

Report to the Legislature

Evaluating Need for Creation of a Bachelor's Level Behavioral Health Credential

December 2019
Chapter 444, Laws of 2019



Prepared by
Health Systems Quality Assurance



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For more information or additional copies of this report:

Sherry Thomas, policy coordinator
Health Systems Quality Assurance
360-545-4612
sherry.thomas@doh.wa.gov

Author

Sherry Thomas

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Executive Summary

[Chapter 444, laws of 2019](#) (Section 31) directs the Department of Health to conduct a sunrise review under [chapter 18.120 RCW](#) to evaluate the need to create a bachelor's level behavioral health professional credential. The credential must include competencies related to the treatment of both substance use and mental health disorders appropriate to the bachelor's level of education; allow for reimbursement in all appropriate settings; and be designed to facilitate work in conjunction with master's level clinicians.

The department engaged stakeholders in this evaluation of need through a web-based survey, written comments on the draft report, and a public meeting.

After evaluating the potential need, the current behavioral health professions, and assessing availability of applicable baccalaureate training programs, the department has concluded there may be a need for this credential for integration of the current substance use disorder professional (SUDP) credential with mental health treatment. There is no current pathway for SUDPs to be credentialed to treat co-occurring conditions and this would create a career path for advancement, which could attract more workers and boost retention.

Private insurance coverage for services provided by people with this credential should be available because it would be a license (or certification) under Title 18 RCW.¹ For Medicaid reimbursement, the Health Care Authority believes an amendment to the Medicaid state plan would be required.

Some technical colleges are developing applied baccalaureate programs for students earning two-year degrees in substance use disorder treatment to build on those degrees. This creates an academic pathway for SUDPs to earn a bachelor's degree that includes mental health disorders and for new students to receive an education that balances mental health and substance use disorder treatment.

¹ According to Office of the Insurance Commissioner (Appendix D, page 33), to be reimbursable under insurance/health plan coverage, the provider of the covered service must be licensed under Title 18 RCW or chapter 70.127 RCW, or be supervised by or the agent of such a licensee (RCW 48.43.005(24) definition of provider.)

Summary of Information

Legislative Request

[Chapter 444, laws of 2019](#) (Section 31) directs the Department of Health to conduct a sunrise review under [chapter 18.120 RCW](#) to evaluate the need to create a bachelor's level behavioral health professional credential that:

- Includes competencies related to the treatment of both substance use and mental health disorders appropriate to the bachelor's level of education;
- Allows for reimbursement of services in all appropriate settings where people with behavioral health disorders are treated; and
- Is designed to facilitate work in conjunction with master's level clinicians in a fashion that enables all professionals to work at the top of their scope of practice.

Background

Reimbursement for private insurance would require a license (or certification) under Title 18 RCW or chapter 70.127 RCW, or supervision by or to be an agent of such a licensee (see Appendix D, page 33). Medicaid reimbursement would likely require amendment to the Medicaid state plan.

The following is a summary of existing behavioral health credentials that are applicable to this review.

Certified Counselor

The department currently issues a bachelor's level credential under [chapter 18.19 RCW](#) for a certified counselor. The profession provides private practice counseling to clients determined through screening to be higher functioning and less severely impaired. The scope of practice consists exclusively of screening the level of functional impairment;² providing guidance in adjusting to life situations; developing new skills; and helping the client make desired changes.

Currently, no bachelor's degree program exists in Washington specifically for certified counselors. Certification requires a bachelor's degree in a counseling-related field and passing an examination in risk assessment, ethics, appropriate screening and referral, and Washington state law.³ A counseling-related bachelor's degree must be from a recognized educational program or institution and include subjects listed in [WAC 246-810-024](#). These subjects include

² The GAF scale is used to rate how serious a mental illness may be through evaluating the overall functioning of a client. The lower the score, the greater the severity.

³ RCW 18.19.090, <https://app.leg.wa.gov/RCW/default.aspx?cite=18.19.090>.

both mental health and addiction and substance abuse counseling. However, since this degree is so individualized, it's unclear how many certified counselors have substantial substance use disorder training.

Substance Use Disorder Professional (SUDP)⁴

SUDPs employ the core competencies of substance use disorder counseling to assist or attempt to assist individuals with substance use disorders (SUD) in their recovery.⁵ Minimum requirements for certification established in [chapter 246-811 WAC](#) are:

- An associate degree in human services or a related field, or 90 quarter or 60 semester college credits in courses from an approved school;
- Forty-five quarter or 30 semester credits in courses related to the chemical dependency profession;⁶
- Varying hours of experience based on level of education (many SUDPs hold a bachelor's degree or higher). These range from 2,500 hours for those with an associate degree, 2,000 hours for those with a bachelor's degree, 1,500 for those with a master's degree, to 1,000 hours for those credentialed under the alternative training route (see below); and
- Successfully passing a national examination.

Alternatively trained SUDPs

There is an alternative training route for practitioners holding other health care licenses, such as licensed mental health counselors.⁷ These practitioners may meet the educational requirements for SUDP by completing 15 quarter or 10 semester college credits in specific topics related to treating individuals with alcohol and substance use disorders.

Agency Affiliated Counselor (AAC)

AACs engage in counseling under [chapter 18.19 RCW](#) and are employed by an agency or facility operated, licensed, or certified by the state of Washington, a federally recognized Indian tribe in the state, or a county to provide specific counseling services. The AAC credential is required before practicing in these settings for providers who do not hold a license that includes counseling in the scope of practice. The applicant must provide evidence of being employed by an agency or having an offer of employment.

⁴ Chemical dependency professionals were renamed substance use disorder professionals (SUDP) in Chapter 444, Laws of 2019.

⁵ [Chapter 18.205 RCW](#) and amended in [chapter 444, laws of 2019](#).

⁶ [WAC 246-811-030](#) has not yet been updated to change chemical dependency to substance use disorders.

⁷ Advanced registered nurse practitioner under chapter 18.79 RCW, marriage and family therapist, mental health counselor, advanced social worker, or independent clinical social worker under chapter 18.225 RCW, psychologist under chapter 18.83 RCW, osteopathic physician under chapter 18.57 RCW, osteopathic physician assistant under chapter 18.57A RCW, physician under chapter 18.71 RCW, or physician assistant under chapter 18.71A RCW.

Individuals holding AAC credentials have a broad range of education and experience, ranging from on-the-job training and 40-hour training programs to master's and higher level degrees. They provide a broad range of services depending on the agency where they work, ranging from non-clinical mental health and substance use peer support services to clinical diagnosis and counseling of mental health and substance use disorders.

In addition, there are two bachelor's level professions that work in licensed behavioral health agencies under a department-issued AAC credential:

Mental Health Care Provider

The Medicaid State Plan administered through Health Care Authority recognizes a "mental health care provider" who has primary responsibility for working with clients to implement an individualized plan for mental health rehabilitation services furnished by state licensed community mental health agencies. Requirements are a bachelor's degree in a related field or an associate degree with two years of experience in the mental health or related fields.

Interns Gaining Experience for Master's Degree

Interns with bachelor's degrees work in community mental health agencies while completing their supervised experience hours for their master's degrees. These interns do much of the same work (under supervision) as master's level clinicians.⁸

⁸ Interns are not authorized under the Medicaid state plan to make determinations of medical necessity. This must be done by a "mental health professional" as defined in WAC 182-538D-0200.

Bachelor's Level Credentials in Other States

In researching other state credentials, the department found only one state with a bachelor's level credential where credential holders can treat co-occurring disorders. Iowa has certified co-occurring disorder professionals who provide assessment and counseling. In addition to a bachelor's degree in co-occurring disorders or behavioral science with a clinical application, this credential requires 200 hours of relevant education (to include 140 hours of co-occurring disorders specific training with at least 30 hours specific to addiction and 30 hours to mental health); and 6,000 hours of supervised work experience.

The department found many bachelor's level social worker credentials. Thirty-two states have bachelor's level social worker credentials that focus only on mental health. Most of these credentials require passing an examination. A majority of states specify that this level of social worker can only provide non-clinical, generalist social work to include services like assessment, case management, client advocacy and education, and referral.⁹ Arizona, Illinois, and Ohio authorize clinical practice under supervision by a mental health professional.

Twenty-two states require supervision of bachelor's level social workers and do not authorize independent practice.¹⁰ Nine states appear to authorize independent practice for non-clinical social work, some under specific conditions:

- Idaho, Minnesota, and Nevada with no additional conditions;
- Arizona, Illinois, and Ohio with no additional conditions except when providing clinical social work;
- Alabama after two years of practice and Missouri after three thousand hours of supervised experience; and
- Maryland and Texas with board approval.

The department found bachelor's level substance use disorder professional credentials in 28 states.¹¹ However, none of these credentials appears to offer an advanced level of practice over Washington's SUDP, so they are not applicable to this review.

⁹ The National Association of Social Workers recommends a master's degree in social work for clinical practice. "NASW Standards for Social Work Practice with Clients with Substance Use Disorders," National Association of Social workers, 2013.

¹⁰ In addition, four states (Hawaii, Louisiana, Tennessee, and South Carolina) restrict practice of bachelor's level social workers to agency settings.

¹¹ Substance use/chemical dependency credential requirements in other states range from coursework hours to master and doctorate level credentials, with many at the bachelor's level.

Co-Occurring Disorder Bachelor's Degree Programs in Washington

The department found that most of the bachelor's level behavioral health programs in Washington train for mental health or substance use disorder treatment, but not both.¹² However, some technical colleges do, which would allow a pathway for training should this new credential be created. Five colleges have developed applied baccalaureate degrees that build upon existing two-year degrees and certificates in mental health and substance use disorders and may qualify for the proposed bachelor's level behavioral health credential if enacted.¹³

For example, Clark College's Bachelor of Applied Science in Human Services is specifically designed for students who hold associate degrees in addiction counseling related fields and balances substance use disorder education with mental health education. This creates an academic pathway for SUDPs to earn a bachelor's degree that includes mental health disorders and for new students to receive an education that balances mental health and substance use disorder treatment. Four other colleges have degrees that may qualify because they address both SUD and MH:

- [Edmonds Community College](#) – Bachelor of Applied Science in Child, Youth, and Family Studies
- [Highline College](#) – Bachelor of Applied Science in Youth Development;
- [Lake Washington Institute of Technology](#) – Bachelor of Applied Science in Behavioral Healthcare ; and
- [Seattle Central College](#) – Bachelor of Applied Science in Behavioral Science.

Ten additional programs offer behavioral health two-year degrees and certificates and have made the academic and accreditation changes to allow them to add applied baccalaureate degrees in behavioral health to meet workforce needs:

- Bellevue College
- Centralia College
- Grays Harbor College
- Olympic College
- Peninsula College
- Pierce College
- Skagit Valley College
- Tacoma Community College
- Wenatchee Valley College
- Yakima Valley College¹⁴

¹² Internet research conducted by the department.

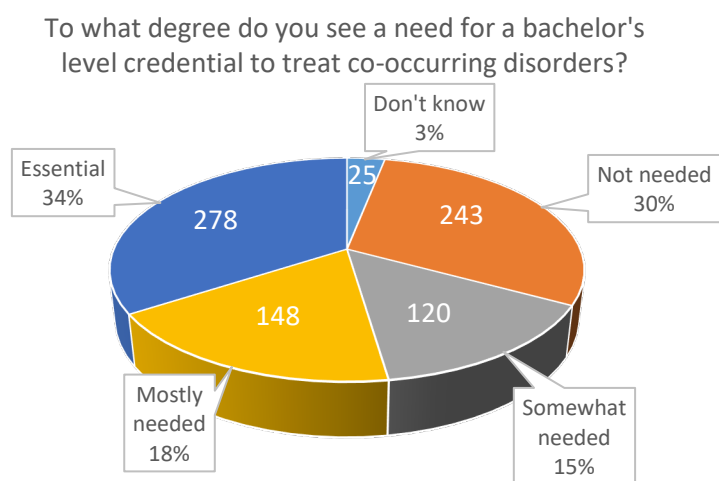
¹³ At least two more, Whatcom and Spokane Falls, have applied baccalaureate programs under development.

¹⁴ Information shared by: Bob Groeschell, Practicum Instructor at Edmonds Community College and Emeritus Faculty at Seattle Central College. Marcia Roi, Chair of the Addiction Counseling Education Department and Bachelor of Applied Sciences in Human Services Department at Clark College and President of the Washington Consortium of Addiction Studies Educators.

Stakeholder Engagement

To gather initial information on the perceived need for a bachelor’s level behavioral health credential, the department conducted a Web survey with stakeholders in July, reaching broadly to professions regulated by the department, professional associations representing health professions, and behavioral health agencies and their professional associations. The survey questions are shown in Appendix A.

Of the 817 people who responded to the survey, 52 percent indicated this credential is “mostly needed” or “essential,” 30 percent believe the credential is “not needed,” 15 percent believe the credential is “somewhat needed,” and three percent “don’t know” whether the credential is needed.



Many of the survey respondents were substance use disorder professionals and mental health counselors. The following table shows the professional affiliation of survey respondents. Many respondents selected multiple categories:

Chemical dependency professional/substance use disorder professional	208
Mental health counselor	198
Behavioral health agency administrator	170
Mental health professional working in a behavioral health agency	149
Agency affiliated counselor	109
Consumer of behavioral health services	85
Psychologist	84
Behavioral health personnel	79
Certified counselor	53
Marriage and family counselor	43
Other medical professionals	39
Manager/supervisor	18
Other	54

Once we analyzed the results of the survey, the department shared a draft report with stakeholders and collected written comments in August and September 2019, followed by a public meeting for oral comments in late September 2019. These comments are summarized in the section titled “Summary of Public Comments on Draft Report” beginning on page 11.

Summary of Survey Responses

52 percent of respondents stated this type of credential is mostly needed or essential.

When asked why they believe this credential is needed, stakeholders responded it could help alleviate backlogs and wait times caused by a shortage of providers by taking lower level tasks from master’s level and higher level providers so they can work at the top of their scopes. These employers would know their staff are trained to work with vulnerable populations in an ethical manner and within the bounds of the law. Some felt the credential could increase reimbursement if case management was included in the scope of practice.¹⁵

Other respondents believe a bachelor’s level behavioral health credential could increase diversity of the workforce. According to the 2017 workforce assessment, “Underrepresented minorities, immigrants and refugees, and others from diverse populations often work at the entry and middle-skilled positions across the healthcare sector.” The behavioral health workforce does not adequately reflect the diversity of the population that accesses services, making it difficult to provide culturally appropriate care in a proactive way that address behavioral health issues before they become acute.¹⁶ Development of career ladders could result in a more diverse workforce.

“I believe having someone who is credentialed to work with clients who require SUD and mental health treatment would be a valuable position....Currently, I'm credentialed as a SUDP, however, I am close to completing my bachelors in Psychology...”

Survey respondents believe this credential could also serve as a career ladder for SUDPs. SUDPs are currently limited to providing treatment for substance use disorder (SUD) but many have bachelor’s degrees or higher, some in mental health fields such as psychology. Some respondents felt it could also push the industry to increase the salary of SUD professionals, which would create incentives to enter the field and increase retention. This could help with the long vacancies identified in the 2017 workforce assessment for SUDPs in community behavioral health settings.¹⁷

Interns working in community mental health agencies working toward their master’s degree are completing their supervised experience hours with a bachelor’s level degree. They are doing

¹⁵ According to the Health Care Authority, case management is not a reimbursable service under Medicaid.

¹⁶ Nova Gattman et al., “Washington State Behavioral Health Workforce Assessment,” Workforce Training and Education Coordinating Board and University of Washington Center for Health Workforce Studies, December 2017, p. 44.

¹⁷ Nova Gattman, “Health Workforce Council 2018 Annual Report,” Workforce Training and Education Coordinating Board, December 2018, p. 8.

similar work as master’s level clinicians. Licensing these practitioners would create consistency in the work they do and ensure they are not doing things like diagnosing or assessing medical necessity for treatment.¹⁸ It would also recognize the work they do by providing a formal credential.

15 percent of respondents stated this type of credential is somewhat needed.

Open text responses for why respondents selected “somewhat needed” were split between supporting and not supporting the new credential and fell into most of the same themes as the “essential,” “mostly needed,” and “not needed” categories. New themes that emerged from this category were that it’s needed as long as it does not eliminate the current CDP/SUDP credential or force them to get a bachelor’s degree; and it would be helpful in facilities treating both substance use and mental health disorders, but would create a burden on facilities that specialize in only substance use disorders.

30 percent of respondents stated this type of credential is not needed.

Stakeholders who indicated this credential is not needed believe that a bachelor’s level education is not sufficient to diagnose or treat mental health disorders and this level of professional would not understand addictive disorders as a primary disease that needs specialty treatment. They argued that quality of care should not be exchanged for the quantity of care available. Instead, they recommend reviewing scopes of practice and training of existing professions to meet the workforce requirements. In addition, bachelor’s level providers can already be agency affiliated counselors or certified counselors, so these respondents saw no need for a separate credential.

“Increased time in supervision and ensuring adequate competency of intervention reduces time that more experienced clinicians would be able to provide intervention directly.”

Respondents who do not see a need for a bachelor’s level behavioral health credential recommend simplifying the master’s level credentialing process through strategies such as interstate reciprocity.¹⁹ They also recommend scholarships, loan reimbursement, and increased opportunities for internships, residencies, and supervised experience to help with recruitment of this level of practitioners. Higher salaries and better Medicaid reimbursement rates would help with retention as well.

¹⁸ For reimbursement of services, the Medicaid state plan requires assessment of medical necessity to be done by a “mental health professional” as defined in WAC 182-538D-0200.

¹⁹ [Chapter 351, laws of 2019](#) (Sec. 2 and 3) requires the department to establish reciprocity programs for SUPDs, advanced social workers, independent clinical social workers, mental health counselors, and marriage and family therapists. It also allows for issuance of a probationary license to applicants who need to address deficiencies in the requirements.

These respondents also argued that the proposed credential would not help with backlogs because supervision by higher level practitioners would still be required, pulling these providers away from direct service delivery. If public and private health plans were to reimburse bachelor's level practitioners in lieu of higher level practitioners as a cost-saving measure, it could put a lot of pressure on master's and higher level practitioners to provide adequate supervision while maintaining their caseloads.

Potential issues with implementation

The survey included a question on whether respondents anticipate any issues with implementing this type of credential. Issues that respondents think would need to be addressed include:

- Ensuring training programs offer bachelor's programs for co-occurring disorders;
- Developing an evidence-based curriculum, including appropriate coursework, for this educational program and professors to teach it;
- Ensuring sufficient supervision;
- Ensuring insurance reimbursement is available for this credential;
- Offering alternative pathways for providers with many years of experience but not a bachelor's degree;
- Addressing the high start-up costs for a new credential to avoid bottlenecks in credentialing; and
- Off-setting the high costs of getting a bachelor's degree, especially for those already working in the field.

Summary of Public Comments on Draft Report

The department shared a draft report with stakeholders in early September 2019 and invited written comments, followed by a public meeting September 24 for oral comments. Most of the comments echoed the results of the Web survey the department conducted. Additional themes in these comments were:

- Consider additional options to address the shortage of providers, such as:
 - Require all insurance companies to open their panels to all licensed providers;
 - Make it easier for new master's level graduates to access supervisors by allowing more practitioners to qualify as supervisors;
 - Increase support for medical education through psychiatric and primary care residencies; and
 - Address the curriculum deficiencies so that current degrees adequately teach both mental health and substance use disorders.
- The draft report did not demonstrate how this credential would improve or increase access to care.

- It is unclear how a bachelor's level credential would be different from existing bachelor's degrees in human services or social work.
- Core competencies need to be identified.
- It is unclear how this credential would overlap or align with existing behavioral health credentials, such as SUDPs and AACs.
- This credential should not be independent and needs to include on-site supervision from a mental health professional.
- This type of credential, if implemented, should not be considered a behavioral health professional, but a support credential that does case management; care management; and wellness, housing and employment support.

Additional Suggestions

If this credential is created, stakeholders suggest:

- Not allowing diagnosis of mental health disorders because the education and training are not sufficient;
- Clearly defining the scope of practice and limits of the credential to a supporting role, such as providing case management; care management; and wellness, housing and employment support;
- Requiring experience and an examination;
- Ensuring appropriate supervision by higher level practitioners (there may need to be a ratio set of how many bachelor's level staff can be supervised by one practitioner);
- Ensuring training programs are available and accessible and include suicide prevention training;
- Ensuring training includes supervised clinical experience; and
- If this credential is created as a career path for SUDPs, not allowing diagnosis of mental health disorders because the additional training offered at the bachelor's level is not sufficient for diagnosis of potentially complex mental health disorders.

Conclusion

The department evaluated the potential need for a bachelor level behavioral health credential, the current workforce needs, current behavioral health professions, and availability of applicable training programs. The department has concluded there may be a need for integration of the current SUDP credential with mental health treatment through a bachelor's level credential focused on treating co-occurring disorders. There is currently no pathway for SUDPs to be credentialed to treat co-occurring conditions and this would create a career path for advancement.

Some technical colleges have been developing applied baccalaureate programs for students earning two-year degrees in substance use disorder treatment to build on those degrees. For example, Clark College has a new Bachelor of Applied Science in Human Services that is specifically designed for students who hold associate degrees in addiction counseling related fields and balances substance use disorder education with mental health education. This creates an academic pathway for SUDPs to earn a bachelor's degree that includes mental health disorder curriculum and for new students to receive an education that balances mental health and substance use disorder treatment.

If this credential is created, stakeholders suggest the legislature consider:

- What practice limitations to include, such as:
 - Limitations on scope of treatment of mental health disorders;
 - Ensuring diagnosis of mental health disorders is not included;
 - Requiring collaboration with licensed mental health practitioners; and
 - Whether supervision by a licensed mental health practitioner, such as a psychologist, mental health counselor, or social worker should be required.
- Whether supervised clinical experience should be included in addition to the bachelor's degree.

Appendix A: Survey Questions

Question 1: I am responding as a: (Please check all that apply)

- Consumer of behavioral health services
- Behavioral health agency administrator
- Chemical dependency professional/substance use disorder professional
- Agency affiliated counselor
- Certified counselor
- Mental health professional working in a behavioral health agency
- Mental health counselor
- Social worker
- Marriage and family counselor
- Other. Please explain

Question 2: To what degree do you see a need for a bachelor's level behavioral health professional credential that includes competencies related to the treatment of both substance use and mental health disorders appropriate to the bachelor's level of education?

Question 3: To what degree would this credential benefit consumers of behavioral health services?

Question 4: To what degree would this credential benefit behavioral health providers?

Question 5: To what degree would this credential disadvantage consumers of behavioral health services?

Question 6: To what degree would this credential disadvantage behavioral health providers?

Question 7: Do you see challenges with enacting any of the requirements in Chapter 444, Laws of 2019?

Question 8: Do you have anything to add that is relevant to analyzing the need for a bachelor's level?

Appendix B: Public Comments on Draft Report

I am responding to the draft report to the Legislature evaluating the need for a Bachelor's Level Behavioral Health Credential as a mental health counselor.

Current bachelor's degree programs in mental health are introductory and theoretical in nature and not designed to develop clinical skills. I am concerned that this is one step backwards to the days of allowing anyone to hang a shingle and practice mental health counseling. Master's degree programs provide a base to develop professional competency. Just because there is a need for more mental health practitioners should not mean lowering standards and decreasing quality of care.

This plan would negatively impact existing mental health practitioners with master's degrees. Many individuals with master's degrees are making very little income based on current insurance repayment. Bringing in individuals with little to no clinical skills would likely be welcomed by insurance companies who are happy to pay as little as they can and make big profits. Lowering the standard of care is in no way helping practitioners or the mentally ill.

Laurel Fullington, MA, LMHC, NCC

I disagree that you can provide effective, humane care and treatment of disorders that are complex responses to biological and social injuries with inadequately educated individuals, even with great supervision. Masters level clinicians should be paid a market rate (in the medical field), and more people would choose that career.

Nancy K Murphy, LMHC

I have about 1000 hours and my CDPT...working towards my CDP. Will I be grandfathered in if this becomes required? I do see benefits to having a BA and hope to go on and finish mine. I'm 60 this month though so I may not do this. Having my CDP means a higher pay and I need that.

Diana Dewey

I am against the idea of creating a Bachelors Level Behavioral Health Credential. My reasoning is that consumers are already very confused by the current credentials & adding another would only cause more confusion for consumers, payors, etc. I also think that it would take extra time to train the BA level clinicians, because most BA programs are grossly insufficient for clinical training...and it would inadvertently create more work for MA & Phd level clinicians, not alleviate their workload.

Erin Menser

I have a Bachelor's Degree in Psychology and a minor in Substance Use Disorders. I have been working in the chemical dependency field since 1990, almost 30 years. I have experienced clients with Co-Occuring disorders from the beginning of my work in this field. Initially, we were trained, as

CDP's, for DSM diagnoses. I have worked every level of chemical dependency from Detox, Intensive Inpatient to Intensive Outpatient and just Outpatient and Education. I worked with my clients who had Co-Occurring Disorders to obtain concurrent Mental Health services and chemical dependency services. I currently work in an Acute Psychiatric facility and as CDP's, we are required to know Pharmacology.

With my experience and credentials, I could easily fill the role of Bachelor's Level Behavioral Health counselor. I realize not every Bachelor's level CDP can do this as it requires experience. My vote would be a requirement of a certain amount of years worked in the field for one to qualify for this and/or some kind of testing to prove knowledge. I do hope that this change will happen as I believe it will benefit the community and give those with the knowledge and experience the ability to use it. Thank you for your consideration.

Sue Brooks

In reference to the Sunrise review of the bachelor's level behavioral health professional credential, I have the following feedback:

Question 1: I am responding as a: Behavioral health agency administrator and; an educator in behavioral health sciences.

Question 2: To what degree do you see a need for a bachelor's level behavioral health professional credential that includes competencies related to the treatment of both substance use and mental health disorders appropriate to the bachelor's level of education?

I see this credential as "needed." This is a good career ladder for SUDPs who may want to pursue graduate work in the future and even allow them to work as they complete a master's degree should they so choose. They may also choose to remain working at the bachelor's level.

Question 3: To what degree would this credential benefit consumers of behavioral health services?

It will give better access to consumers with a range of different clinicians and different skill sets. It helps treatment services be truly 'co-occurring.'

Question 4: To what degree would this credential benefit behavioral health providers?

It will be good for agencies to offer employment to "Co-Occurring" case managers at the bachelor's level without having to pay the higher wage for a Master's degree to do more day-to-day case management work. Would also be easier to find staff once the pool began to be supplied from area colleges. It could also free master's level counselors to perform essential functions such as diagnosis/evaluations. Bachelor's level case managers could take over groups and case management. Pools of applicants could be larger once the community colleges produces graduates.

Question 5: To what degree would this credential disadvantage consumers of behavioral health services? None

Question 6: To what degree would this credential disadvantage behavioral health providers?

I would be very careful of allowing BA level clinicians diagnosis mental health when they lack the appropriate training and supervision such as classes in evaluation and consultation normally offered at the graduate level.

Question 7: Do you see challenges with enacting any of the requirements in Chapter 444, Laws of 2019?

Service Encounter Reporting Instructions (SERI) will be to be revised to allow persons with this new credential to “bill” Medicaid for things like treatment groups, treatment planning and case management. Medicaid needs to be aligned with this change.

Question 8: Do you have anything to add that is relevant to analyzing the need for a bachelor’s level?

I hope the State will partner with area colleges and community colleges to outline curriculum that will offer value to this new credential. The program could even offer prerequisites for a graduate degree if the student desires.

Ronald Tussey

Question 1: I am responding as a: (Please check all that apply)

Mental health counselor

Question 2: To what degree do you see a need for a bachelor’s level behavioral health professional credential that includes competencies related to the treatment of both substance use and mental health disorders appropriate to the bachelor’s level of education?

None in terms of treatment or diagnosis, perhaps more community liason roles.

Question 3: To what degree would this credential benefit consumers of behavioral health services?

None, too risky lack of training, maturity and experience.

Question 4: To what degree would this credential benefit behavioral health providers? Not likely

Question 5: To what degree would this credential disadvantage consumers of behavioral health services?

Lack of experiences, training hours under supervision puts consumers at risk.

Question 6: To what degree would this credential disadvantage behavioral health providers?

Create more confusion for the consumer, puts the already delicate consumer and public trust in mental health at risk.

Question 7: Do you see challenges with enacting any of the requirements in Chapter 444, Laws of 2019?

Question 8: Do you have anything to add that is relevant to analyzing the need for a bachelor’s level?

When many other health care professions are increasing their requirements to ensure adequate care why would our division cheapen the profession?

Mary Peters

I am reaching out as a LMHCA to add my comments and cautions around adding a BA mental health credential. Sitting with clients as a mental health counselor is an incredibly important job, one that requires training, wisdom and education. The additional education and training I received during my Graduate education prepared me for this role, and I do not believe the maturity or education of a B.A. would support this role in a way that gives clients the support that they deserve and need.

I think credentialing at a BA level devalues the responsibility that LMHCs and LMFTs take on in the mental health care of clients and instead supports looking at counseling as a coaching or supporting role rather than realizing that life and death decisions are made. The credentials given by the department of health separate mental health care from supportive helpers in the community, such as pastors, coaches and other supporting members and are resources not just for life transitions and minor depression and anxiety but for major diagnosis's such as schizophrenia and borderline personality disorder.

Sarah Valrejean LMHCA

I am writing as a licensed marriage and family therapist in Bellingham, WA, voicing my **opposition** to legislation that would certify independently-practicing bachelor's-level counselors to work with clients with mental illness or substance abuse diagnoses. My reasons for opposing this legislation are as follows:

- 1) Bachelor's education could not possibly prepare anyone to treat complex mental illness, much less dually diagnosed individuals with substance abuse disorders. There are people in medical schools, as well as in upper-level graduate programs, trying to learn how to treat these difficult disorders. They would be the first to say they had no preparation to do this work as an undergraduate.
- 2) The reason we all pursue a master's degree (or above) is not only that it has been the standard of care for decades, but because it provides specific training in the treatment of mental illness, after a general education in many subjects, including introductory psychology and/or sociology. An undergraduate curriculum could not provide this specific advanced training, as well as the introductory coursework, plus the general education requirements needed to be awarded a bachelor's degree.
- 3) Within all master's level/doctorate degree programs, there is also a year of internship. A bachelor's level person would also need to complete an internship, but they would be doing so with less in-class education and formalized training than those in a master's level+ degree program.
- 4) While I do agree that access to mental health services is fraught with problems, these problems could be alleviated by WA State Dept. of Health making other changes that affect reimbursement for psychotherapy services, and that remove barriers to access. For example, you could require that

ALL insurance companies (including Kaiser and Humana) open their panels to ALL licensed providers. Additionally, you could increase Medicaid and Medicare reimbursement, so that practitioners make enough money to remain in their private practices. Finally, you could enable new master's level graduates to find easier access to supervisors, by allowing more master's level practitioners to become supervisors. Remove the barriers that you have the power to remove, before licensing lowly-educated graduates to treat the most vulnerable of clients.

5) It is very difficult, now, to succeed in private practice, considering the amount of education, training, supervision and continuing education we are required to confirm. I do not believe you would allow EMTs to perform surgery in outpatient surgical centers, with less training than M.D. or D.O. surgeons. Allowing bachelor's level graduates to do the same work as master's or doctoral level practitioners would evidence the same lack of concern for the patient.

6) If bachelor's level people are already working in clinical environments, that was a first mistake on the part of the WA Dept. of Health. However, if this cow is already out of the barn, I could see such a bachelor's - level license being ONLY applicable for agency workers, and ONLY if those persons are under direct supervision of master's level or doctorate-level staff. Additionally, the ONLY tasks these persons could do would be intake, case management with other agencies, and referral to master's level or doctorate-level providers. Finally, these bachelor's-level persons could never receive insurance reimbursement.

7) With no evidenced-based bachelor's curriculum in WA State, it seems to me that this idea is being pushed before any groundwork has been laid. I have relocated here from CA, which has among the toughest standards for the practice of psychotherapy of any state in the U.S. I did not see CA listed in your draft as a state that licenses bachelor's-level providers. Why would WA State need to be the place where a lesser standard of care is promoted? Why would we need to be the "backwater" state, a place where there are not enough master's level and doctorate-level practitioners, because the bachelor's-level staff are the ones receiving the bulk of insurance reimbursement, as well as lower-paying jobs in clinics and agencies! Why can we not be the state that sets and supports the highest standard of care, instead of the lower standard of care??

If you pass this legislation, you are undermining the careers of thousands of master's level and doctorate-level professionals, all of whom have years of education and training beyond their undergraduate degree, as well as many hours of supervision and continuing education. Why would you want to harm one of the greatest healthcare assets you have?

This is a bad decision, one that seems to be driven more by the "dollar" than by what is best for those with mental illness or substance abuse disorders, and not holding those interests as foremost, much less withdrawing your advocacy of those of us already licensed and struggling to provide services in a marketplace that is far from level. Require ALL insurance companies to reimburse ALL master's/doctorate-level practitioners first, as well as Medicaid/Medicare reimbursing all providers as well, and you will see that access to mental health care will skyrocket!

Your idea is trying to get away with paying less to poorly trained staff, not to actually provide more access and better care to the vulnerable population of mentally ill and/or substance-abusing clients.

I request a receipt of acknowledgement that I have submitted my comments before the deadline required, and that my correspondence will be put with others who will stand against this legislation.

Vermeda M. Fred, LMFT

I am writing on behalf of the Washington Mental Health Counselors Association (WMHCA) and the 460 members spread across WA state. We are asking that you consider the comments from the board representing the Washington Mental Health Counselor members of the association. The WMHCA appealed to Jay Inslee's office requesting amendment to ESHB 1768 to avoid a lengthy, costly, and harmful obstacle for credentialing licensed mental health (MH) counselors to provide treatment for co-occurring substance use disorders (SUDs).

The premise that SUD disorders can only be effectively treated by substance abuse professionals too narrowly focuses the breadth of training of master's level therapists. Licensed mental health counselors (master's level training with supervised hours) are trained and licensed to treat co-occurring disorders which are present in the majority of substance abuse cases.

Diagnosing and treating complex co-occurring disorders requires years of training and supervised experience. Contrast this with the limited training (associate degree) and supervision typically required of chemical dependency or substance abuse disorder professionals. WMHCA also opposes a bachelor level mental health credential for the same rationale. The licensed professional's responsibility is to make sound judgments based on both science and knowledge of an array of psychotherapeutic methods; if they cannot perform this function, they are technicians. Technician, or specialist, is exactly where we should conceptualize Bachelor's level professionals.

Loosening the important requirements and advanced training that would credential bachelor level practitioners confuses consumers and conflates professional experience which prevents the professions from working together effectively.

These sections of the bill create a narrow, restricted, and unnecessarily complex and burdensome requirement for master's level counselors who have already taken 6 years of training and an additional 3000 hours of supervised practice.

I have attached a more detailed description of the problems associated with the position of ESHB 1768 which bears strongly on concerns of this committee. Thank you for considering the concerns of mental health counselors as we all deal with the serious problem of mental health and chemical dependency use in our society.

Marianne Marlow, LMHC, President, Washington Mental Health Counselors Association

Shannon Thompson, LMHC, Education and Advocacy Director, Washington Mental Health Counselors Association

WMHCA has determined that the following concerns exist should the bill be passed as currently written:

1. By restricting the current workforce of mental health professionals (MHPs) to align with requirements in ESHB 1768, fewer master's level mental health professionals will seek this

credential, the scope in which they may already be practicing, because of the time away from work, the cost of the training, the cost of supervision, and the overall loss of wages necessary to achieve the new hurdle of additional credentialing.

2. Washington Licensed Mental Health Counselor (LMHC) licensing fees will be applied to monitor and develop standards for a professional designation being created in this bill for which not all LMHCs will benefit from but in fact will be funded through dues, nonetheless.

3. The requirements would be burdensome and costly for an already practicing mental health practitioner to leave a practice for retraining for a specialization covering diagnostics, treatment and support. LMHCs routinely treat clients with co-occurring mental health and substance abuse disorders already.

4. Developing a whole new system, along with the study in section 30 of the bill, creates a behemoth difficult to slog through for those already credentialed to treat and diagnose SUDs. Researching how to develop a credential for clinical MHPs who, arguably, already have the treatment of SUDs within their scope of practice, (requiring mastery and use of the Diagnostic and Statistical Manual of Mental Disorders (DSM), Fifth Edition) is unnecessarily costly to Washington state taxpayers. As an example, the federal Veteran's Administration routinely has clinical social workers and other clinical MH professionals treating both a patient's co-occurring SUD and MH issues at the same time.

5. Washington state is the only state identified up to this point by the Washington Mental Health Counselors Association that bifurcates MH and SUD treatment. Providers testifying in the legislative process openly referred to their SUD treatment work as an "industry." That industry, threatened by masters-level therapists able to treat all of an individual's behavioral health issues and not just their SUD, is prepared to narrow client's ability to access all kinds of treatment offered through mental health professionals that treat SUDs. Our goal is not to usurp professions, but to expand access to a competent, versatile workforce that can treat co-occurring behavioral health conditions for the people that need it.

6. The SUD treatment industry successfully convinced WA lawmakers to create a hurdle, an additional credential for MH professionals mandating training and supervision hours, treatment allowed and settings where that treatment can be provided, that not only limits but deters those with training and experience. More people who need care will suffer from the continued lack of available providers and services while the state performs a study of a credential that is set up to be underutilized and ineffective.

7. Estimates are that 50 to 60 percent of people with a SUD have associated MH issues(1) – issues that chemical dependency professionals are not qualified to treat, but clinical mental health professionals are qualified to address. As WA integrates behavioral and physical healthcare into a single system, we need to find solution to integrate the fragmented SUD and mental health treatment as well. The sections of ESHB 1768 we are asking you to veto in no way accomplishes this goal.

8. Bachelor's level personnel (with a few exceptions) are not versed in the balancing of scientific and practical psychotherapeutic methods. Many are exceptional in their roles, but always under the supervised of an independently licensed professional. Guidance and supervision is critical, as the lack of depth and breadth in their understanding and experience of employing advanced intervention methods puts them in a para-professional role. The education system has much the same delineation, with certificated teachers working alongside para-pros. This continuum of professional roles makes sense, and exists throughout the health care system (e.g., physicians, physicians' assistants, ARNP's, RN's, LPN's, CNA's, etc.).

For these reasons, the Washington Mental Health Counselors Association respectfully asks that the committee thoughtfully consider our concerns.

I am an Associate Licensed Mental Health Counselor with a Master's Degree in Clinical Mental Health Counseling at Sound, formerly Community Psychiatric Clinic. I work with several Bachelors-level clinicians on my team. Based on my experience working in the mental health field with these professionals, while fulfilling the conditions of my own Associate License, I believe it would be a positive development in our state's mental health credentialing program to offer a Bachelors-level license including competencies in mental health and substance abuse. I believe all professionals working on the same team should be subject to regulatory credentialing requirements to improve quality outcomes for clients. I believe that it is of particular importance to include a continuing education requirement in the Bachelors-level credential, to ensure ongoing increase of knowledge and competency in working with clients.

Adrienne Delaney, MA, LMHCA, MHP, Clinician

On behalf of the Washington State Medical Association and our more than 11,000 members across the state, thank you for the opportunity to provide comment on the evaluation of the need to create a bachelor's level behavioral health professional credential.

The WSMA appreciates the need to strengthen the behavioral health workforce and increase access to behavioral health treatment. The draft report however does not detail the scope or responsibilities that would be permitted by this credential. Adequate training and education are critical to the safe and effective treatment of a patient. As such, the WSMA would strongly oppose allowing individuals to diagnose or treat mental health disorders, and to prescribe medications, if they did not receive education and training commensurate with a psychiatrist or similarly situated provider.

Additionally, the draft report does not appear to demonstrate how this credential would directly improve or increase access to care in ways that cannot already be achieved by individuals without this credential.

We share the goal of increasing health care workforce, particularly as it pertains to mental and behavioral health practitioners. Our advocacy in this space has been focused on increasing state support for medical education through psychiatric and primary care residencies, as well as health

professional student loan repayment programs – both of which help draw psychiatrists and other health care professionals to rural and underserved areas. We would encourage the legislature to prioritizing continuing its commitment to those areas in the interest of increasing workforce.

We appreciate the opportunity to provide comment on this critical issue. With questions, please contact Billie Dickinson, WSMA policy analyst at billie@wsma.org.

Jeb Shepard, WSMA Director of Policy

Comments Provided at September 24th Public Comment Meeting Orally and in Writing

Dr. Marcia Roi, Department Chair of the Addiction Counseling Education Department and Chair of the Bachelor's of Applied Sciences in Human Services Department, discussed Clark College's Bachelor's Degree in Applied Sciences and Human Services they implemented last year. This program is competency-based like the CDP program. Her substance abuse counseling committee has been asking for a balanced mental health and substance use disorder bachelor's degree to help implement the integration required in the Affordable Care Act. They no longer want to hire social workers with one course in substance use disorder treatment as addiction counselors. Clark College's bachelor's program combines an associate degree in substance abuse that qualifies for the SUDP exam with two years mental health that meets the Alaska Core Competencies in Human Services.²⁰ The mental health education is provided by licensed social workers (MSWs) with agency experience. Dr. Roi is President of the Washington Consortium of Addiction Studies Educators (WACASE) and they asked her to comment that this needs to be competency-based. Students and their parents want to know what they're getting for their tuition dollars. This isn't to replace master's level clinicians, but as a pathway to an MSW degree. She encourages students to go to graduate school.

Challenges with a pathway from the associate's degree to MSW is that 45 credits are required in addiction studies for the associate degree, but universities only accept 15. The bachelor's creates this pathway to higher education. The human services program was built with advice from Eastern Washington University's MSW program and Portland State's MSW program. If balanced with two years each of substance use and mental health, this is what employers are looking for.

This was also required in the ACA and Clark was an early adopter of behavioral health integration as required in the ACA. She discussed bouncing clients back and forth between a mental health provider and addiction counselor, where neither side knows the other's diagnosis. It was not integrated, they must be treated as behavioral health.

Calling this degree behavioral health would have put it with nursing, which wouldn't have worked, which is why it's called human services. They used the Alaska Core Competencies for behavioral health to build the competencies for the program. The student knows what is expected of them based on the competencies in the syllabi. Affective education is taught throughout, what are their

²⁰ <http://aktc.org/training-solutions/alaska-core-competencies-for-direct-care-workers/>.

biases? They need to be addressed because the mental health biases are different than the substance use disorder biases.

Judy Holman, who is a licensed social worker and mental health counselor, as well as an SUDP. She opposes bachelor's level clinicians to be able to diagnose. In the draft report, there is a statement about interns doing intake assessments, which is inappropriate because they aren't educated to diagnose. She received her BSW in 1993. She had intended to get her BSW only but learned she couldn't do anything with the bachelor's that she couldn't do without it. She could not diagnose. She stated Clark College seems advanced in the program being competency-based but worries the rest of the state isn't. She went on to get her MSW, where she had to advocate to get chemical dependency classes because they aren't easy to get in a master's level program. She worries about a bachelor's level person diagnosing mental health conditions. This diagnosis follows you forever. She used to be on the committee for the dangerously mentally ill offenders. She's not sure what the current name is. This committee reads people histories and most of these individuals had up to 10 diagnoses through the course of their incarceration. She wondered how many diagnoses came from competent, educated people. She understands they would work under supervision of a master's level clinician, but worries whether there are enough master's level clinicians to provide this supervision.

On the SUDP side, she supports this credential. She had to re-test in 1996 for chemical dependency counselor because there was no reciprocity. Back then, she had heard there would be a requirement for a bachelor's degree for this credential, which hasn't happened.

Dr. Roi came back up to clarify that the bachelor's level providers shouldn't be diagnosing. She said if there is a way to ensure a diagnosis for mental health comes from a master's or doctoral level, she feels this credential will work.

Dr. Samantha Slaughter, Director of Professional Affairs for the Washington State Psychological Association (WSPA) and a psychologist stated the WSPA is opposed to this credential for many of the reasons already provided in the draft report. They also provided written comments earlier. She agrees with the question, how do we define the scope of practice. They sympathize with the workforce issues. However, if they want to ensure we have enough clinicians educated in both substance use dependence and mental health, it seems that is a curriculum issue that should be addressed there. Washington is one of the few states that has chemical dependency siloed separate from mental health and that's been a problem for a really long time. She said she qualifies for a CDP but hasn't gotten one because she's heard she would get paid less if she did. And she already has chemical dependency in her scope of practice as long as she has the training. She feels this will cause more confusion about where people fit in the field.

I write today on behalf of the Washington Council for Behavioral Health regarding the potential creation of a Bachelor's level behavioral health credential. The Council is the professional association of licensed community behavioral health agencies (BHAs), representing more than 40 agencies across the state that employ a wide variety of differently credentialed clinicians.

We previously provided comments as part of the sunrise review survey distributed by the Department of Health. After reviewing the draft report to the Legislature, we continue to have many of the same concerns about roles and “scope of practice.” It is still not clear what gap this potential new credential would fill, and it could create administrative and regulatory complexity, as well as confusion for the public.

Role of a BA Behavioral Health Clinician

The draft report does not provide any greater clarity about the role or scope of practice for this proposed credential. It is not at all clear how a BA level behavioral health credential would be different from existing bachelor degrees in human services or social work, what the core competencies would be for this new credential, or how it overlaps or aligns with existing behavioral health system credentials, including Substance Use Disorder Professionals (SUDPs) and Agency-Affiliated Counselors (AACs).

The report references multiple times that BA level interns (attending graduate school to earn their master’s degree) are doing much of the same work as master’s level clinicians, such as intake assessments and individual and group therapy. These references significantly overstate the role of a BA level intern in community behavioral health. For example, according to the Medicaid state plan, in order to be eligible for Medicaid reimbursement, an intake evaluation must be provided by a mental health professional, which with a few waived exceptions must be a clinician who is master’s level or above.

Role of a BA Behavioral Health Clinician within the Behavioral Health System

The Council participates in several rulemaking and stakeholdering processes with DOH on a number of issues related to the behavioral health system in our state. We continue to have conversations about which credentialed professionals may provide mental health, SUD, and/or co-occurring disorder services, and in what settings. The alternative training pathway that allows a Master’s level clinician to earn a SUDP credential in a streamlined fashion took years to end up in the WACs. Stakeholders continue to have disagreements about whether the alternative pathway is too streamlined now or still not streamlined enough. House Bill 1768, which created a new COD Specialist endorsement, eventually passed the Legislature last session, but it faced significant opposition. If we cannot (as a system) reach agreement about a streamlined pathway for Master’s level mental health clinicians to become qualified to provide SUD, how will a combined MH/SUD BA level scope of practice and related education and experience requirements be accomplished?

The draft report seems to contemplate a BA level behavioral health clinician could work within any type of setting. If this credential is expected to practice in non-BHA settings, there must be on-site, available supervision from a mental health professional. That said, this credential should not be presented as an independent practice credential. We would also like to point out that, in the behavioral health system, the largest demand and need for SUDPs, mental health counselors, social workers, and marriage and family therapists is in community behavioral health agencies (**not** community health centers as stated on page 5).

Terminology Used Within the Draft Report

We would also like to briefly point out that the draft report uses inconsistent and unclear terminology. For example, the last sentence in the first paragraph of page five doesn’t make sense—what is a “behavioral mental health clinic” versus an “outpatient mental health and substance abuse clinic.” It is important to use language that aligns with regulatory terms and

definitions, and we would suggest that there is consistency in terms before submitting a final report to the Legislature.

Finally, we remain concerned about “deprofessionalizing” mental health and/or addiction treatment by calling this credential a behavioral health professional, and creating confusion in an already complex regulatory and scope of practice environment. The state should focus on the appropriate support role that can be played by BA human services/social work staff, such as case management, care management, wellness support, and housing and employment support.

Thank you for your time and consideration. We are happy to answer any questions and look forward to participating in next steps in this process.

Joan Miller, JD , Senior Policy Analyst, Washington Council for Behavioral Health

Appendix C: Research on Other State Bachelor's Level Credentials

State	Bachelor's level social worker	Bachelor's level SUDP	Supervision	Independent practice	Additional requirements	Notes
Alabama	Licensed bachelor social worker		Yes for 2 years	After 2 years practice under supervision	Examination	Basic licensing level. Must begin practice in public and private social service agencies.
Alaska	Baccalaureate social worker		Not addressed	No addressed	Examination	Cannot practice clinical social work without a master's degree
Arizona	Baccalaureate social worker		Direct supervision for clinical practice	For non-clinical	Examination	Can engage in clinical practice under direct supervision.
Arizona		Lic. Assoc. substance abuse counselor (LASAC) Lic. substance abuse tech. (LSAT)	Direct supervision	No	LASAC - 3200 hours supervised experience. LSAT - exam and must practice under direct supervision.	
Arkansas	Licensed social worker		Yes	No	Examination	Non-clinical generalist practice.
Arkansas		Licensed Associate Alcoholism & Drug Abuse Counselor (LAADAC)			270 clock hours specific coursework, 6,000 hours supervised experience, and exam.	May practice after successfully completing a schedule of direct supervision prescribed by the board.
Colorado	Social worker		Supervision or consultation	No	Supervised work experience and examination	Non-clinical
Colorado		Certified Addiction Counselor III (CAC III)	No	Yes	Supervised work experience, examination, and 2,000 hours of supervised experience.	Master's level licensed addiction counselor can treat co-occurring disorders.
Delaware	Licensed Bachelors of Social Work		Not addressed	Not addressed	Examination	BA is entry level generalist practice.

State	Bachelor's level social worker	Bachelor's level SUDP	Supervision	Independent practice	Additional requirements	Notes
Florida		Certified Addiction Professional (CAP) (voluntary)				CAP is a voluntary bachelor's level credential recognized as billable under Florida's Medicaid plan.
Georgia		Certified Addiction Counselor Level II	Not addressed	Not addressed	6,000 hours practice, 270 contact hours specific coursework, 144 hours clinical supervision, & exam.	Certification is under state association, rather than government.
Hawaii	Licensed Bachelors of Social Work		Yes	No	Examination	Must work in an agency setting.
Hawaii		Certified Substance Abuse Counselor-bachelor	Not addressed	Not addressed	4,000 hours supervised experience, 270 hours specific education, & exam.	
Idaho	Licensed baccalaureate social worker		Not required	For generalist practice	Examination	Includes independent practice but not private practice.
Illinois	Licensed social worker		For clinical social work	For non-clinical	3 years of experience and examination	
Indiana	Licensed social worker		Not for non-clinical	Not addressed	Examination	Social work practice without psychotherapy or diagnosis
Indiana		Licensed addiction counselor	Not for non-clinical	No	Two years of experience and examination	
Iowa	Certified Co-Occurring Disorder Professional		Not addressed	Not addressed	BA in co-occurring disorders or behavioral science, 200 hours education, and 6,000 hours experience.	Licenses programs, not personnel but sets minimum standards including certification by the Iowa Certification Board.
Iowa	Licensed Bachelors of Social Work		Doesn't appear so	No	Examination	
Kansas	Licensed baccalaureate Social Worker		No addressed	No private practice		May not diagnose or treat mental disorders
Kansas		Licensed Addiction Counselor	Yes	No	Additional coursework and examination	To practice independently requires a master's degree.

State	Bachelor's level social worker	Bachelor's level SUDP	Supervision	Independent practice	Additional requirements	Notes
Kentucky		Certified Alcohol and Drug Counselor	Not addressed	Not addressed	6,000 hours experience, 270 hours specific coursework and examination.	All levels appear to be title protection.
Louisiana	Registered Social Worker		No	No - must work in an agency		Generalist social work practice in an agency and cannot engage in advanced practice or clinical social work.
Louisiana		Certified Addiction Counselor	Yes	No	180 hours specific coursework, 300 hours supervised practical training, 4,000 hours supervised experience, and examination	Master's degree required for independent practice - licensed addiction counselor.
Maine		Licensed Addiction Counselor	No	Yes	4,000 hours supervised experience and 2,000 hours documented supervised practice.	May practice independently within an agency or in private practice.
Maryland	Licensed Bachelor Social Worker		Yes	After completion 3 years practice and 4,500 hours supervision	None included in statute	Generalist practice under supervision.
Maryland		Certified associate counselor-alcohol and drug	Yes		2,000 hours clinically supervised experience plus 33 semester hours of specific coursework.	
Massachusetts	Licensed Social Worker		Yes	No	If bachelor's in a field besides social work, 3,500 hours supervised experience.	Non-clinical social work services under supervision
Minnesota	Licensed Social Worker		Not required after post-licensure supervision	Yes	Examination	Must receive 100 hours supervision after receipt of license.

State	Bachelor's level social worker	Bachelor's level SUDP	Supervision	Independent practice	Additional requirements	Notes
Minnesota		Licensed alcohol and drug counselor	No		28 semester hours of specific coursework, 880 hour practicum, & comprehensive exam or 2,000 hours supervised practice.	
Minnesota		Licensed Alcohol and Drug Counselor	Doesn't appear so	Yes	270 hours specific coursework, 880 hours supervised practicum, and examination.	
Mississippi	Licensed Social Worker		Yes	No	Examination	
Mississippi		Certified Alcohol and Drug Counselor			270 hours specific coursework, 200 hours supervised practical training,	Certification is through state association.
Missouri	Licensed Baccalaureate Social Worker		Yes - until completion of 3,000 hours supervised experience	After completion of 3,000 hours supervised experience		Generalist practice, excluding diagnosis and treatment of mental illness.
Nebraska	Certified Social Worker		No	No	Examination	Title protection - certification is voluntary
Nevada	Licensed Social Worker		No	Yes	Examination	Does not include clinical social work.
Mississippi		Certified Alcohol and Drug Counselor-I	Assuming not required as this is a voluntary credential	Yes	270 hours specific coursework, 200 hours supervised practical training, and examination	Voluntary certification through state association
Nevada		Certified Drug and Alcohol Counselors	No	Yes	4,000 hours experience and examination	Licensed clinical alcohol and drug abuse counselor (master's level) can perform clinical social work and diagnosis and treatment of mental illness when co-occurring.
New Jersey	Certified Social Worker		Yes	No		Non-clinical.

State	Bachelor's level social worker	Bachelor's level SUDP	Supervision	Independent practice	Additional requirements	Notes
New Jersey		Certified alcohol and drug counselor	Yes	No	300 hours supervised practical training, two years of supervised experience, 270 hours specific coursework, attended 30 alcohol & drug abuse self-help group meetings, and exam.	
New Mexico	Licensed Bachelors Social Worker		Yes	No	Examination	Generalist practice.
N. Carolina	Certified Social Worker		No	No	Examination	Non-clinical social work and is title protection.
N. Dakota	Licensed Social Worker		Not addressed	No	Examination	Generalist practice.
Ohio	Licensed Social Worker		Must be supervised if working outside agency or diagnosing and treating.	No	Examination	To diagnose and treat mental and emotional disorders, must be supervised.
Ohio		Licensed Chemical Dependency Counselor III	Yes for clinical counseling & diagnoses & treatment.	No	Supervised work experience	Can diagnose and treat under supervision. May not practice as an individual practitioner.
Oregon		Certified alcohol and drug counselor II (CADC)			4,000 hours supervised experience, and exam.	Certification is through Mental Health & Addiction Certification Board of Oregon - not state licensure.
S. Carolina	Licensed Baccalaureate Social Worker		Yes	No	Examination	Generalist practice.

State	Bachelor's level social worker	Bachelor's level SUDP	Supervision	Independent practice	Additional requirements	Notes
S. Carolina		Certified addictions counselor (CAC) I & II			CAC I - 270 hours specific coursework, 4,000 hours experience, 150 hours clinical supervision, & exam. CAC II - 450 hours specific coursework, 8,000 hours experience, 150 hours supervision, & exam.	Voluntary certifications
S. Dakota	Licensed Social Worker		Yes	No	Examination	Independent practice two years of experience under supervision.
S. Dakota		Certified Prevention Specialist	Yes	No	Specific courses, 2,000 hours supervised experience, and examination.	Independent practice requires master's level credential plus two years of supervised experience.
Tennessee	Baccalaureate Social Worker		Yes	No - must work in agency	Examination	Not qualified to diagnose or treat mental illness or provide psychotherapy.
Tennessee		Level II Licensed Alcohol and Drug Abuse Counselor	No	No	4,000 hours supervised experience and examination	Must work in treatment program or recovery support program.
Texas	Licensed Baccalaureate Social Worker		No	Non-clinical with recognition from board	Examination	Generalist practice in non-clinical social work.
Utah	Licensed social worker		General supervision	No	Examination	May perform general entry level services.
Utah		Certified Advanced Substance Use Disorder counselor	Direct supervision	No	300 hours specific coursework, 4,000 hours supervised experience, 350 hour practicum, and examination.	Does not include diagnosis or engaging in the practice of mental health therapy.
Virginia		Certified Substance Abuse Counselor	Clinical supervision	No	Specified didactic education, and experience.	

State	Bachelor's level social worker	Bachelor's level SUDP	Supervision	Independent practice	Additional requirements	Notes
WA D.C.	Licensed social work associate		Yes	No	Examination	
WA D.C.		Certified addiction counselor II	Direct supervision	No	180 hours supervised experience and examination	
W. Virginia	Social Worker Level A		Yes	No	Examination	
Wyoming	Certified Social Worker		Clinical supervision	No		
Wyoming		Certified Addictions Practitioner	Clinical supervision	No	Examination	

Appendix D: Letter RE: Reimbursement



Memorandum

To: Sherry Thomas, Washington State Department of Health

From: Lonnie Johns-Brown, Washington State Office of the Insurance Commissioner

Date: September 19, 2019

Subject: Provider Credentials – Behavioral Health: Legislative Implementation Questions – Insurance Reimbursement

Thank you for asking the Office of the Insurance Commissioner (OIC) for input to support Department of Health (DOH)'s implementation of ESHB 1768 and 2SHB 1907. In order to be 'reimbursable' under insurance/health benefit plan coverage, the provider of the covered service must be licensed under title 18 or chapter 70.127 RCW, or be supervised by or the agent of such a licensee. RCW 48.43.005 (24) [definition of "provider"].

For the Medicaid program, we believe that any new credential would need to be included by Health Care Authority in the WAC 182-502-0002, which lists eligible provider types, but recommend you confirm this with the Health Care Authority. However, there isn't a comparable list of eligible provider types under the insurance code, and instead the more general "scope of practice under the license" determines whether the provider is eligible to provide a covered service. See, RCW 48.43.045, WAC 284-170-270.

Finally, depending on the taxonomy system used by the carrier or Medicaid program, the medical billing and payment system would need to recognize the classification of the provider in order to adjudicate and pay the claim.