement of this chapter;

(11) To contract with licensees or other persons or organizations to provide services necessary for the monitoring and supervision of licensees who are placed on probation, whose professional

activities are restricted, or who are for any authorized purpose subject to monitoring by the disciplining authority;

(12) To adopt standards of professional conduct or practice;

(13) To grant or deny license applications, and in the event of a finding of unprofessional conduct by an applicant or license holder, to impose any sanction against a license applicant or license holder provided by this chapter;

(14) To designate individuals authorized to sign subpoenas and statements of charges;

(15) To establish panels consisting of three or more members of the commission to perform any duty or authority within the commission's jurisdiction under this chapter;

(16) To review and audit the records of commission decisions in which a licensee's practice privilege or employment is terminated or restricted. Each health facility or service shall produce and make accessible to the disciplining authority the appropriate records and otherwise facilitate the review and audit. Information so gained shall not be subject to discovery or introduction into evidence in any civil action pursuant to RCW 70.41.200(3).

NEW SECTION. **Sec. 9.** (1) The secretary shall issue a mental health practitioner license to any applicant who demonstrates to the satisfaction of the commission that the following requirements have been met. The mental health practitioner's license requirements vary according to the level of education and experience requirements of the particular practice area of the practitioner.

(a) Licensed social work classifications:

(i) Licensed social worker:

(A) Graduation from a bachelor's level education program approved by the commission based upon nationally recognized standards; and

(B) Successful completion of an approved examination.

(ii) Licensed master level social worker:

(A) Graduation from a master's level educational program approved by the commission based upon nationally recognized standards; and

(B) Successful completion of an approved examination.

(iii) Licensed advanced social worker:

(A) Graduation from a master's or doctorate educational program approved by the commission based upon nationally recognized standards;

(B) Successful completion of an approved examination; and

(C) Successful completion of a supervised experience requirement. The experience requirement consists of a minimum of three thousand two hundred hours of experience, of which eight hundred

hours must be direct client contact, over a two-year period as a licensed social worker, with supervision of at least ninety hours by a licensed mental health practitioner. Of the total supervision, fifty hours must be with an independent clinical social worker; the other forty hours may be with an equally qualified mental health practitioner. Forty hours must be in one-to-one supervision and fifty hours may be in one-to-one supervision or group supervision. Distance supervision is limited to forty supervision hours.

(iv) Licensed independent clinical social worker:

(A) Graduation from a master's or doctorate level educational program approved by the commission based upon nationally recognized standards;

(B) Successful completion of an approved examination; and

(C) Successful completion of a supervised experience requirement. The experience requirement consists of a minimum of four thousand hours of experience, of which one thousand hours must be direct client contact, over a three-year period as a licensed social worker, licensed master level social worker, or licensed advanced social worker, with supervision of at least one hundred thirty hours by a licensed mental health practitioner. Of the total supervision, seventy hours must be with an independent clinical social worker; the other sixty hours may be with an equally qualified mental health practitioner. Sixty hours must be in one-to-one supervision and seventy hours may be in one-to-one supervision or group supervision. Distance supervision is limited to sixty supervision hours.

(b) Licensed mental health counselor:

(i) Graduation from a master's or doctoral level educational program in mental health counseling or a related discipline from a college or university approved by the commission based upon nationally recognized standards;

(ii) Successful completion of an approved examination; and

(iii) Successful completion of a supervised experience requirement. The experience requirement consists of a minimum of thirty-six months full-time counseling or three thousand hours of postgraduate mental health counseling under the supervision of a qualified licensed mental health counselor in an approved setting. The three thousand hours of required experience includes a minimum of one hundred hours spent in immediate supervision with the qualified licensed mental health counselor, and includes a minimum of one thousand two hundred hours of direct counseling with individuals, couples, families, or groups.

(c) Licensed marriage and family therapist:

(i) Graduation from a master's degree or doctoral degree educational program in marriage and family therapy or graduation from an educational program in an allied field equivalent to a master's

degree or doctoral degree in marriage and family therapy approved by the commission based upon nationally recognized standards;

(ii) Successful completion of an approved examination; and

(iii) Successful completion of a supervised experience requirement. The experience requirement consists of a minimum of two calendar years of full-time marriage and family therapy under approved supervision by a qualified licensed marriage and family therapist.

Total experience requirements include:

(A) One thousand hours of direct client contact; plus

(B) At least two hundred hours of formal meetings with an approved supervisor. At least one hundred of the two hundred hours must be individual formal meetings. The remaining hours may be in group formal meetings.

Applicants who have completed a master's program accredited by the commission on accreditation for marriage and family therapy education of the American association for marriage and family therapy may be credited with one hundred hours of supervision toward the two hundred hour formal meeting requirement.

(2) The commission shall establish by rule what constitutes adequate proof of meeting the criteria.

(3) In addition, applicants shall be subject to the grounds for denial of a license or issuance of a conditional license under chapter 18.130 RCW.

NEW SECTION. **Sec. 10.** Mental health practitioners licensed under this chapter shall biennially attend at least thirty-six hours of continuing education in curricula approved by the commission as a condition of license renewal, of which six hours must be devoted to professional law and ethics. In approving the curricula, the commission shall consider the educational and training standards of nationally recognized professional organizations of social work, mental health counseling, and marriage and family therapy and accredited schools offering graduate degrees in these programs in the state of Washington.

NEW SECTION. **Sec. 11.** The commission shall establish by rule educational, experience, and alternative training requirements. The commission may utilize or contract with individuals or organizations having expertise in the profession or in education to assist in the evaluations. The commission shall establish by rule the standards and procedures for revocation of approval of education programs. The standards and procedures set shall apply equally to educational programs and

training in the United States and in foreign jurisdictions. The secretary may establish a fee for educational program evaluations.

NEW SECTION. **Sec. 12.** In addition to acts of unprofessional conduct specified in RCW 18.130.180, a mental health practitioner licensed under this chapter committing any of the following acts of unethical conduct is subject to the disciplinary process and sanctions under the uniform disciplinary act, chapter 18.130 RCW.

(1) A licensee shall not engage in sexual relations with a past, present, or future client who has been, or is, in a counseling or therapeutic relationship with the licensee.

(2) A licensee shall not diagnose or treat a relative or other person who has a social relationship with the licensee.

(3) A licensee shall not have a business relationship outside the counseling or psychotherapeutic relationship with his or her client during the counseling or psychotherapy and for at least two years after the end of the counseling or psychotherapy.

NEW SECTION. **Sec. 13.** A person licensed under this chapter must provide clients at the commencement of any program of treatment with accurate disclosure information concerning the practice, in accordance with rules adopted by the commission, including the right of clients to refuse treatment, the responsibility of clients to choose the provider and treatment modality which best suits their needs, and the extent of confidentiality provided by this chapter. The disclosure information must also include the license holder's professional education and training, the therapeutic orientation of the practice, the proposed course of treatment where known, financial requirements, and such other information as required by rule. The disclosure must be acknowledged in writing by the client and license holder.

NEW SECTION. **Sec. 14.** (1) The date and location of examinations shall be established by the secretary. Applicants who have been found by the secretary to meet the other requirements for licensure shall be scheduled for the next examination following the filing of the application. The secretary shall establish by rule the examination application deadline.

(2) The secretary or the secretary's designees shall examine each applicant, by means determined most effective, on subjects appropriate to the scope of practice, as applicable. Such examinations shall be limited to the purpose of determining whether the applicant possesses the minimum skill and knowledge necessary to practice competently.

(3) The examination papers, all grading of the papers, and the grading of any practical work shall be preserved for a period of not less than one year after the secretary has made and published the decisions. All examinations shall be conducted under fair and wholly impartial methods.

(4) Any applicant failing to make the required grade in the first examination may take up to three subsequent examinations as the applicant desires upon prepaying a fee determined by the secretary under RCW 43.70.250 for each subsequent examination. Upon failing four examinations, the secretary may invalidate the original application and require such remedial education before the person may take future examinations.

(5) The secretary may approve an examination prepared or administered by a private testing agency or association of licensing agencies for use by an applicant in meeting the licensing requirements.

NEW SECTION. **Sec. 15.** Applications for licensing shall be submitted on forms provided by the secretary. The secretary may require any information and documentation which reasonably relates to the need to determine whether the applicant meets the criteria for licensing provided for in this chapter and chapter 18.130 RCW. Each applicant shall pay a fee determined by the secretary under RCW 43.70.250. The fee shall accompany the application.

NEW SECTION. **Sec. 16.** Any person certified under chapter 18.19 RCW is eligible for a license under this chapter without taking the examination. Any person certified under chapter 18.19 RCW within twelve months prior to the effective date of this act is eligible for an endorsement as an advanced social worker or independent clinical social worker without taking the examination if the person meets the supervision and experience requirements within three years of the effective date of this act. Any person who has not obtained certification under chapter 18.19 RCW is eligible for a license under this chapter without taking the examination if the person has been a registered counselor under chapter 18.19 RCW and the person has been counseling full time for a period of five years prior to the effective date of this act, and the person meets the supervision and experience requirements for licensure.

NEW SECTION. **Sec. 17.** An applicant holding a credential in another state may be licensed to practice in this state without examination if the commission determines that the other state's credentialing standards are substantially equivalent to the licensing standards in this state.

NEW SECTION. **Sec. 18.** The secretary shall establish by rule the procedural requirements and fees for renewal of a license. Failure to renew shall invalidate the license and all privileges granted by the license. If a license has lapsed for a period longer than three years, the person shall demonstrate competence to the satisfaction of the commission by taking continuing education courses, or meeting other standards determined by the secretary.

NEW SECTION. **Sec. 19.** The uniform disciplinary act, chapter 18.130 RCW, shall govern the issuance and denial of licenses, unauthorized practice, and the discipline of persons licensed under this chapter. The commission, with the assistance of the secretary, shall be the disciplining authority under this chapter.

Sec. 20. RCW 18.19.010 and 1987 c 512 s 1 are each amended to read as follows:

The qualifications and practices of counselors in this state are virtually unknown to potential clients. Beyond the regulated practices of psychiatry and psychology, there are a considerable variety of disciplines, theories, and techniques employed by other counselors under a number of differing titles. The legislature recognizes the right of all counselors to practice their skills freely, consistent with the requirements of the public health and safety, as well as the right of individuals to choose which counselors best suit their needs and purposes. This chapter shall not be construed to require or prohibit that individual or group policies or contracts of an insurance carrier, health care service contractor, or health maintenance organization provide benefits or coverage for services and supplies provided by a person registered ((~~or certified~~)) under this chapter.

Sec. 21. RCW 18.19.020 and 1991 c 3 s 19 are each amended to read as follows:

Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter.

(1) ((~~"Certified marriage and family therapist" means a person certified to practice marriage and family therapy pursuant to RCW 18.19.130.~~

~~(2) "Certified mental health counselor" means a person certified to practice mental health counseling pursuant to RCW 18.19.120.~~

~~(3) "Certified social worker" means a person certified to practice social work pursuant to RCW 18.19.110.~~

~~(4)~~)) "Client" means an individual who receives or participates in counseling or group counseling.

((~~(5)~~)) (2) "Counseling" means employing any therapeutic techniques, including but not limited to social work, mental health counseling, marriage and family therapy, and hypnotherapy, for a fee that offer, assist or attempt to assist an individual or individuals in the amelioration or adjustment of mental, emotional, or behavioral problems, and includes therapeutic techniques to achieve sensitivity and awareness of self and others and the development of human potential. For the purposes of this chapter, nothing may be construed to imply that the practice of hypnotherapy is necessarily limited to counseling.

((~~(6)~~)) (3) "Counselor" means an individual, practitioner, therapist, or analyst who engages in the practice of counseling to the public for a fee, including for the purposes of this chapter, hypnotherapists.

((~~(7)~~)) (4) "Department" means the department of health.

((~~(8)~~)) (5) "Secretary" means the secretary of the department or the secretary's designee.

Sec. 22. RCW 18.19.030 and 1991 c 3 s 20 are each amended to read as follows:

No person may, for a fee or as a part of his or her position as an employee of a state agency, practice counseling without being registered to practice by the department under this chapter unless exempt under RCW 18.19.040. ((~~No person may represent himself or herself as a certified social worker, certified mental health counselor, or certified marriage and family therapist without being so certified by the department under this chapter.~~))

Sec. 23. RCW 18.19.040 and 1987 c 512 s 4 are each amended to read as follows:

Nothing in this chapter may be construed to prohibit or restrict:

(1) The practice of a profession by a person who is either registered, certified, licensed, or similarly regulated under the laws of this state and who is performing services within the person's authorized scope of practice, including any attorney admitted to practice law in this state when providing counseling incidental to and in the course of providing legal counsel;

(2) The practice of counseling by an employee or trainee of any federal agency, or the practice of counseling by a student of a college or university, if the employee, trainee, or student is practicing solely under the supervision of and accountable to the agency, college, or university, through which he or she performs such functions as part of his or her position for no additional fee other than ordinary compensation;

(3) The practice of counseling by a person without a mandatory charge;

(4) The practice of counseling by persons offering services for public and private nonprofit organizations or charities not primarily engaged in counseling for a fee when approved by the organizations or agencies for whom they render their services;

(5) Evaluation, consultation, planning, policy-making, research, or related services conducted by social scientists for private corporations or public agencies;

(6) The practice of counseling by a person under the auspices of a religious denomination, church, or organization, or the practice of religion itself;

(7) Counselors whose residency is not Washington state from providing up to ten days per quarter of training or workshops in the state, as long as they don't hold themselves out to be registered ((~~or certified~~)) in Washington state.

Sec. 24. RCW 18.19.050 and 1991 c 3 s 21 are each amended to read as follows:

(1) In addition to any other authority provided by law, the secretary has the following authority:

(a) To adopt rules, in accordance with chapter 34.05 RCW, necessary to implement this chapter;

(b) To set all ((~~certification,~~)) registration((~~,~~)) and renewal fees in accordance with RCW 43.70.250 and to collect and deposit all such fees in the health professions account established under RCW 43.70.320;

(c) To establish forms and procedures necessary to administer this chapter;

(d) To hire clerical, administrative, and investigative staff as needed to implement this chapter;

(e) To issue a registration to any applicant who has met the requirements for registration; and

(f) ((~~To set educational, ethical, and professional standards of practice for certification;~~

~~(g) To prepare and administer or cause to be prepared and administered an examination for all qualified applicants for certification;~~

~~(h) To establish criteria for evaluating the ability and qualifications of persons applying for a certificate, including standards for passing the examination and standards of qualification for certification to practice;~~

~~(i) To evaluate and designate those schools from which graduation will be accepted as proof of an applicant's eligibility to receive a certificate and to establish standards and procedures for accepting alternative training in lieu of such graduation;~~

~~(j) To issue a certificate to any applicant who has met the education, training, and conduct requirements for certification;~~

~~(k) To set competence requirements for maintaining certification; and~~

~~(l)~~)) To develop a dictionary of recognized professions and occupations providing counseling services to the public included under this chapter.

(2) The uniform disciplinary act, chapter 18.130 RCW, governs the issuance and denial of ((~~certifications and~~)) registrations and the discipline of ((~~certified practitioners and~~)) registrants under this chapter. The secretary shall be the disciplining authority under this chapter. The absence of educational or training requirements for counselors registered under this chapter or the counselor's use of nontraditional nonabusive therapeutic techniques shall not, in and of itself, give the secretary authority to unilaterally determine the training and competence or to define or restrict the scope of practice of such individuals.

(3) The department shall publish and disseminate information in order to educate the public about the responsibilities of counselors and the rights and responsibilities of clients established under this chapter. ((~~Solely for the purposes of administering this education requirement, the secretary shall assess an additional fee for each registration and certification application and renewal, equal to five percent of the fee. The revenue collected from the assessment fee may be appropriated by the legislature for the department's use in educating consumers pursuant to this section. The authority to charge the assessment fee shall terminate on June 30, 1994.~~))

Sec. 25. RCW 18.19.060 and 1987 c 512 s 6 are each amended to read as follows:

Persons registered ((~~or certified~~)) under this chapter shall provide clients at the commencement of any program of treatment with accurate disclosure information concerning their practice, in accordance with guidelines developed by the department, that will inform clients of the purposes of and resources available under this chapter, including the right of clients to refuse treatment, the responsibility of clients for choosing the provider and treatment modality which best suits their needs, and the extent of confidentiality provided by this chapter. The disclosure information provided by the counselor, the receipt of which shall be acknowledged in writing by the counselor and client, shall include any relevant education and training, the therapeutic orientation of the practice, the proposed course of treatment where known, any financial requirements, and such other information as the department may require by rule. The disclosure information shall also include a statement that registration of an individual under this chapter does not include a recognition of any practice standards, nor necessarily imply the effectiveness of any treatment.

Sec. 26. RCW 18.19.080 and 1991 c 3 s 23 are each amended to read as follows:

The secretary shall keep an official record of all proceedings, a part of which record shall consist of a register of all applicants for registration ((~~or certification~~)) under this chapter, with the result of each application.

Sec. 27. RCW 18.19.180 and 1991 c 3 s 33 are each amended to read as follows:

An individual registered ((~~or certified~~)) under this chapter shall not disclose the written acknowledgment of the disclosure statement pursuant to RCW 18.19.060 nor any information acquired from persons consulting the individual in a professional capacity when that information was necessary to enable the individual to render professional services to those persons except:

(1) With the written consent of that person or, in the case of death or disability, the person's personal representative, other person authorized to sue, or the beneficiary of an insurance policy on the person's life, health, or physical condition;

(2) That a person registered ((~~or certified~~)) under this chapter is not required to treat as confidential a communication that reveals the contemplation or commission of a crime or harmful act;

(3) If the person is a minor, and the information acquired by the person registered ((~~or certified~~)) under this chapter indicates that the minor was the victim or subject of a crime, the person registered ((~~or certified~~)) may testify fully upon any examination, trial, or other proceeding in which the commission of the crime is the subject of the inquiry;

(4) If the person waives the privilege by bringing charges against the person registered ((~~or certified~~)) under this chapter;

(5) In response to a subpoena from a court of law or the secretary. The secretary may subpoena only records related to a complaint or report under chapter 18.130 RCW; or

(6) As required under chapter 26.44 RCW.

Sec. 28. RCW 18.19.190 and 1987 c 512 s 18 are each amended to read as follows:

This chapter shall not be construed as permitting the administration or prescription of drugs or in any way infringing upon the practice of medicine and surgery as defined in chapter 18.71 RCW, or in any way infringing upon the practice of psychology as defined in chapter 18.83 RCW, or restricting the scope of the practice of counseling for those registered ((~~or certified~~)) under this chapter.

Sec. 29. RCW 18.120.020 and 2000 c 93 s 15 are each amended to read as follows:

The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Applicant group" includes any health professional group or organization, any individual, or any other interested party which proposes that any health professional group not presently regulated be regulated or which proposes to substantially increase the scope of practice of the profession.

(2) "Certificate" and "certification" mean a voluntary process by which a statutory regulatory entity grants recognition to an individual who (a) has met certain prerequisite qualifications specified

by that regulatory entity, and (b) may assume or use "certified" in the title or designation to perform prescribed health professional tasks.

(3) "Grandfather clause" means a provision in a regulatory statute applicable to practitioners actively engaged in the regulated health profession prior to the effective date of the regulatory statute which exempts the practitioners from meeting the prerequisite qualifications set forth in the regulatory statute to perform prescribed occupational tasks.

(4) "Health professions" means and includes the following health and health-related licensed or regulated professions and occupations: Podiatric medicine and surgery under chapter 18.22 RCW; chiropractic under chapter 18.25 RCW; dental hygiene under chapter 18.29 RCW; dentistry under chapter 18.32 RCW; denturism under chapter 18.30 RCW; dispensing opticians under chapter 18.34 RCW; hearing instruments under chapter 18.35 RCW; naturopaths under chapter 18.36A RCW; embalming and funeral directing under chapter 18.39 RCW; midwifery under chapter 18.50 RCW; nursing home administration under chapter 18.52 RCW; optometry under chapters 18.53 and 18.54 RCW; ocularists under chapter 18.55 RCW; osteopathic medicine and surgery under chapters 18.57 and 18.57A RCW; pharmacy under chapters 18.64 and 18.64A RCW; medicine under chapters 18.71 and 18.71A RCW; emergency medicine under chapter 18.73 RCW; physical therapy under chapter 18.74 RCW; practical nurses under chapter 18.79 RCW; psychologists under chapter 18.83 RCW; registered nurses under chapter 18.79 RCW; occupational therapists licensed under chapter 18.59 RCW; respiratory care practitioners licensed under chapter 18.89 RCW; veterinarians and veterinary technicians under chapter 18.92 RCW; health care assistants under chapter 18.135 RCW; massage practitioners under chapter 18.108 RCW; acupuncturists licensed under chapter 18.06 RCW; persons registered ((~~or certified~~)) under chapter 18.19 RCW; persons licensed as mental health practitioners under chapter 18.-- RCW (sections 1 through 19 of this act); dietitians and nutritionists certified by chapter 18.138 RCW; radiologic technicians under chapter 18.84 RCW; and nursing assistants registered or certified under chapter 18.88A RCW.

(5) "Inspection" means the periodic examination of practitioners by a state agency in order to ascertain whether the practitioners' occupation is being carried out in a fashion consistent with the public health, safety, and welfare.

(6) "Legislative committees of reference" means the standing legislative committees designated by the respective rules committees of the senate and house of representatives to consider proposed legislation to regulate health professions not previously regulated.

(7) "License," "licensing," and "licensure" mean permission to engage in a health profession which would otherwise be unlawful in the state in the absence of the permission. A license is granted

to those individuals who meet prerequisite qualifications to perform prescribed health professional tasks and for the use of a particular title.

(8) "Professional license" means an individual, nontransferable authorization to carry on a health activity based on qualifications which include: (a) Graduation from an accredited or approved program, and (b) acceptable performance on a qualifying examination or series of examinations.

(9) "Practitioner" means an individual who (a) has achieved knowledge and skill by practice, and (b) is actively engaged in a specified health profession.

(10) "Public member" means an individual who is not, and never was, a member of the health profession being regulated or the spouse of a member, or an individual who does not have and never has had a material financial interest in either the rendering of the health professional service being regulated or an activity directly related to the profession being regulated.

(11) "Registration" means the formal notification which, prior to rendering services, a practitioner shall submit to a state agency setting forth the name and address of the practitioner; the location, nature and operation of the health activity to be practiced; and, if required by the regulatory entity, a description of the service to be provided.

(12) "Regulatory entity" means any board, commission, agency, division, or other unit or subunit of state government which regulates one or more professions, occupations, industries, businesses, or other endeavors in this state.

(13) "State agency" includes every state office, department, board, commission, regulatory entity, and agency of the state, and, where provided by law, programs and activities involving less than the full responsibility of a state agency.

Sec. 30. RCW 18.130.040 and 1999 c 335 s 10 are each amended to read as follows:

(1) This chapter applies only to the secretary and the boards and commissions having jurisdiction in relation to the professions licensed under the chapters specified in this section. This chapter does not apply to any business or profession not licensed under the chapters specified in this section.

(2)(a) The secretary has authority under this chapter in relation to the following professions:

(i) Dispensing opticians licensed under chapter 18.34 RCW;

(ii) Naturopaths licensed under chapter 18.36A RCW;

(iii) Midwives licensed under chapter 18.50 RCW;

(iv) Ocularists licensed under chapter 18.55 RCW;

(v) Massage operators and businesses licensed under chapter 18.108 RCW;

(vi) Dental hygienists licensed under chapter 18.29 RCW;

(vii) Acupuncturists licensed under chapter 18.06 RCW;

(viii) Radiologic technologists certified and X-ray technicians registered under chapter 18.84 RCW;

(ix) Respiratory care practitioners licensed under chapter 18.89 RCW;

(x) Persons registered ((~~or certified~~)) under chapter 18.19 RCW;

(xi) Persons licensed as mental health practitioners under chapter 18.-- RCW (sections 1 through 19 of this act);

(xii) Persons registered as nursing pool operators under chapter 18.52C RCW;

(((~~xii~~))) (xiii) Nursing assistants registered or certified under chapter 18.88A RCW;

(((~~xiii~~))) (xiv) Health care assistants certified under chapter 18.135 RCW;

(((~~xiv~~))) (xv) Dietitians and nutritionists certified under chapter 18.138 RCW;

(((~~xv~~))) (xvi) Chemical dependency professionals certified under chapter 18.205 RCW;

(((~~xvi~~))) (xvii) Sex offender treatment providers certified under chapter 18.155 RCW;

(((~~xvii~~))) (xviii) Persons licensed and certified under chapter 18.73 RCW or RCW 18.71.205;

(((~~xviii~~))) (xix) Persons registered as adult family home providers and resident managers under RCW 18.48.020;

(((~~xix~~))) (xx) Denturists licensed under chapter 18.30 RCW;

(((~~xx~~))) (xxi) Orthotists and prosthetists licensed under chapter 18.200 RCW; and

(((~~xxi~~))) (xxii) Surgical technologists registered under chapter 18.215 RCW.

(b) The boards and commissions having authority under this chapter are as follows:

(i) The podiatric medical board as established in chapter 18.22 RCW;

(ii) The chiropractic quality assurance commission as established in chapter 18.25 RCW;

(iii) The dental quality assurance commission as established in chapter 18.32 RCW;

(iv) The board of hearing and speech as established in chapter 18.35 RCW;

(v) The board of examiners for nursing home administrators as established in chapter 18.52 RCW;

(vi) The optometry board as established in chapter 18.54 RCW governing licenses issued under chapter 18.53 RCW;

(vii) The board of osteopathic medicine and surgery as established in chapter 18.57 RCW governing licenses issued under chapters 18.57 and 18.57A RCW;

(viii) The board of pharmacy as established in chapter 18.64 RCW governing licenses issued under chapters 18.64 and 18.64A RCW;

(ix) The medical quality assurance commission as established in chapter 18.71 RCW governing licenses and registrations issued under chapters 18.71 and 18.71A RCW;

(x) The board of physical therapy as established in chapter 18.74 RCW;

(xi) The board of occupational therapy practice as established in chapter 18.59 RCW;

(xii) The nursing care quality assurance commission as established in chapter 18.79 RCW governing licenses issued under that chapter;

(xiii) The examining board of psychology and its disciplinary committee as established in chapter 18.83 RCW; and

(xiv) The veterinary board of governors as established in chapter 18.92 RCW.

(3) In addition to the authority to discipline license holders, the disciplining authority has the authority to grant or deny licenses based on the conditions and criteria established in this chapter and the chapters specified in subsection (2) of this section. This chapter also governs any investigation, hearing, or proceeding relating to denial of licensure or issuance of a license conditioned on the applicant's compliance with an order entered pursuant to RCW 18.130.160 by the disciplining authority.

(4) All disciplining authorities shall adopt procedures to ensure substantially consistent application of this chapter, the Uniform Disciplinary Act, among the disciplining authorities listed in subsection (2) of this section.

Sec. 31. RCW 5.60.060 and 1998 c 72 s 1 are each amended to read as follows:

(1) A husband shall not be examined for or against his wife, without the consent of the wife, nor a wife for or against her husband without the consent of the husband; nor can either during marriage or afterward, be without the consent of the other, examined as to any communication made by one to the other during marriage. But this exception shall not apply to a civil action or proceeding by one against the other, nor to a criminal action or proceeding for a crime committed by one against the other, nor to a criminal action or proceeding against a spouse if the marriage occurred subsequent to the filing of formal charges against the defendant, nor to a criminal action or proceeding for a crime committed by said husband or wife against any child of whom said husband or wife is the parent or guardian, nor to a proceeding under chapter 70.96A or 71.05 RCW: PROVIDED, That the spouse of a person sought to be detained under chapter 70.96A or 71.05 RCW may not be compelled to testify and shall be so informed by the court prior to being called as a witness.

(2)(a) An attorney or counselor shall not, without the consent of his or her client, be examined as to any communication made by the client to him or her, or his or her advice given thereon in the course of professional employment.

(b) A parent or guardian of a minor child arrested on a criminal charge may not be examined as to a communication between the child and his or her attorney if the communication was made in the

presence of the parent or guardian. This privilege does not extend to communications made prior to the arrest.

(3) A member of the clergy or a priest shall not, without the consent of a person making the confession, be examined as to any confession made to him or her in his or her professional character, in the course of discipline enjoined by the church to which he or she belongs.

(4) Subject to the limitations under RCW 70.96A.140 or 71.05.250, a physician or surgeon or osteopathic physician or surgeon or podiatric physician or surgeon shall not, without the consent of his or her patient, be examined in a civil action as to any information acquired in attending such patient, which was necessary to enable him or her to prescribe or act for the patient, except as follows:

(a) In any judicial proceedings regarding a child's injury, neglect, or sexual abuse or the cause thereof; and

(b) Ninety days after filing an action for personal injuries or wrongful death, the claimant shall be deemed to waive the physician-patient privilege. Waiver of the physician-patient privilege for any one physician or condition constitutes a waiver of the privilege as to all physicians or conditions, subject to such limitations as a court may impose pursuant to court rules.

(5) A public officer shall not be examined as a witness as to communications made to him or her in official confidence, when the public interest would suffer by the disclosure.

(6)(a) A peer support group counselor shall not, without consent of the law enforcement officer making the communication, be compelled to testify about any communication made to the counselor by the officer while receiving counseling. The counselor must be designated as such by the sheriff, police chief, or chief of the Washington state patrol, prior to the incident that results in counseling. The privilege only applies when the communication was made to the counselor while acting in his or her capacity as a peer support group counselor. The privilege does not apply if the counselor was an initial responding officer, a witness, or a party to the incident which prompted the delivery of peer support group counseling services to the law enforcement officer.

(b) For purposes of this section, "peer support group counselor" means a:

(i) Law enforcement officer, or civilian employee of a law enforcement agency, who has received training to provide emotional and moral support and counseling to an officer who needs those services as a result of an incident in which the officer was involved while acting in his or her official capacity; or

(ii) Nonemployee counselor who has been designated by the sheriff, police chief, or chief of the Washington state patrol to provide emotional and moral support and counseling to an officer who needs those services as a result of an incident in which the officer was involved while acting in his or her official capacity.

(7) A sexual assault advocate may not, without the consent of the victim, be examined as to any communication made by the victim to the sexual assault advocate.

(a) For purposes of this section, "sexual assault advocate" means the employee or volunteer from a rape crisis center, victim assistance unit, program, or association, that provides information, medical or legal advocacy, counseling, or support to victims of sexual assault, who is designated by the victim to accompany the victim to the hospital or other health care facility and to proceedings concerning the alleged assault, including police and prosecution interviews and court proceedings.

(b) A sexual assault advocate may disclose a confidential communication without the consent of the victim if failure to disclose is likely to result in a clear, imminent risk of serious physical injury or death of the victim or another person. Any sexual assault advocate participating in good faith in the disclosing of records and communications under this section shall have immunity from any liability, civil, criminal, or otherwise, that might result from the action. In any proceeding, civil or criminal, arising out of a disclosure under this section, the good faith of the sexual assault advocate who disclosed the confidential communication shall be presumed.

(8) A licensed mental health practitioner shall not be examined as to any communications made by his or her client to the licensed mental health practitioner in the course of the professional relationship without the consent of his or her client. This privilege is limited by the practitioner's duty to mandatorily report abuse and neglect. This privilege is limited by the practitioner's duty to warn of and protect from a client's threatened violent behavior if the client communicated a serious threat of physical violence against a reasonably identifiable victim or victims. Communications remain confidential and privileged even under circumstances where the client's parent, in the case of a minor, is present at the time of the communication.

Sec. 32. RCW 9A.44.010 and 1997 c 392 s 513 and 1997 c 112 s 37 are each reenacted and amended to read as follows:

As used in this chapter:

(1) "Sexual intercourse" (a) has its ordinary meaning and occurs upon any penetration, however slight, and

(b) Also means any penetration of the vagina or anus however slight, by an object, when committed on one person by another, whether such persons are of the same or opposite sex, except when such penetration is accomplished for medically recognized treatment or diagnostic purposes, and

(c) Also means any act of sexual contact between persons involving the sex organs of one person and the mouth or anus of another whether such persons are of the same or opposite sex.

(2) "Sexual contact" means any touching of the sexual or other intimate parts of a person done for the purpose of gratifying sexual desire of either party or a third party.

(3) "Married" means one who is legally married to another, but does not include a person who is living separate and apart from his or her spouse and who has filed in an appropriate court for legal separation or for dissolution of his or her marriage.

(4) "Mental incapacity" is that condition existing at the time of the offense which prevents a person from understanding the nature or consequences of the act of sexual intercourse whether that condition is produced by illness, defect, the influence of a substance or from some other cause.

(5) "Physically helpless" means a person who is unconscious or for any other reason is physically unable to communicate unwillingness to an act.

(6) "Forcible compulsion" means physical force which overcomes resistance, or a threat, express or implied, that places a person in fear of death or physical injury to herself or himself or another person, or in fear that she or he or another person will be kidnapped.

(7) "Consent" means that at the time of the act of sexual intercourse or sexual contact there are actual words or conduct indicating freely given agreement to have sexual intercourse or sexual contact.

(8) "Significant relationship" means a situation in which the perpetrator is:

(a) A person who undertakes the responsibility, professionally or voluntarily, to provide education, health, welfare, or organized recreational activities principally for minors;

(b) A person who in the course of his or her employment supervises minors; or

(c) A person who provides welfare, health or residential assistance, personal care, or organized recreational activities to frail elders or vulnerable adults, including a provider, employee, temporary employee, volunteer, or independent contractor who supplies services to long-term care facilities licensed or required to be licensed under chapter 18.20, 18.51, 72.36, or 70.128 RCW, and home health, hospice, or home care agencies licensed or required to be licensed under chapter 70.127 RCW, but not including a consensual sexual partner.

(9) "Abuse of a supervisory position" means a direct or indirect threat or promise to use authority to the detriment or benefit of a minor.

(10) "Developmentally disabled," for purposes of RCW 9A.44.050(1)(c) and 9A.44.100(1)(c), means a person with a developmental disability as defined in RCW 71A.10.020.

(11) "Person with supervisory authority," for purposes of RCW 9A.44.050(1) (c) or (e) and 9A.44.100(1) (c) or (e), means any proprietor or employee of any public or private care or treatment facility who directly supervises developmentally disabled, mentally disordered, or chemically dependent persons at the facility.

(12) "Mentally disordered person" for the purposes of RCW 9A.44.050(1)(e) and 9A.44.100(1)(e) means a person with a "mental disorder" as defined in RCW 71.05.020.

(13) "Chemically dependent person" for purposes of RCW 9A.44.050(1)(e) and 9A.44.100(1)(e) means a person who is "chemically dependent" as defined in RCW 70.96A.020(4).

(14) "Health care provider" for purposes of RCW 9A.44.050 and 9A.44.100 means a person who is, holds himself or herself out to be, or provides services as if he or she were: (a) A member of a health care profession under chapter 18.130 RCW; or (b) registered ((~~or certified~~)) under chapter 18.19 RCW or licensed under chapter 18.-- RCW (sections 1 through 19 of this act), regardless of whether the health care provider is licensed, certified, or registered by the state.

(15) "Treatment" for purposes of RCW 9A.44.050 and 9A.44.100 means the active delivery of professional services by a health care provider which the health care provider holds himself or herself out to be qualified to provide.

(16) "Frail elder or vulnerable adult" means a person sixty years of age or older who has the functional, mental, or physical inability to care for himself or herself. "Frail elder or vulnerable adult" also includes a person found incapacitated under chapter 11.88 RCW, a person over eighteen years of age who has a developmental disability under chapter 71A.10 RCW, a person admitted to a long-term care facility that is licensed or required to be licensed under chapter 18.20, 18.51, 72.36, or 70.128 RCW, and a person receiving services from a home health, hospice, or home care agency licensed or required to be licensed under chapter 70.127 RCW.

Sec. 33. RCW 18.100.050 and 1999 c 128 s 1 are each amended to read as follows:

(1) An individual or group of individuals duly licensed or otherwise legally authorized to render the same professional services within this state may organize and become a shareholder or shareholders of a professional corporation for pecuniary profit under the provisions of Title 23B RCW for the purpose of rendering professional service. One or more of the legally authorized individuals shall be the incorporators of the professional corporation.

(2) Notwithstanding any other provision of this chapter, registered architects and registered engineers may own stock in and render their individual professional services through one professional service corporation.

(3) Licensed health care professionals, providing services to enrolled participants either directly or through arrangements with a health maintenance organization registered under chapter 48.46 RCW or federally qualified health maintenance organization, may own stock in and render their individual professional services through one professional service corporation.

(4) Professionals may organize a nonprofit nonstock corporation under this chapter and chapter 24.03 RCW to provide professional services, and the provisions of this chapter relating to stock and referring to Title 23B RCW shall not apply to any such corporation.

(5)(a) Notwithstanding any other provision of this chapter, health care professionals who are licensed or certified pursuant to chapters 18.06, 18.19, 18.-- (sections 1 through 19 of this act), 18.22, 18.25, 18.29, 18.34, 18.35, 18.36A, 18.50, 18.53, 18.55, 18.57, 18.57A, 18.64, 18.71, 18.71A, 18.79, 18.83, 18.89, 18.108, and 18.138 RCW may own stock in and render their individual professional services through one professional service corporation and are to be considered, for the purpose of forming a professional service corporation, as rendering the "same specific professional services" or "same professional services" or similar terms.

(b) Notwithstanding any other provision of this chapter, health care professionals who are regulated under chapters 18.59 and 18.74 RCW may own stock in and render their individual professional services through one professional service corporation formed for the sole purpose of providing professional services within their respective scope of practice.

(c) Formation of a professional service corporation under this subsection does not restrict the application of the uniform disciplinary act under chapter 18.130 RCW, or applicable health care professional statutes under Title 18 RCW, including but not limited to restrictions on persons practicing a health profession without being appropriately credentialed and persons practicing beyond the scope of their credential.

Sec. 34. RCW 18.205.090 and 1998 c 243 s 9 are each amended to read as follows:

(1) The secretary shall issue a certificate to any applicant who demonstrates to the secretary's satisfaction that the following requirements have been met:

(a) Completion of an educational program approved by the secretary or successful completion of alternate training that meets established criteria;

(b) Successful completion of an approved examination, based on core competencies of chemical dependency counseling; and

(c) Successful completion of an experience requirement that establishes fewer hours of experience for applicants with higher levels of relevant education. In meeting any experience requirement established under this subsection, the secretary may not require more than one thousand five hundred hours of experience in chemical dependency counseling for applicants who are licensed under chapter 18.83 RCW or under chapter 18.79 RCW as advanced registered nurse practitioners.

(2) The secretary shall establish by rule what constitutes adequate proof of meeting the criteria.

(3) Applicants are subject to the grounds for denial of a certificate or issuance of a conditional certificate under chapter 18.130 RCW.

(4) Certified chemical dependency professionals shall not be required to be registered under chapter 18.19 RCW or licensed under chapter 18.-- RCW (sections 1 through 19 of this act).

Sec. 35. RCW 25.05.510 and 1998 c 103 s 1103 are each amended to read as follows:

(1) A person or group of persons licensed or otherwise legally authorized to render professional services, as defined in RCW 18.100.030, within this state may organize and become a member or members of a limited liability partnership under the provisions of this chapter for the purposes of rendering professional service. Nothing in this section prohibits a person duly licensed or otherwise legally authorized to render professional services in any jurisdiction other than this state from becoming a member of a limited liability partnership organized for the purpose of rendering the same professional services. Nothing in this section prohibits a limited liability partnership from rendering professional services outside this state through individuals who are not duly licensed or otherwise legally authorized to render such professional services within this state.

(2)(a) Notwithstanding any other provision of this chapter, health care professionals who are licensed or certified pursuant to chapters 18.06, 18.19, 18.-- (sections 1 through 19 of this act), 18.22, 18.25, 18.29, 18.34, 18.35, 18.36A, 18.50, 18.53, 18.55, 18.64, 18.79, 18.83, 18.89, 18.108, and 18.138 RCW may join and render their individual professional services through one limited liability partnership and are to be considered, for the purpose of forming a limited liability partnership, as rendering the "same specific professional services" or "same professional services" or similar terms.

(b) Notwithstanding any other provision of this chapter, health care professionals who are licensed pursuant to chapters 18.57 and 18.71 RCW may join and render their individual professional services through one limited liability partnership and are to be considered, for the purpose of forming a limited liability partnership, as rendering the "same specific professional services" or "same professional services" or similar terms.

(c) Formation of a limited liability partnership under this subsection does not restrict the application of the uniform disciplinary act under chapter 18.130 RCW, or any applicable health care professional statutes under Title 18 RCW, including but not limited to restrictions on persons practicing a health profession without being appropriately credentialed and persons practicing beyond the scope of their credential.

Sec. 36. RCW 25.15.045 and 1999 c 128 s 2 are each amended to read as follows:

(1) A person or group of persons licensed or otherwise legally authorized to render professional services within this or any other state may organize and become a member or members of a professional limited liability company under the provisions of this chapter for the purposes of rendering professional service. A "professional limited liability company" is subject to all the provisions of chapter 18.100 RCW that apply to a professional corporation, and its managers, members, agents, and employees shall be subject to all the provisions of chapter 18.100 RCW that apply to the directors, officers, shareholders, agents, or employees of a professional corporation, except as provided otherwise in this section. Nothing in this section prohibits a person duly licensed or otherwise legally authorized to render professional services in any jurisdiction other than this state from becoming a member of a professional limited liability company organized for the purpose of rendering the same professional services. Nothing in this section prohibits a professional limited liability company from rendering professional services outside this state through individuals who are not duly licensed or otherwise legally authorized to render such professional services within this state. Persons engaged in a profession and otherwise meeting the requirements of this chapter may operate under this chapter as a professional limited liability company so long as each member personally engaged in the practice of the profession in this state is duly licensed or otherwise legally authorized to practice the profession in this state and:

(a) At least one manager of the company is duly licensed or otherwise legally authorized to practice the profession in this state; or

(b) Each member in charge of an office of the company in this state is duly licensed or otherwise legally authorized to practice the profession in this state.

(2) If the company's members are required to be licensed to practice such profession, and the company fails to maintain for itself and for its members practicing in this state a policy of professional liability insurance, bond, or other evidence of financial responsibility of a kind designated by rule by the state insurance commissioner and in the amount of at least one million dollars or a greater amount as the state insurance commissioner may establish by rule for a licensed profession or for any specialty within a profession, taking into account the nature and size of the business, then the company's members are personally liable to the extent that, had the insurance, bond, or other evidence of responsibility been maintained, it would have covered the liability in question.

(3) For purposes of applying the provisions of chapter 18.100 RCW to a professional limited liability company, the terms "director" or "officer" means manager, "shareholder" means member, "corporation" means professional limited liability company, "articles of incorporation" means certificate of formation, "shares" or "capital stock" means a limited liability company interest,

"incorporator" means the person who executes the certificate of formation, and "bylaws" means the limited liability company agreement.

(4) The name of a professional limited liability company must contain either the words "Professional Limited Liability Company," or the words "Professional Limited Liability" and the abbreviation "Co.," or the abbreviation "P.L.L.C." or "PLLC" provided that the name of a professional limited liability company organized to render dental services shall contain the full names or surnames of all members and no other word than "chartered" or the words "professional services" or the abbreviation "P.L.L.C." or "PLLC."

(5) Subject to the provisions in article VII of this chapter, the following may be a member of a professional limited liability company and may be the transferee of the interest of an ineligible person or deceased member of the professional limited liability company:

(a) A professional corporation, if its shareholders, directors, and its officers other than the secretary and the treasurer, are licensed or otherwise legally authorized to render the same specific professional services as the professional limited liability company; and

(b) Another professional limited liability company, if the managers and members of both professional limited liability companies are licensed or otherwise legally authorized to render the same specific professional services.

(6)(a) Notwithstanding any other provision of this chapter, health care professionals who are licensed or certified pursuant to chapters 18.06, 18.19, 18.-- (sections 1 through 19 of this act), 18.22, 18.25, 18.29, 18.34, 18.35, 18.36A, 18.50, 18.53, 18.55, 18.57, 18.57A, 18.64, 18.71, 18.71A, 18.79, 18.83, 18.89, 18.108, and 18.138 RCW may own membership interests in and render their individual professional services through one limited liability company and are to be considered, for the purpose of forming a limited liability company, as rendering the "same specific professional services" or "same professional services" or similar terms.

(b) Notwithstanding any other provision of this chapter, health care professionals who are regulated under chapters 18.59 and 18.74 RCW may own membership interests in and render their individual professional services through one limited liability company formed for the sole purpose of providing professional services within their respective scope of practice.

(c) Formation of a limited liability company under this subsection does not restrict the application of the uniform disciplinary act under chapter 18.130 RCW, or any applicable health care professional statutes under Title 18 RCW, including but not limited to restrictions on persons practicing a health profession without being appropriately credentialed and persons practicing beyond the scope of their credential.

Sec. 37. RCW 48.43.087 and 1996 c 304 s 1 are each amended to read as follows:

(1) For purposes of this section:

(a) "Health carrier" includes disability insurers regulated under chapter 48.20 or 48.21 RCW, health care services contractors regulated under chapter 48.44 RCW, plans operating under the health care authority under chapter 41.05 RCW, the basic health plan operating under chapter 70.47 RCW, the state health insurance pool operating under chapter 48.41 RCW, insuring entities regulated under this chapter, and health maintenance organizations regulated under chapter 48.46 RCW.

(b) "Intermediary" means a person duly authorized to negotiate and execute provider contracts with health carriers on behalf of mental health care practitioners.

(c) Consistent with their lawful scopes of practice, "mental health care practitioners" includes only the following: Any generally recognized medical specialty of practitioners licensed under chapter 18.57 or 18.71 RCW who provide mental health services, advanced practice psychiatric nurses as authorized by the nursing care quality assurance commission under chapter 18.79 RCW, psychologists licensed under chapter 18.83 RCW, social workers, marriage and family therapists, ((~~and~~)) mental health counselors ((~~certified~~)) registered under chapter 18.19 RCW, and mental health practitioners licensed under chapter 18.-- RCW (sections 1 through 19 of this act).

(d) "Mental health services" means outpatient services.

(2) Consistent with federal and state law and rule, no contract between a mental health care practitioner and an intermediary or between a mental health care practitioner and a health carrier that is written, amended, or renewed after June 6, 1996, may contain a provision prohibiting a practitioner and an enrollee from agreeing to contract for services solely at the expense of the enrollee as follows:

(a) On the exhaustion of the enrollee's mental health care coverage;

(b) During an appeal or an adverse certification process;

(c) When an enrollee's condition is excluded from coverage; or

(d) For any other clinically appropriate reason at any time.

(3) If a mental health care practitioner provides services to an enrollee during an appeal or adverse certification process, the practitioner must provide to the enrollee written notification that the enrollee is responsible for payment of these services, unless the health carrier elects to pay for services provided.

(4) This section does not apply to a mental health care practitioner who is employed full time on the staff of a health carrier.

NEW SECTION. **Sec. 38.** A new section is added to chapter 70.02 RCW to read as follows:

Mental health practitioners licensed under chapter 18.-- RCW (sections 1 through 19 of this act) are subject to this chapter.

NEW SECTION. **Sec. 39.** If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

NEW SECTION. **Sec. 40.** Sections 1 through 19 of this act constitute a new chapter in Title 18 RCW.

NEW SECTION. **Sec. 41.** The following acts or parts of acts are each repealed:

(1) RCW 18.19.070 (Council established--Membership--Qualifications--Removal--Vacancy--Duties and powers--Compensation) and 1996 c 191 s 4, 1994 sp.s. c 9 s 501, 1991 c 3 s 22, & 1987 c 512 s 7;

(2) RCW 18.19.110 (Certification of social workers) and 1991 c 3 s 26 & 1987 c 512 s 12;

(3) RCW 18.19.120 (Certification of mental health counselors--Practice defined--Continuing education) and 1995 c 183 s 1, 1991 c 3 s 27, & 1987 c 512 s 13;

(4) RCW 18.19.130 (Certification of marriage and family therapists--Practice defined) and 1993 c 259 s 1, 1991 c 3 s 28, & 1987 c 512 s 14;

(5) RCW 18.19.140 (Applications for certification) and 1991 c 3 s 29 & 1987 c 512 s 17;

(6) RCW 18.19.150 (Examination of applicants for certification) and 1991 c 3 s 30 & 1987 c 512 s 16;

(7) RCW 18.19.160 (Certification of persons credentialed out-of-state--Temporary retirement of certified persons) and 1991 c 3 s 31 & 1987 c 512 s 19; and

(8) RCW 18.19.170 (Renewal of certificates--Continuing education) and 1998 c 32 s 1, 1996 c 191 s 6, 1991 c 3 s 32, & 1987 c 512 s 15.

--- END ---

APPENDIX: B

APPLICANT REPORT

Applicant Report

Mental Health Counselors

Social Workers

Marriage and Family Therapists

Contents:

I. Introduction

This report is submitted to the Department of Health to comply with RCW 120 on behalf of the Washington Mental Health Counselors Association, the National Association of Social Workers -- Washington Chapter, the Washington State Society for Clinical Social Work, and the Washington Association for Marriage and Family Therapy. These are the major groups representing the three professions of mental health counseling, social work, and marriage and family therapy in Washington. The report is based on House Bill 5332 and Senate Bill 5218, which would authorize the establishment of Licensed Mental Health Counselors, Licensed Social Workers, and Licensed Marriage and Family Therapists.

The applicant group is pursuing licensing in order to:

- ***Eliminate harm to the public*** by raising educational and professional standards for the applicant group to national standards; providing privileged communication status for clients; and eliminating public confusion about the qualifications and regulations of the profession.
- ***Benefit the public*** by defining scopes of practice and by qualifying clients for Medicare and Medicaid coverage. The public will also benefit by having a clear distinction between licensed practitioners and practitioners or groups which lack the education, training, and formalized standards of clinical practice defined in the licensure process.
- ***Provide effective professional oversight*** through the formation of a joint commission to implement licensed professional standards.

Mental health has become as important to good overall health as physical health. Studies have shown that 98 percent of U.S. citizens support access to mental health care (Parade, May 10, 1995). Mental illness affects more than 22 percent of the adult population. The importance of increased attention to mental health was impressively outlined in the Surgeon General's Report on Mental Health in December of 1999. The Surgeon General estimated that of the 40 percent of the public who will experience a mental health disorder during their life, more than half do not receive mental health treatment. Without such treatment there is increased absenteeism, reduced productivity, impaired family relationships, and unnecessary suffering. For children -- one of the most underserved groups as a whole -- the consequences can be a lifetime of emotional distress.

To meet the public need for quality mental health treatment, three disciplines have become an important part of the mental health delivery system. These include mental health counseling, social work (including clinical social work), and marriage and family therapy. Currently there are approximately 7,000 mental health counselors, social workers, and marriage and family therapists certified to practice in Washington State.

It is vital for the people of Washington state to understand the qualifications of these professionals. A recent survey (July, 2000) by the Seattle-based Evans/McDonough Research Company revealed that of Washington residents surveyed:

> *61 percent* assume that practitioners in the applicant group are required to have a license to practice.

90 percent favored the formation of a licensing system for the applicant group when informed that practitioners do not currently need a license.

To protect the citizens of Washington state, we believe it is essential that all practitioners in the applicant group who practice mental health treatment be licensed. The vast majority of states -- 45 for social workers, 42 for marriage and family therapists, and 41 for mental health counselors -- already license these professional groups. Licensure would protect the public more effectively than the present system by requiring experience and training requirements in line with the recommended national standards. Certification provides the right to use a title, but does not meet the higher requirements a licensure law would institute.

The applicant groups represent the national organizations that oversee these professions and have joined together to detail below the reasons licensure will better protect the public. This includes data from a recent study that shows the public is confused about the training and expertise of certified mental health practitioners, but understands that a licensed mental health practitioner has a recognized body of knowledge and expertise.

HB-5332 and SB-5218 will benefit the public by defining the scope of practice and the qualifications of the practitioner, and will also lessen the vulnerability of the public to unqualified practitioners.

II. Professional Education

The educational regulation of these disciplines confirms that there is a clear body of knowledge that must be learned to practice professionally. The need for a structured, clearly identified body of knowledge is self-evident. For example, an in-depth understanding of human development and the ability to develop and use clinical objectivity are key aspects of qualified mental health professionals. Only through recognized well-established training programs can this knowledge be acquired. The three applicant groups -- along with the three other major mental health clinical groups: psychiatry, psychology, and psychiatric nursing -- provide this kind of training to their graduates (see attached Table of Graduate and Post-Graduate Training). In addition, this formal education allows the applicant groups to provide a variety of services to the most vulnerable client populations, including children, the elderly, the disabled, the mentally ill, those with physical illnesses, etc.

1. Mental Health Counselors

Mental health counseling is a distinct profession with national standards for education, training, and ethical practice. Mental health counselors are prepared through graduate education and clinical training to provide a full range of services for individuals, couples, families adolescents, and children. The Council for Accreditation of Counseling and Related Educational Programs (CACREP) is the national accrediting body for schools offering degrees in mental health counseling, both at the the master's degree level and the doctorate degree level. In Washington, there are seven schools offering degree programs at the master's degree level or higher: the University of Washington, Eastern Washington University, Western Washington University, Seattle University, Leadership Institute of Seattle, Antioch University, St. Martin's College, and City University.

The core areas of mental health programs approved by the Council for Accreditation of Counseling and Related Educational Programs (CACREP) include:

- Diagnosis and psychopathology
- Psychotherapy
- Psychological testing and assessment
- Professional orientation
- Research and program evaluation
- Group Counseling
- Human growth and development
- Counseling theory
- Social and cultural foundations
- Lifestyle and career development
- Supervised practicum and internship

Mental health counselors are licensed as mental health professionals by 41 states and certified by six, including Washington.

Typically a licensed mental health counselor has met or exceeded the following professional qualifications: a master's degree in counseling or a closely related mental health discipline; completion of a minimum of two years post master's clinical work under the supervision of a licensed or certified mental health professional; and a passing score on a state-developed or national licensure or certification examination.

According to the report, Mental Health, United States, 1998, more than 96,000 professional counselors are licensed or certified for independent practice in the United States. The American Mental Health Counselors Association (AMHCA) is the national professional membership organization that exclusively represents the mental health counseling profession. Clinical membership in this organization requires a master's degree in counseling or a closely related mental health field and adherence to their National Standards for Clinical Practice and the AMHCA Code of Ethics.

In addition, the National Board of Certified Counselors (NBCC), a free-standing corporate body which has certified counselors in the general practice of counseling since 1981, also qualifies mental health counselors beyond the basic National Certified Counselor (NCC) credential with a specialty certification, Certified Clinical Mental Health Counselors (CCMHC).

The certified mental health counselors in Washington State are represented by the Washington Mental Health Counselors Association (WMHCA). This professional organization is affiliated with both the American Mental Health Counselors Association and the Washington Counselors Association.

2. Social Workers

The Council on Social Work Education (CSWE) is the accrediting body of professional schools of social work. Three levels of social work education are the national standard: baccalaureate (B.S.W.), master's (M.S.W.), and doctorate (Ph.D./D.S.W.). Promoting the importance of best practices, the CSWE "has developed official curriculum policy that specifies required content areas and identifies important professional values and purposes to which the content areas must relate." (Suppes and Wells, An Introduction to Social Work and Social Welfare, McGraw-Hill, 2000.)

In the United States there currently are 145 accredited schools of social work. In Washington State there are five: University of Washington campuses at Seattle (B.A.S.W., M.S.W., and Ph.D.), Tacoma and Port Angeles (M.S.W.); Eastern Washington University at Cheney (B.S.W. and M.S.W.), Toppenish and Everett (M.S.W.); Walla Walla College (B.S.W. and M.S.W.); Pacific Lutheran University at Tacoma (B.S.W.); Heritage College at Toppenish (B.S.W.). In addition, Seattle University is in the process of applying for accreditation of a B.S.W. program.

The CSWE policy statement has identified four major purposes of the social work profession (Council on Social Work Education, 1992, Section B4.0):

1. The promotion, restoration, maintenance, and enhancement of the functioning of individuals, families, groups, organizations, and communities by helping them to accomplish tasks, prevent and alleviate distress, and use resources.
2. The planning, formulation, and implementation of social policies, services, resources and programs needed to meet basic human needs and support the development of human capacities.
3. The pursuit of policies, services, resources, and programs through organizational or administrative advocacy and social or political action, to empower groups at risk and to promote social and economic justice.
4. The development and testing of professional knowledge and skills related to these purposes. Most states have recognized, through licensure, the specific knowledge base of qualified, professional social workers by limiting the use of the term "social worker" to those who have received their B.S.W., M.S.W., Ph.D., or D.S.W. in social work. At the master's (M.S.W.) level, social workers learn advanced skills and techniques that are used in specific practice concentrations. The concentrations differ at the various graduate schools and include methods of practice such as: clinical social work; medical social work; administrative social work; social work with children, couples, and families; school social work; community organization; and generalist practice in a rural setting.

Generalist Social Workers are trained to take a comprehensive systems approach to their clients, understanding each client in the context of the social environment. Generalist Social Workers are trained in human development; community organization; development of social policy; techniques for working with individuals, families, and groups; ethnic and cultural diversity; and special problems of the poor.

Independent Clinical Social Workers receive training in human development; ethnic and cultural diversity; the use of unconscious and conscious process in psychotherapy; the major theoretical orientations of psychotherapy practice; the concepts of neutrality, transference, and internal conflict; and how to recognize and use counter transference.

The training for Generalist Social Work practice includes a Master's degree in social work and two years post graduate experience and supervision. The training for Independent Clinical Social Work practice includes a Master's degree in social work and three years of post-graduate experience and supervision.

At the doctoral (Ph.D. or D.S.W.) level, social workers again choose a specific concentration and apply research techniques to the areas studied. Doctoral programs may last from 3-6 years, depending on the time needed to write a dissertation. A social worker who has received a doctorate must demonstrate the requirements for Generalist Social Work or Independent Clinical Social Work have been met or fulfill them after graduation.

3. Marriage and Family Therapists

Marriage and family therapy is a distinct professional discipline with graduate and post-graduate programs. Three options are available for those interested in becoming a marriage and family therapist: a master's degree (2-3 years), a doctoral program (3-5 years), or post-graduate clinical training (3-4 years). Historically, marriage and family therapists have come from a wide variety of educational backgrounds including psychology, psychiatry, social work, sociology, nursing, pastoral counseling and education.

Because the entry level practice degree for MFT is the master's degree while the doctorate degree is aimed at educating teachers and researchers, there are considerably more master's degree programs than doctoral degrees in the state. Masters degree programs include: Pacific Lutheran University, Tacoma; Seattle Pacific University, Seattle; Antioch University, Seattle; Chapman University, Fort Lewis; St. Martin's College, Lacey; and City University, Renton. The only doctorate program is at Seattle Pacific University, Seattle. Postgraduate programs typically offer training in MFT for individuals who already have a graduate degree in a related discipline. Postgraduate programs in Washington include: Presbyterian Counseling Service, Seattle; Montlake Institute, Seattle; and the Leadership Institute of Seattle; Baylor University, Seattle.

As can be seen, there are several avenues for obtaining MFT education in the state. The Federal government has designated MFT as a core mental health profession along with psychiatry, psychology, social work and psychiatric nursing. Since 1978, the federal government has also recognized the Commission on Accreditation for Marriage and Family Therapy Education of the American Association of Marriage and Family Therapy (COAMFTE) as the national accrediting body for the field of MFT. In addition, the Council for Higher Education Accreditation recognizes the COAMFTE as the non-governmental accrediting body insuring the quality of post-secondary education in MFT.

Although there are 14 doctoral programs, 44 master's programs, and 17 post-graduate programs accredited by COAMFTE in the United States and Canada, there are only two in the state of Washington. The master's program at Pacific Lutheran University and the postgraduate program at Presbyterian Counseling have both been accredited for over a decade. Accreditation involves an intensive review of the program, including a site-visit of

trained professionals, to insure that national standards are being met. The master's program at Seattle Pacific University is currently in candidacy status of the accreditation process. Candidacy indicates that the program has voluntarily gone through a peer review and a self-study with the intention of applying for accreditation by COAMFTE. There are no accredited doctoral programs within Washington. The COAMFTE standard curriculum requires course work in the following areas for master's degrees: theoretical foundations of the field, clinical practice of MFT, individual development and family relations, professional identity and ethics, research, and at least one course in additional learning. All COAMFTE accredited programs must have 500 hours of face-to-face clinical contact with clients under the supervision of an AAMFT Approved Supervisor or the equivalent.

As can be seen, the ratio of clinical contact to supervision is one to five. The current Washington counselor law allows for individuals to attend COAMFTE non-accredited degree granting programs as long as the candidates for certification can demonstrate the equivalent course work and the college or university itself is accredited by the appropriate post-secondary accrediting body. This decision is based on the relatively few programs that are accredited by the COAMFTE. Accreditation is an expensive and time consuming process that requires programs to meet rigorous educational standards. Post-graduate courses, however, must stem from a COAMFTE accredited program to count towards MFT certification since there is no outside body that regulates post-graduate institutions. After graduation from an accredited program, a period of usually two years, post-degree supervised clinical experience is necessary before licensure or certification. When the supervision period is completed, the therapist can take a state licensing exam, or the national examination for marriage and family therapists conducted by the AAMFT Regulatory Boards. This exam is used as a licensure requirement in most states. Washington uses the national examination with an added examination regarding state laws.

This report will now address the specific areas of current Washington law where the public is not protected by existing law.

III. Scopes of Practice

The three disciplines within the applicant group represent three of the five largest groups of mental health clinicians in the country, according to a 1996 study by the U.S. Public Health Service's Center for Mental Health Services. Social workers comprise 22 percent of the mental health work force (ranking first), mental health counselors rank fourth at 14 percent, and marriage and family therapists rank fifth at 11 percent. Practitioners from the applicant group work in a wide variety of health care settings, including inpatient facilities, HMOs, community mental health centers, business and consulting companies, schools, social service agencies, nursing homes, universities, and correctional facilities, as well as in private practice. This wide disbursement means that professionals in these disciplines are able to serve the public in settings other mental health care professions do not.

Serving the public in such a wide variety of venues has helped build public trust in these professions. The Evans/McDonough Survey of Washington residents found that:

77 percent have a favorable opinion of marriage and family therapists, with mental health counselors having a *70 percent* favorable and social workers having *67 percent*.

85 percent were less likely to go to a mental health practitioner knowing that their practice is not licensed by the state.

Licensure for the applicant group is essential to the public because it reduces confusion about the regulatory levels which define a scope of practice.

1. Mental Health Counselors

Mental health counselors practice in a variety of settings, including independent practice, community agencies, managed behavioral health care organizations, integrated delivery systems, hospitals, employee assistance programs, schools, correctional facilities, and substance abuse treatment centers. Mental health counselors provide a full range of services including:

- Assessment and diagnosis
- Psychotherapy
- Treatment planning and utilization review
- Brief and solution-focused therapy
- Alcoholism and substance abuse treatment
- Psycho-educational and prevention programs
- Crisis management

While typically agencies and institutions employing mental health counselors have their own defined supervisory processes (generally using more senior clinicians as supervisors and consultants), independent practitioners are ethically bound to contract privately for clinical consultation regarding their work with private clients. The standard of ethical practice for clinical supervision/consultation among independent practitioners consists of a combination of regularly scheduled face-to-face clinical consultation with either a clinical psychologist or psychiatrist (generally one to two hours per month), and frequent peer consultation (an additional one to two hours per month).

2. Social Workers

The following information details the scopes of practice for the two levels of licensure being requested for social workers, Generalist Social Work and Independent Clinical Social Work. Social workers are mental health professionals trained to take a comprehensive systems approach to their clients, understanding each client in the context of the social environment. The client may be an individual, couple family, group, organization, or a community. Social workers provide services in a wide variety of settings, including hospitals, nursing homes, schools, businesses, mental health centers, disaster relief centers, child welfare agencies, government agencies, counseling centers, and private practice. Services include assessment, counseling, psychotherapy, linkage to community resources, discharge planning, crisis counseling, case management, advocacy, community organization, and development of social

policy. Social Workers often serve the disenfranchised members of our society - the poor, the mentally or physically ill, immigrants, children, and the elderly. Social workers share certain values, including respect for every individual and the need for social justice.

The Council on Social Work Education has delineated the core competencies of generalist social work as follows:

- Assessment of Daily Functioning of Individuals and Families
- Assessment of Systems Functioning of Groups, Organizations and Communities
- Restoration of Basic Needs through Social Services
- Restoration of Well-Functioning Systems in Groups and Communities
- Alleviation of Emotional Distress through Counseling
- Alleviation of Emotional Distress through Psychotherapy (supervised)
- Development and Implementation of Social Service Programs

The primary settings in which Generalist Social Workers practice in include Medical Social Work in hospitals and nursing homes, School Social Work in schools, EAP Providers in business settings, Debriefing Consultants after traumatic disasters, and Social Work in public and private social service agencies.

The Clinical Social Work Federation and the Association of Social Work Boards have delineated additional areas of expertise necessary for practice as an Independent Clinical Social Worker as follows:

- Diagnosis Of Emotional and Behavioral Disorders
- Development and Implementation of Treatment Plans
- Psychotherapy - Brief, Short-term, and Long-Term
- Understanding of Conscious and Unconscious Process
- Understanding of Human Development
- Crisis Intervention and Management
- Liaison with Medical Services
- Supervision of Clinical Work of Social Workers
- Clinical Objectivity and Management of Personal Mental Health
- Advocacy for Public Access to Quality Mental Health Treatment

The primary settings in which Independent Clinical Social Workers practice include Independent Private Practice, Forensic Assessment, Mental Health Agencies, Supervision, and Consultation. The scope of practice for Independent Clinical Social Workers also can include the work done primarily by Generalist Social Workers.

The Evans/McDonough Survey showed public confusion about what social workers do and what their level of education is. When participants were asked what social workers do, there

were 18 different responses, suggesting confusion about the topic. Only 12 percent of those polled thought certified social workers - currently required to have a Master's degree in social work and two years of post-graduate experience - had graduate training. Finally, 87 percent of those polled said the state should require anyone called a social worker to have social work education. For these reasons, we believe the only way to clarify the meaning of the term "social worker" for the public is to have regulatory clarity through licensure and title protection for the term "social worker."

Current regulation of social work practice or Certification includes some acknowledgment of independent clinical social work practice. The limitations of Certification, i.e., the right to use a title without a scope of practice, seriously undermine any use Certification could have for consumers to understand the training and expertise of social workers at various levels. In addition, there are three levels of social work practice that are not acknowledged under current law. These include:

1. **Licensed Independent Clinical Social Worker** - licensed in 45 states to designate social workers who have met standards more rigorous than current standards for Certification to guarantee clinical skills and independent judgment so that LICSWs can practice independently. The requirements for LICSWs should be three years of post-graduate experience, 4000 supervised hours, and 1000 direct client hours.
2. **Licensed Generalist Social Worker** - licensed in 15 states to designate social workers who have clinical skills and use independent judgment but do not practice independently. This category generally includes school social workers, medical social workers, agency social workers, and others. The requirements for becoming a Licensed Generalist Social Worker should be two years of post-graduate experience, 3200 supervised hours, and 800 direct client hours.

It is important for these levels of social work practice to be regulated and understood by the public to protect consumers from social workers who may attempt to work outside their scope of practice.

3. Marriage and Family Therapists

Marriage and family therapists are core mental health practitioners educated and trained to help with relationship difficulties, and diagnose and treat the mental disorders and emotional problems of individuals, couples, families, and groups. MFTs practice early crisis intervention and brief, focused psychotherapy to resolve problems or reduce symptoms in the shortest time possible. They also have the expertise and skills to work with persons where more intensive, long-term treatment is necessary to cure or relieve mental or emotional conditions.

Patients who are treated by MFTs are more productive at work, visit their doctors less often, and have lower average lengths of stay at in-patient facilities. Marriage and family therapy is highly effective because of the "systemic" orientation that its therapists bring to treatment. They believe that an individual's mental or emotional problems must be treated within the

context of his or her current or prior relationships if the gains are to be meaningful and productive for the patient. This treatment philosophy is consistent with current thinking in the health care field, which increasingly emphasizes interagency cooperation, involvement of the family, and integration and coordination of services. Our health care system is now moving toward a more systemic approach and is increasingly rejecting individually-focused-care.

The development and widespread acceptance among researchers and clinicians of marriage and family therapy as a critical modality for intervening with an array of mental and nervous disorders has helped to foster the rapid evolution of the practice. For example, marriage and family therapy is considered an essential treatment for substance abuse disorders and chemical dependency. In addition, the treatment of major mental illnesses often include marriage and family therapy as an important modality of treatment. These illnesses include schizophrenia and other forms of psychosis; anorexia, bulimia, and other serious eating disorders; and depression and many other forms of psychopathology. Furthermore, virtually all disorders of childhood and adolescence, including delinquency, truancy from school, and dysfunction of the parent-child relationship, are routinely treated within a marriage and family therapy context.

Of all the reasons that individuals seek help, nearly half directly relate to interpersonal relationship problems, including marital issues, child-rearing difficulties, a common disorder, or schizophrenia, a severe mental illness. Today, family life is more complex than ever. There are more step-families, single parents, and homes where both parents work. The frantic pace of daily life and increased economic pressures often overwhelm families, breeding dysfunctional behaviors like alcoholism, drug abuse, family violence, and child molestation. As traditional family support systems continue to erode, families can increasingly turn to mental health professionals for help. Marriage and family therapists are trained in family dynamics. They work to develop healthy and productive relationships and nurture positive behaviors in families so that each family member can realize his or her full potential.

IV. Disparities Between Washington State and National Professional Standards

1. Mental Health Counselors

Washington State residents who seek mental health counseling from Certified Mental Health Counselors deserve and probably hold an expectation that state regulation of its mental health clinicians will at least keep pace with national standards for education and experience. Unfortunately, current state educational and experience requirements for Washington State Certified Mental Health Counselors do not.

The current national standard required by 22 states is 60 semester hours or 90 quarter hours. Current Washington State Certified Mental Health Counselor educational requirements specify a master's degree in mental health counseling or a related field, or completion of 30 graduate semester hours or 45 quarter hours. Washington State is only one of four states specifying this lower standard of accumulated credit hours. Thirteen states require 48 semester hours or 72 quarter hours. This, of course, means that Washington State Certified Mental Health Counselor requirements fall behind at least 34 other states in their educational requirements.

Currently, requirements for Washington State Certified Mental Health Counselors specify a minimum of 2000 hours post-master's supervised experience over a twenty-four month period. Thirty states require 50 percent more experience by stipulating at least 3,000 hours experience.

2. Social Workers

Standards for experience and supervision in the certified social worker category are below national standards. Twenty states require more *experience* than Washington to allow a clinical social worker to practice independently. Thirty states require more *supervision* or a higher level of supervisor training than Washington to allow a clinical social worker to practice independently (Social Work Laws and Board Regulations: A Comparison Guide, AASSWB, 1998). Increasing the standards of supervision and experience for independent practice and creating standards for advanced practice social workers who use independent judgment but do not practice independently, e.g., in schools, hospitals, agencies, etc., will protect the public more fully than current standards. Currently, Oregon, California, and Kansas require higher standards of experience (California = 3200 hours, Oregon = 3500 hours, Kansas = 4000 hours) to become licensed for independent clinical practice. Many states require higher standards of supervision to become a clinical social worker, including Alaska (100), Oregon (100), Maryland (144), and Kentucky (200). Finally, several states require a higher level of testing (Clinical Examination from ASWB) than Washington, including Alaska, Oregon, and Utah.

The two most important disparities between Washington State law and national professional standards are as follows:

1. In Washington State, current law does not acknowledge the ability of Certified Social Workers to make clinical diagnoses of mental disorders. This is an extremely important part of the mental health treatment process. Insurance companies, Medicare, and Medicaid require a mental health diagnosis according to the Diagnostic and Statistical Manual IV (and future editions) or DSM-IV for reimbursement purposes. This is necessary for social workers who work in agencies, hospitals, clinics, or as private practitioners. In almost all other states, social workers are licensed to make diagnoses of mental disorders.
2. All states use national tests developed by ASWB to test experience at all levels of practice. The Clinical Examination is the test designed to assess the skills of a clinical social worker who wants to work independently. The Advanced Examination is designed to assess Generalist skills at an advanced level. Currently, a social worker is allowed to become Certified if either examination is passed. The right to practice Independent Clinical Social Work should be based on passing the national examination that specifically tests clinical expertise.

3. Marriage and Family Therapists

The regulatory requirements in most states are substantially equivalent to the AAMFT Clinical Membership standards. Although Washington's Counselor Law has been judged by

the AAMFT as equivalent to national standards, there are several areas in which there is disparity between Washington State and national professional standards.

First, the qualifications of supervisors who are deemed acceptable in our state law are significantly less than national standards. The AAMFT sets national standards for supervision in MFT and designates individuals as Approved Supervisors. AAMFT requirements to be designated as an Approved Supervisor include: extensive practice as a marriage and family therapist, a course in MFT supervision, and supervision of supervision from an experienced supervisor. In Washington, the requirements are less demanding with no required special training in supervision. The current WACs require individuals to be certified, employed for three years in the profession as a marriage and family therapist, and to have supervised therapists for one year. WAC 246-810-332 requires 1,000 hours of direct client contact. The licensure provisions would increase requirements to 3,000 hours of supervised experience and client contact. This would bring Washington in line with national standards, which include 3,000 hours of supervised experience, 500 hours of client contact, and 100 hours of clinical supervision

Although these practice requirements are similar to national standards, there is no requirement that supervisors learn about supervision via a course and receiving supervision of their supervision from an experienced supervisor. Essentially, if individuals are in a position as a supervisor and have met the practice requirements as a marriage and family therapist, they are qualified to supervise. Given the key role supervisors play during graduate internships and during the required two-year supervised practice period, the lack of specific supervisory training is surprising and disturbing. Trained supervisors are one of the necessary ingredients to consumer protection. Therapists who are not fully credentialed are allowed to practice because supervisors are overseeing their work. Supervisors are responsible for counseling out untrained or impaired counselors from the field, and for assisting therapists-in-training to provide quality care to consumers until they are fully credentialed.

Second, a more minor disparity exists between the course work required by state law and national standards. The current specified course work is dated. The COAMFTE has changed the curriculum and Washington law has not kept up with the changes. However, the overall curriculum is still reasonably equivalent. This does pose problems for educational programs who are trying to serve two masters -- state law and COAMFTE accreditation.

V. Professional Regulation: Certification vs. Licensure

The word “certify” simply means “to vouch for the truth of.” In common use, certification indicates that an individual or entity has met certain minimum qualifications specified by voluntary associations, agencies, or governmental bodies such as legislatures and departments of education. Depending on the type of organization granting the certification, the process of certifying a professional can be either statutory or non-statutory.

On the other hand, “licensure” is defined as “permission granted by a competent authority to engage in a business or occupation” and is a term recognized by the public as having higher standards than certification.

The Evans/McDonough Survey showed the public has much greater confidence in state-licensed mental health care treatment:

85 percent stated they would be less likely to go to a mental health practitioner with the knowledge that the practices are unlicensed by the state; and

90 percent favored licensure for the applicant group.

Licensing mental health professionals would allow the public to be protected by a regulatory level that is understood and trusted. This is a major reason why – in each of the mental health disciplines – more than 40 states have established licensure as a professional standard.

A case in point is the certification offered to mental health counselors by Washington state (CMHC) and the certification (NCC) offered to mental health counselors by the corporate organization known as the National Board of Certified Counselors (NBCC). An individual trained as a mental health counselor who has met NBCC's requirements may accurately refer to him or herself as a "mental health counselor with certification," and may not actually be certified by Washington state as a certified mental health counselor (CMHC). Is it fair to assume that the average counseling client will know or even suspect the difference?

While this scenario is probably not common or hopefully even likely, it is a possibility due to the current use of the generic and non-specific term "certification" in reference to mental health counselors in Washington State. In addition to the professional certifications, our society contains an abundance of other certified designations— certified lawn mower repair, certified automobile mechanic, certified loan officer, etc. Much of the public does not know what the term "certified" means in relationship to their mental health needs.

What gets lost to the public in all this is that the designation of "certified" among the applicant group is a state-recognized level of clinical professionalism that has some significant relevance to their mental health needs. In the Evans/McDonough Survey, respondants believe "licensed" mental health practitioners were more qualified than "certified" practitioners by more than a three-to-one margin.

When the levels of registration and certification were added to Washington state mental health regulatory law in 1987, the intent of our legislators was to enable members of the public seeking mental health services to discern between: a) those who simply wanted to offer their help, talent, advice, insights, etc., to others (registered counselors); and b) professionals who pursued specialized training and experience and agreed to follow formally adopted standards of practice and a professional code of ethics, prior to offering their help (certified practitioners). In spite of 13 years of use, the term "certified" is still misunderstood by the public.

In more recent years, the state has accepted the use of the term "certified" to identify practitioners with a lower level of education and/or experience as the three masters level certified mental health disciplines, further confusing the meaning of the term. Chemical dependency counselors with only two years of college education are now referred to as Certified Chemical Dependency Professionals. Recreational therapists are pursuing their own legislative process to be recognized by the state as Certified Recreational Therapists without requiring a master's degree. This increase of state-designated certifications labeling a variety of educational and experience standards -- in addition to the privately offered certifications -- creates further confusion for members of the public trying to find an appropriate mental health treatment provider.

Washington State set an educational standard in the 1980's with certification of the applicant group, but the use of the term "certification" created confusion for the public. Licensure will benefit the public by insuring the professional training and ability of practitioners, and by enabling them to associate a familiar term - licensure - that has the consistent meaning of high quality and standards with the applicant groups.

VI. Access to Mental Health Care

The benefit of licensure to the public can also be examined in the access to mental health care services across socio-economic and geographic lines. In Washington state, the public's access to mental health care services is severely limited within Medicare and Medicaid guidelines. Since 'licensed' providers are recognized by Medicare and Medicaid but 'certified' providers are not, it is essential to the public – especially those of limited means – that members of the applicant group become licensed.

The importance of access to mental health treatment is best understood through what happens if the public does not have access to mental health services. Work productivity goes down; more people are homeless or in jail; health outcomes for people with heart disease; chronic pain, cancer, etc., go down; and the need for medical care, including hospital admissions, goes up (from information developed by the Coalition for Insurance Parity, January 12, 2000).

In addition, the vast and widely accepted empirical literature in health policy and economics suggests that a "cost-offset" phenomenon exists for mental health coverage. This phenomenon refers to the fact that the use of traditional and expensive medical services is found to decrease when appropriate mental health services are included within health benefit plans. The provision of mental health services, including those provided by the applicant groups, contributes to the "cost-offset" effect. Numerous studies show a decrease from 5% to 80% in medical service use following appropriate and well-managed mental health treatment. In fact, this well-documented phenomenon in health benefit plan design and management has been thoroughly researched, with significant support from the Department of Health and Human Services' Alcohol, Drug Abuse and Mental Health Administration, specifically from the National Institute on Mental Health.

The "cost-offset" phenomenon also has been found to exist in studies analyzing data from Federal Employee Health Benefit Program plans. These and other studies have documented that marital stress, separation, and divorce have a profound impact on health and medical utilization. For example, it has been found that hospital admissions are generally highest for separated and divorced individuals. In fact, admission rates for the divorced have been reported to be from six-to-120 times greater than the rate for married individuals. Evidence also suggests that divorced individuals have the highest hospital admission rates for most diagnostic categories, the highest rate of alcoholism and suicide attempts, and four-to-five times as great a utilization of outpatient psychiatric services as their married counterparts.

Since access to mental health services benefits the public both in terms of their overall health and by reducing other health care costs, it is critical that any barriers to accessing mental health providers and their services be addressed. The Evans-McDonough survey shows the public does not clearly understand the choices they have when it comes to selecting a mental health provider. Given the fact that the applicant group constitutes the largest number of providers of mental health in Washington State, this confusion is a serious barrier to the

public's access to mental health treatment. Licensure of these practitioners would eliminate this barrier by bringing clarity in the matter of who can provide these essential services.

VII. Privileged Communication

In order for genuine therapeutic work to occur in mental health treatment, clients need to feel safe to talk about intimate and personal aspects of their lives. Clients will be reluctant to share personal information freely unless they can trust that their privacy will be respected. While it is true that clients who consult with either registered or certified clinicians in Washington state have a degree of confidentiality, their confidentiality by no means comes close to the level of privileged communication of clients who receive treatment from either psychiatrists or psychologists.

The importance of utmost levels of privacy - or privilege - is essential to ethical standards of practice in all clinical disciplines in the field of mental health treatment (Codes of Ethics for American Psychiatric Association, American Psychological Association, American Association of Marriage and Family Therapists, American Mental Health Counselors Association, National Association of Social Workers, and Clinical Social Work Federation).

To the public, the need for privileged communication with their health care provider is vital. In the Evans/McDonough Survey:

> *81 percent* were more in favor of licensing for the applicant group if that licensing included privileged communication provisions.

Privileged communication -- included in the vast majority of the states granting licensure to these disciplines -- recognizes the importance of an individual to confide without fear of an unauthorized disclosure. Subsequent court orders may force disclosure of information in a variety of lawsuits, allowing this information to become public record.

Current Washington state law provides for some measure of privacy to communications by a client to registered or certified mental health practitioners (RCW18.19.180); however, there are exceptions to this confidentiality. Most importantly, this law indicates that disclosures made to registered or certified counselors may be subpoenaed by a court of law. This rather vulnerable degree of confidentiality protection strikes quite a contrast to the privileged communication status offered clients of psychiatrists and psychologists, despite the fact that all of the above mentioned clinicians provide some form of “counseling” to members of the public and all could be providing treatment for the same clients.

Discriminatory privacy standards for those with less wealth was one of the issues discussed by the Supreme Court in Jaffee v. Redmond in 1996, in which the majority opinion granted privileged communication in federal court for communication to clients obtaining therapy from a licensed social worker. Justice Stevens, in writing the majority opinion, acknowledged the universally accepted standard that a psychotherapist-client privilege covers confidential communications made to licensed psychiatrists and psychologists. He also observed that in the case before the court, the psychotherapist was a licensed social worker— a licensed master’s level clinician.

Justice Stevens suggested that the reasons for recognizing a privilege for treatment by psychiatrists and psychologists apply equally to treatment offered by the master’s level licensed clinical social worker involved in the case. He also called attention to the fact that

"the poor and those of modest means" cannot afford the services of a psychiatrist or psychologist, but that their counseling sessions "serve the same public goals."

We cannot in good conscience legislate a discriminatory and compromised form of psychotherapy for those who seek mental health treatment from master's level clinicians in Washington state who have the same level of training as clinicians who currently have privilege when cost prevents a client from being able to access counseling that is guaranteed ahead of time to be held in confidence.

No less than our highest court has affirmed that, "[e]ffective psychotherapy... depends upon an atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosure of facts, emotions, memories, and fears.

Justice Stevens, in Jaffee v. Redmond also wrote, "given the importance of the patient's understanding that her communications with her therapist will not be publicly disclosed, any state's promise of confidentiality would have little value if the patient were aware that the privilege would not be honored..." He further stated: "a psychotherapist-patient privilege will serve a 'public good transcending the normally predominant principle of utilizing all rational means for ascertaining truth.'"

In the state of Washington, the right to privilege would not supersede the need to keep children and adults safe from abuse and/or neglect. However, with licensure, all other information discussed by a client should remain the private domain of the clinician, improving the chances for the client's mental health treatment to be successful.

VIII. Disciplinary Process

Professional review of complaints in a given profession is essential to maintaining high standards of practice. In the area of health care, the Uniform Disciplinary Act, RCW 18.130, including its broad descriptions of unprofessional conduct (RCW 18.130.180), was adopted in Washington State in 1984. This section of law is currently the basis upon which the Department of Health evaluates complaints brought against members of all health professions.

The applicant group seeks to create a new regulatory entity with licensure. The format would be that of a commission which would include representatives of the applicant group, staff from the Department of Health, and members of the public who would review complaints. This model would allow members representing the professional organizations to bring both their clinical and experiential expertise to the review of complaints. Another way that licensure for the applicant group would set a higher standard (in some areas) than the Uniform Disciplinary Act, would be by setting in law specific acts that would be identified as "unprofessional conduct," giving consumers additional grounds for complaint and action. A similar process was adopted by the Washington State psychologists in their licensure law (see RCW 18.83.050 (5); 18.83.120; and WAC 246-924). States that have adopted similar models have seen a lower level of complaint because there is a clear scope of practice and standards of behavior that are applied to the actions of professionals.

Professional organization membership is optional for practitioners in each field, which means that formal subscription to a professional ethics code is also optional. Without statutory rules of ethical conduct, such as those adopted by the psychologists in their licensure laws, the

unwary public may be victimized by the ignorance as well as the irresponsible behaviors of a clinician who could not find any specific objection in law to his or her behavior.

The formation of a single commission to oversee the three professions will save the public money by not duplicating processes. In addition, it will create a more cohesive understanding of standards within the three fields, and provide a unified voice in these professions.

IX. Summary

Without clearer and higher standards, the public will not be adequately protected. Knowledge of the particular expertise that mental health counselors, social workers, and marriage and family therapists possess will only be achieved if there are:

- Clearly defined scopes of practice.
- Clarification of different levels of practice.
- Clarity and consistency in regulatory titles.
- Privileged communication status.
- Adequate professional standards of practice that conform to national standards.

The need for clarity and regulation within these areas is paramount to the public. Washington citizens responding to the Evans/McDonough Survey sent a clear message:

> *90 percent* of those surveyed favor licensure for the applicant group, with only *4 percent* opposed to licensure.

That mandate reflects the public's desire for the protection, accountability, and privileged communication licensure would bring.

Consumers deserve to have knowledge about and access to the services provided by professional mental health practitioners. Licensure would benefit all the citizens of Washington by providing this knowledge and establishing clear standards of practice.

X. History of the Professions

1. Mental Health Counselors

Professional counseling is a product of two kinds of historical development; the first of these is the vocational guidance movement. The publication in 1906 of the book, *Choosing a Vocation*, by Frank Parsons, is usually pointed to as the beginning of this movement. Parsons was impressed with the great need in an industrial society for helping young people find suitable places in the world of work. As he thought through the problem, it took on a clear structure for him, and this structure has dominated vocational counseling ever since. What a person must have in order to make a good choice is dependable information about: (1) the characteristics of different occupations, and (2) his own talents and limitations. The task of the vocational counselor is to make both these kinds of information available to the client and to help him comprehend and utilize it.

The second of the two historical streams that merged with vocational guidance to form our present counseling profession was the mental health movement. Here, too, an influential book forms a convenient landmark from which we can chart its beginning. Clifford Beers, in *The Mind That Found Itself*, published in 1908, called public attention to mental illness as an individual experience and a social problem. People began to be concerned about prevention as well as cure, about the less serious as well as the more serious emotional difficulties.

It was during this same period that psychoanalysis emerged both as a method of treatment for the emotionally disabled and as a way of thinking about human motivation and behavior. Persons who in previous eras would have accepted anxiety and frustration as inevitable, began to look within themselves for its sources. This development did not reach its peak until the 1940's.

As World War I had convinced people that mental abilities were measurable, so World War II convinced them that emotional difficulties were curable. The professions of psychiatry and clinical psychology expanded rapidly with an increase in the practice of psychotherapy.

Professionals who participated in the mental health movement (who had no connection with vocational guidance) began to use the term *counseling* in reference to *psychotherapy*. Although the vocational guidance emphasis tended to be dominant in schools, the mental health emphasis was dominant in clinics and social agencies; the force of circumstances tended to bring these two disparate meanings of the term together. Vocational counselors repeatedly encountered personal, social, and emotional problems in the clients they interviewed. Mental Health Counselors found that they needed to concern themselves with their clients' outer circumstances as well as their inner realities. Thus, while the speciality of Vocational Counseling remains, the two kinds of service—helping people to make wise choices and helping them to improve their emotional health and well-being—have increasingly been offered by the same professional person: a Mental Health Counselor.

2. Social Workers

Social workers are represented across the nation and across the world through two major social work associations. The National Association of Social Workers (NASW), based in Washington, D.C., incorporated in 1967 and now has 155,000 active members in 50 states and three territories. Washington State NASW, now 25 years old, has 2550 members. The other major organization is the Clinical Social Work Federation. CSWF incorporated in 1976 and now has 8000 active members in all 50 states and Puerto Rico. The Washington State Society for Clinical Social Work was founded in1976 and incorporated in 1988. It currently has 160 members. The current National President of CSWF, Keith Myers, is a member of the Board of WSSCSW.

The social work profession is supported by the Council on Social Work Education (CSWE), the accrediting body for professional schools of social work across the country. This agency develops the educational standards that must be maintained by schools of social work to maintain their accreditation. Many states will not license social workers unless they have graduated from a CSWE accredited school of social work. The Association of Social Work Boards (ASWB) is the national body that writes and administers the written examinations that are accepted as the national standard for testing skills, knowledge, and competency of social work graduates for licensure.

The social work profession has grown and matured in its scope of practice since the turn of the century. Indeed, the profession celebrated its 100th anniversary in 1998. Social work started in England in the late 1800s and took hold in Buffalo, New York in 1877. Though very well meaning, this early movement viewed poverty to be the result of personal character defects. "Friendly visitors" visited people in their home to provide "moral uplift." Material aid was rarely offered.

A second movement, which actually led to the birth of social work as a true profession, began with the formation of settlement houses, starting in England and then in the United States in 1877. These early workers viewed poverty as resulting from unjust and unfortunate social conditions, rather than personal defects. This movement began by developing needed services such as day care for children of factory workers.

A third movement, the child welfare movement, began when the Children's Aid Society was founded in 1853 in New York City to prevent cruelty to children.

During the 1940s, many social workers began to give attention to the internal (mental and emotional) needs of their clients as well as their external (food, clothing and shelter). These social workers began to seek and receive the kind of training that psychologists and psychiatrists were also receiving in the mid 1940s. This group of social workers became known as "Clinical Social Workers."

The movement toward licensure within the field of social work began with efforts to regulate the practice of clinical social work. In 1947, California became the first state to license Clinical Social Work. Since that time, all but five states have adopted licensure laws for clinical social work. In addition, licensure laws have been passed in 15 states to regulate "Generalist Social Work." These two levels of licensure are needed to regulate the diverse kinds of work trained social workers do and the need to protect the public in all these diverse areas. The underlying purpose of social work licensure and regulation is to protect the variety of vulnerable populations with whom social workers work. As outlined above, social workers have traditionally worked with the most vulnerable of populations. Washington is one of the five remaining states that does not license any practice of social work.

3. Marriage and Family Therapists

More than 50,000 marriage and family therapists (MFTs) in the United States provide health care services to more than 1.8 million people at any given time, according to the American Association for Marriage and Family Therapists. MFTs cross wider geographic and socio-economic bounds than other mental health care fields. To maximize their availability to the public, MFTs practice in a variety of work settings, including:

- Inpatient facilities
- Employee Assistance Programs
- Health Maintenance Organizations
- Community Mental Health Centers
- Business and Consulting Companies
- Schools and Head Start Centers

- Social Service Agencies
- Nursing Homes
- Universities and Research Centers
- Courts and Prisons
- Private Practice

Sometimes MFTs work in teams with other health care professionals, such as family physicians. And some are involved in family research and public policy analysis from a family perspective.

The number of states utilizing licensure status for MFTs has grown from 11 in 1986 to 42 today. Most of the states that do not have licensure – including Washington – are working through state legislatures for licensure. The states without licensure status include: Delaware, Idaho, Louisiana, Montana, New York, North Dakota, Ohio, and Washington.

MFTs in states that have obtained licensure have discovered many benefits, including:

- Public trust that MFTs have met a legal standard of qualifications to practice.
- Protection of clients' insurance reimbursement rights, as well as Medicare and managed care benefit rights.
- Protecting or obtaining privileged communication status.

The Washington Association for Marriage and Family Therapy (WAMFT) is the recognized professional organization for MFTs, representing more than 800 marriage and family therapists in the state.

WAMFT is a division of the American Association for Marriage and Family Therapy (AAMFT), which represents more than 25,000 therapists, providing education and research opportunities for MFTs since 1942. AAMFT believes that therapists with specific education and training in marriage and family therapy provide an effective approach to mental health care to individuals, couples and families.

To support the work of divisions such as Washington, AAMFT facilitates research, theory development, and education. The association develops standards for graduate education and training, clinical supervision, professional ethics, and the clinical practice of marriage and family therapy.

MFTs comprise 11 percent of the clinically trained mental health personnel in the United States, according to a recent report from the U.S. Public Health Service's Center for Mental Health Services. This percentage ranks fifth among professions, behind social work and psychosocial rehabilitation (22 percent each), counseling (14), and psychology (16); and ahead of psychiatry (8), school psychology (5), and psychiatric nursing (2).

MFTs, along with social workers and counselors, are the primary clinical staff of mental health and other health clinics. Approximately 50,000 clinically trained professionals are employed in clinics throughout the country, either as their primary or secondary work setting. MFTs and psychologists predominate the approximately 140,000 clinically trained mental

health personnel who work in private practice, either as their primary or secondary work setting.

A total of 88.4 percent of MFTs are involved in direct patient care, one of the highest percentages of any of the mental health disciplines. In addition, nearly half of all MFTs (46.7 percent) are involved in teaching, and 16.5 percent participate in research activities.

Marriage and family therapy is among the few mental health care disciplines which cross geographic bounds, not only in a state-by-state basis, but also in terms of community size and make-up. The west coast – including Washington -- has one of the highest concentrations of MFTs in the country.

XI. Bibliography

Evans/McDonough Survey of Washington Citizens re: Mental Health Professionals, July, 2000.

American Mental Health Counselors Association (2000). Requirements for Counselor Licensure: Education, Experience & Examination.

U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration.

Data compiled by American Counseling Association and was effective July 1, 1999. <www.counseling.org>

Fischer, L., & Sorenson, G.P. (1996). *School Law for Counselors, Psychologists, and Social Workers* (3rd ed.). New York: Longman.

Psychotherapy Finances, April 1997.

Jaffee v. Redmond, Supreme Court of the United States, No. 95-266, June 13, 1996.

Suppes, M. and Wells, K. An Introduction to Social Work and Social Welfare. New York: McGraw-Hill, 2000.

American Association of State Social Work Boards, 1997 Report.

Comparison of Training Programs for Mental Health Disciplines, 1999.

Consumer Reports, "Does Therapy Help?", November, 1995.

Psychotherapy Finances, "Therapist's Fees and Incomes are Under Growing Pressure", Vol. 23, No. 5, Issue 277, May, 1997.

Supreme Court Decision, Jaffee v. Redmond, June 13, 1996.

New York Times Magazine, "Keeping Secrets", June 16, 1996.

Mental Health: A Report of the Surgeon General. December,1999.

Parade, "Mental Health for All", May 10, 1995.

New York Times, "Social Workers Vault into a Leading Role in Psychotherapy", April 30, 1985.

Council on Social Work Education (CSWE), Summary of Information on Master of Social Work Programs, 1997-8.

Sanville, J. and Edward, J. Fostering Healing and Growth. New Jersey: Jason Aronson, 1996.

Levine, S. Useful Servants: Psychodynamic Approaches to Clinical Practice. New Jersey: Jason Aronson, 1996.

Lazar, S., Hersh, E., and Hershberg, S. "The Long term Needs of Psychiatric Patients". American Journal Of Psychiatry, 1995.

American Association for Marriage and Family Therapy, Educational Standards, 2000.

APPENDIX: C

PUBLIC HEARING SUMMARY

Public Hearing Summary
September 27, 2000

Mental Health Counselors Sunrise Review

Review Panel:

Rick Buell, Department of Health
Frank Westrum, Department of Health

Department of Health staff:

Steve Boruchowitz

Applicant Group:

Barbara Lynn, MHC
Susan Childers, WSSCSW
Glee Palmer Davis, SW, WS Chapter National ASW
Chris Lien, WAMFT

This proposal is being presented to eliminate harm to the public, raise education and professional standards, provide a privileged communication benefit to patients, eliminate public confusion about regulation of professions. Benefit: define scopes, qualify for Medicare/aid, distinction between licensed group and those groups less qualified. It will provide professional oversight, and create "commission" to implement program.

Mental Health (MH) is important to overall health. Most people support access to MH care. It affects 22% of the adult population. Many don't get treatment, which results in increased social and personal costs. Children are very underserved.

These three groups are an important part of the mental health delivery system. There are 7,000 providers in the three groups currently certified. Our survey of the public, reveals how these professionals are viewed. (Survey results available separately). Most other states license…license in line with national standards, certification is lower. Therefore, less protection.

A survey of the public shows that 90% feel that a state license is needed, but 80% are less likely to go if they are not licensed. Certification doesn't mean what it did when first passed. At that time, it was effective by setting standards, defining professional contact, and engendered public trust. The term is now used too broadly (chem. Dep. Counselors with only two years are certified, etc.). Some do not require supervised client experience. It is easy for

the public to be confused. Licensure also creates real improvements which equals increased client contact hours, and supervised hours, up to national standards. Licensure is the national standard.

Also: health benefits contacts, if try to find licensed , get confused, do not get treatment.

Scope of practice

People understand if there are boundaries to a professional's practice. This provides an assurance of expertise, conduct, and process for redress. We work in a wide variety of settings, with a wide variety of clients, and are in settings the other MH professionals do not serve. The survey showed a arge majority had favorable view of MH groups. Report outlines scope of practice of the three groups…MH provide full range (assess, diagnose, treatment, crisis management, etc)…standard of ethical practice for independent practitioners, includes consultation with peers.

Social Workers: Our report details two levels being requested. Distinctions allow clarity in scope of practice. Independent SW can also include generalists' work, but not other way around.

Only 12% of the public surveyed thought certified SW had graduate training.
Certification allows some of the same practice scope. This will allow a better understanding.

Marriage and Family Therapists (MFT): Educated and trained for relationships, emotional problems, etc., early crisis intervention. Expertise for long term treatment, too. The profession has developed rapidly in recent years, now also includes drug abuse treatment. Family life today demands we have well trained providers.

Privileged communication

Critical elements for success therapy is the ability of a client to trust that their personal life will remain confidential. 1998 study showed that clients who do not feel privacy protected are unwilling to fully discuss problems. Privilege is essential. Currently 36 states give this privilege. Washington has a degree of confidentiality, but not close to those served by psychologists and psychiatrists. Files are available for some lawsuits, including marital disputes, etc. We support violating privacy if there is a danger to self or others, otherwise it needs to be kept privileged. Supreme Court case said licensed social workers should have this. There are weaker standards for those who are served by Masters level folks. From survey: 81% more in favor of licensing if it included privileged communication.

Disciplinary Process (Glee Palmer Davis)

Professional review of cases is essential. Envision a commission to include the three groups, and public members. Currently staff review, that's all.

Psychologists adopted what is being suggested here. Certification is optional, so adherence to code of ethics is optional. Definitions currently in the law are unclear to those practitioners who want to comply.

Education standards:

Confusion about license/certified leads to lack of access to needed care. License eliminates hesitation on part of patients.

Benefit contracts often just say "license" so they think benefits are not covered, even though they probably are.

Distinction of licensure vs. certification becomes more known if passed. An educated public can make an informed decision.

Question to SW:

With two classifications, does that increase confusion? Poll showed people cannot describe what SW do, few think of them as mental health providers…clinical SW do provide 22% of MH services….45% in rural areas….two categories help identify them as providers.

SW are employed in many work settings. Some are under supervision, some aren't. That is the distinction. The non-independent work in a wide variety of settings but under supervision. Both do have clinical skills, it is the independence that makes the difference.

Question:

Attrition rates?? Would we lose total number of professionals, particularly in rural areas? (Are the requirements too stringent to meet??)

Answer: In VA 15 years ago, there was no attrition when the state went to license from certified.MFT. (42 states are now licensed) May drop out of professional association, but not the profession altogether. Schools generally support license, so they will provide adequate training so people can meet the higher standards.

SW provide large service in rural areas, the sense is that it would not cause someone to drop out…some concerns about supervision perhaps to get license…when pocket exist, we can make services/supervision available.

Access to care issue Question:

Does requiring licensure raise the bar of access for uninsured? Does cost of license raise cost of care?

Answer:

70% of MFT patients do not now use health benefit. Also, privileged communication would entice people to go and get their money's worth. We do not anticipate any change in charges.

Social service agency rep: see people on sliding scale, will not affect.

BREAK

Question:

Is the exam "approved" – is it nationally recognized, has the exam been validated so if there are questions on the content that it is valid??

Answer:

The SW exam is national, administered by Social Work Boards…
The National Board for Certified Counseling has a national validated exam.
MFT is the same.

Question:

Do supervisors go through an approval process?

Answer:

Yes, they need course work and supervised hours themselves.
MH Counselor supervision through the board is available, but not required.

Question:

Are educational institutions accredited?

Answer:

Yes.

Question:

CE: Increase in skills and knowledge for all groups…if passed, will there be a disparity in new professionals and the seasoned, veterans out there? Is there a need to upgrade those educated a while ago?

Answer:

We are not requiring additional education, just client contact hours. Members already have them. This is true for all groups.

Mike Fitzpatrick, past president MFT, on national board

Two important things: First, the licensing process started 20 years ago (in other states) and the level of standards are much higher. Two, our model law started as licensure and did not ask for certification at the beginning. Few states started with certification moving to licensure.

Comment:

Several MH programs across the state, licensed to provide, but accredited by Council on Accreditation. Standards include requirement MHC have MA and are licensed. 4 years between accreditation… had to explain why not licensed.

"My hairdresser is licensed"!

His mother had understanding of license and what a plumber had to do to become licensed.

Consumers know the difference, if they see a licensed person doing something wrong, they know to go to state for redress.
License requirements are reassuring to patients.

Keith Myers:
(See written comments)

Denise Gordon: (Certified SW…licensed SW Clinical in Maryland)

Portability….if a Washington resident moves to another state, they cannot have that level of regulation in another state. Most professionals want highest degree of training.
Schools have requirements for supervisors…License means Washington does not lag behind.
Why do we license massage therapists and not MH counselors??

Question:

Does proposed law clearly provide for standards for reciprocity?
If national standard curriculum is available we can look at that.
Hours of supervision and documenting it is an issue.

Joan Lindell Holcom:

Just want to underscore what has been said, has been SW for 41 years. This is way overdue. People we deal with have very serious problems…(teaches at UW)….if people are just registered, have caused real harm to people. Thought certification would do it, but it doesn't. Agencies do help people without insurance.

Dr. Jim Ingersoll:

40 years of experience…confidentiality…is PhD psychologist…approved MF supervisor. 25 years in WA state…essence of this work rests on confidentiality.

Years ago people went to priests because of confidentiality. All healing practices need confidentiality. As a licensed person, I know state stands behind me in confidentiality. It comforts me as a practitioner because I'm accountable.
Practitioners are part of the public, too.
Access is one of the threats to confidentiality, not money.

Laura Groshong:

Certified social worker, 23 years practice, Legislative Chair for State Society for Clinical SW.

I have worked with 10 states on licensure issues. Have seen these questions before.

1. Two levels of SW licensure…Texas has 5 levels; 22 states have 4 levels. 20 states have 3 levels. Because of the range of tasks, we need to have at least those two levels. These two are the ones the public needs to know about.
2. On the question of whether there could be privilege for certified categories…It would work, but it has not passed before, and is a public concern that we don't have it.
3. Registered being grandfathered—want as many trained people in license category. If trained, wanted them to be licensed, be recognized. We need clear standards to do that, not just anybody who is registered.
4. Reciprocity: want it to be same as for other states. If meet supervision, etc., we should have it.

Tina Sellers: UW professors, family medicine, preceptor.
SPU clinical professor, MFT. MFT accredited program. Supervisor approved MFT.

License will serve public:
1. As trainer of MFTs, aware of strict professional guidelines for students. 500 on client hours in graduate training. Then hours for certification. Problems created/resolved in systems. Students sit with more than one person. Licensure is clear definition, clear meaning about competence. Closely equates to particular level of training, experience. Matches what we are asking students to do (nationally). This would be better understood by the public and practitioners.
2. Licensure facilitates collaboration among providers, especially medicine and MH providers. Physicians understand license. They feel certification has nothing to do with competence. 2/3 of MH issues are presented to Primary Care physician at first. Could collaborate with physicians more readily, open door to care faster. Helps physician improve their care, too. When psychosocial care with medical, patient and provider satisfaction and outcomes goes up.
3. Licensure improves and increases public access with no affect on economics. Insurers, etc., recognize License and have in mind a meaning about competence. Therefore, improving parity among providers and improving flow for integrated care. More access

Brian Kennedy: Personal exp…MFT…When he worked at Student health services at Evergreen…

He had to turn clients away because he wasn't licensed. Blue Cross of Idaho requires plan members be seen by a licensed practitioner. Two folks had this and could not be seen. NCQA standard moving toward license as respected credential.
Re: privacy…1/3 work with couples. Research at UW showed that most couples come to therapy after a lot of pain and the despair level is high. A degree of safety for both people to discuss all issues is tantamount to success. As info is discoverable, patients are less amendable to treatment. Process needs to be very safe for patients. Info can be misused in court proceedings.

APPENDIX: D

PARTICIPANT LIST

Participant List

NAME	ORGANIZATION
Cristi Lien	Washington Association of Marriage and Family Therapy
Ann Simons	Washington Association of Marriage and Family Therapy
Mike Fitzpatrick	American Association of Marriage and Family Therapy
Doug Araham	Washington Mental Health Counselors Association
Judy Roberts	Washington Mental Health Counselors Association
Lisa Erickson	Washington Mental Health Counselors Association
Susan Childers	Washington State Society for Clinical Social Workers
Lonnie Johns-Brown	National Association for Social Workers
Suzanne Brown	Washington Coalition of Sexual Assault Programs
Shelby Dragila	National Association of Social Workers
Glee Palmer-Davis	National Association of Social Workers
Barbara Wend	Washington Mental Health Counselors Association
Brian Kennedy	Washington Association of Marriage and Family Therapy
Nancy Albrecht	National Association of Social Workers
William Etnyre	National Association of Social Workers/WSSCSW
Claudia Doss	National Association of Social Workers/WSSCSW
Joan Duroe	Washington State Society for Clinical Social Workers/BCD
Audrey Shiffman	NSSCSW/NASW
Pam Lovinger	Washington State Department of Health
Shellie Pierce	Washington State Department of Health
Keith Meyers	Washington State Society for Clinical Social Workers
Ann Crabtree	Washington State Society for Clinical Social Workers
Jenny Pearson	Washington State Society for Clinical Social Workers
Thomas Dighm	UWT
Denise Gordon	National Association of Social Workers
Laurie Jinkins	Washington State Department of Health
Gail McGaffick	Washington State Psychology Association
Joan Lindall Holcomb	National Association of Social Workers
John Briganti	Maharishi Vedic Health Center
Dr. Jim Ingersoll	Private Practice
Laura Groshong	Washington State Society for Clinical Social Workers
Tina Sellers	Washington Association of Marriage and Family Therapists
Michelle Eager	Group Health Cooperative
Robert C. Strauss	Clinical Social Worker
Christine Ingersoll	Clinical Social Worker
Kathryn A. Cox	Clinical Social Worker
Constance Schnell	Clinical Social Worker
Jean W. Eakins	Certified Marriage and Family Therapist
Sarah Ellingson	Certified Social Worker/Certified Mental Health Counselor
Kathleen Hockey	
Punkey Adams	Social Worker
Marcia Robbins	Clinical Social Worker
Michael Hays	Clinical Social Worker
Keith Meyers	Clinical Social Worker
Diane Debiec	Clinical Social Worker
Judith Mendenhall	Clinical Social Worker

Gita Foltynewicz	Clinical Social Worker
Marianne Pettersen	Clinical Social Worker
Dr. Nancy Hooyman	University of Washington
Anne Thureson	Social Worker
J'May Rivara	Social Worker
Dennis Anderson	Certified Mental Health Counselor
Barbara Minogue	Clinical Social Worker
Kathleen Ringwood	Clinical Social Worker
Janice Hickey	Clinical Social Worker
Dr. Bonnie Bhatti	Clinical Social Worker
Midge Levy	Social Worker, Group Health Cooperative
Beverly Underwood	Clinical Social Worker
Raetta Daws	Clinical Social Worker
Laura Funk	
Kay Kessel-Hanna	
BJ Harold	
Rodney Jong	American Association of Marriage and Family Therapists
Anne Armstrong	Certified Marriage and Family Therapist
Nancy Paul	Certified Marriage and Family Therapist
Dr. Donald Smith	Certified Marriage and Family Therapist
River Malcolm	Certified Marriage and Family Therapist
Dr. Joseph L. Price	Family Medicine of Southwest Washington
Amanda Franklin	Washington Association of Marriage and Family Therapy
Gaaren Anderson	Certified Marriage and Family Therapist
Jolee Darnell	Clinical Social Worker
Chuck Bender	Certified Marriage and Family Therapist
Carli MacColl	Certified Marriage and Family Therapist
Dr. Brian DesRoches	
Kerry Ann Shaughnessy	University of Washington student
Oliver Goss	Social Worker
Lynn Stedman	Certified Mental Health Counselor
Kirk Roberts	
Roy Anderson	American Association for Marriage and Family Therapists
Tina Schermer Sellers	Seattle Pacific University
Peggy Scaief	Clinical Social Worker
Ellen Roberts	Certified Social Worker
Kay Drescher	Certified Marriage and Family Therapist
Lottie Triplett-Fitts	Clinical Social Worker
Larry Martin	Social Worker
Lorelyn VanderBilt	Certified Marriage and Family Therapist
Joyce Roth	Clinical Social Worker

Review Panel

Frank Westrum, Department of Health
Rick Buell, Department of Health

Department of Health Staff

Steve Boruchowitz

APPENDIX: E

REFERENCES

References

"Counselor Licensure." [Online] Available at
http://www.tarleton.edu/~counseling/coreesour/counselors/counselors.htm

"Marrriage and Family Therapist Licensure." [Online] Available at
http://www.tarleton.edu/~counseling/coresour/family/family.htm

"Rehabilitation Counselor Education Program." The University of Texas. [Online]
Available at http://www.ebd.utexas.edu/coe/depts/sped/Rehab/homepage.html

"Social Worker." Occupational Outlook Handbook. [Online] Available at
http://www.stats.bls.gov/oco/ocos060.htm

"Social Work Licensure." [Online] Available at
http://www.tarleton.edu/~counseling/coresor/socialworkers/socialworkers.htm

"Summary of Licensing Law and Regulations for Professional Counselors and Marriage and
Family Therapists." [Online] Available at
http://www.oblpct.state.or.us/docs/summary.htm

APPENDIX: F

REBUTTALS

Dennis Anderson, MS, CMHC

I read with disappointment the recommendations of the review. I would like to respond to the findings, specifically Finding #9 which states the "Department did not find any evidence to confirm a problem with reimbursement".

Within the State's own bureaucracy, there is not equitable treatment of certified professionals. I have attempted for years to provide mental health services to Labor and Industries patients only to be told that they contract only with "licensed" professionals. Since I am certified and not licensed I am restricted in providing services to this population (actually I have been told I am free to provide services to this population but I just won't be reimbursed). I find this situation to be inequitable and an example in direct contrast to your recommendations. L&I clearly is not an "out of state" insurance program.

If the final recommendation is not to go forward with licensure, I would strongly recommend developing equity within the State programs themselves. I would ask you to contact the L&I office and inquire as to their policy regarding mental health services for their population.

Thank you for your time and consideration.

Washington Mental Health Counselors Association, the National Association of Social Workers (Washington Chapter), the Washington State Society for Clinical Social Work, and the American Association for Marriage and Family Therapy (Washington Division)

The following is the applicant groups' response to the Department of Health's Mental Health Counselor Sunrise Recommendation.

Page 2, Item 2. The problems with reimbursement are primarily with national companies who require national standards and mental health providers to be "licensed". The Washington "any category of provider" law does not adequately protect the public's access to certified mental health providers. It would be difficult for the Office of the Insurance Commissioner to construct a law that would require national insurance companies to reimburse certified mental health professionals if this is against their companies' policies. The applicant groups included examples of a variety of reimbursement problems caused by the applicant groups being certified and not licensed.

Page 2, Item 3. The Department of Health is recommending the granting of privilege to the applicant groups as requested, but, in addition, is also recommending granting privilege to registered counselors. The applicant groups have serious concerns to extending privilege to registered counselors.

The standard of privileged communication supported and affirmed by the Supreme Court in Jaffee v. Redmond, was for a master's level licensed clinician. The judicial system uses the "Wigmore Criteria" in weighing whether privileged communication ought to be considered. The criteria consider whether "the relation must be one which in the opinion of the community ought

to be considered sedulously fostered". (sedulously = diligently) Privilege is extended to specific professions in specific situations. Registered counselors have no training, education, and supervision requirements and are not bound by the ethical codes of the applicant groups. The public would not be served nor likely agree that the relationship between a registered member of the general public who is untrained and unsupervised should be "sedulously fostered".