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Report of the Registered Counselor Work Group

November 2007



Health Systems Quality Assurance

Information Summary and Recommendations

Report of the Registered Counselor Work Group

November 2007



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Executive Summary

As part of the 2007-2009 operating budget approved in the 2007 legislative session, the Washington State Legislature directed the Department of Health (DOH) to “convene a work group to develop recommendations regarding the need to regulate those individuals currently registered with the department of health as counselors”. (See Appendix C.) The recommendations were to be submitted to the Legislature and Governor by November 15, 2007. This report presents those recommendations.

The department convened a work group representing registered counselors, consumers, legislators, community mental health and chemical dependency treatment organizations, state agencies, and other mental health professions including hypnotherapists, mental health counselors, social workers, psychologists, advanced practice psychiatric nurses, and marriage and family therapists. (See Appendix B.) A letter was sent to all registered counselors (approximately 18,000 credential holders) to inform them of the work group. (See Appendix D.) A random survey of registered counselors was conducted by an independent research firm to provide the work group with statistically significant data regarding the background, work settings, and professional activities of currently registered counselors. (See Appendix E.)

Working with a facilitator and department staff, the work group met six times and identified issues, shared expertise, discussed proposals, and adopted recommendations. (See Work Group Process Section.) Minority reports were submitted. (See Appendix A)

Recommendations

The work group finds that current registered counselor regulations do not set adequate minimum standards for registered counselors to practice counseling and should be modified to clarify their role, establish different categories and minimum requirements, improve public understanding of state standards and consumer rights, and retain agency oversight.

The work group recommendations are as follows.

Recommendation 1: Create Seven New Credentials and Abolish the Registered Counselor Credential

The work group recommends replacing the registered counselor credential through creating new types of credentials. Five of the new recommended credentials include: Chemical Dependency Professional Trainee, Marriage and Family Therapy Associate, Mental Health Counselor Associate, Clinical Social Work Associate, and Advanced Social Work Associate.

A new credential called Agency Affiliated Counselor would replace the registered counselor credential for counselors working in state regulated facilities.

Finally, a new credential would replace the registered counselor credential for counselors in private practice. This credential will be referred to as the “new credential for counselors in private practice” in this report.

The work group recommends that for a phase-in period of one year, counselors registered for at least five years be permitted to grandparent into the new credential for counselors in private practice, provided that their registration is in good standing, that they are compliant with any disciplinary process and orders, and that they have taken courses and have passed tests in risk assessment, ethics, appropriate screening and referral, and Washington State law. Additionally, counselors who grandparent from registered counselor to this credential would be required to have a written consultation agreement (as opposed to supervision agreement) with an agency-qualified supervisor. The Secretary shall establish the details of the requirements by rule.

Current registered counselors in private practice who do not meet grandparenting requirements for the new credential for counselors in private practice, as well as new applicants for this credential, would be required to have a bachelors degree in a counseling related field or the equivalent in education and supervised experience, that may, among other things, include an associate degree in a counseling related field plus a supervised internship. These credential seekers would also be required to pass an examination in core knowledge including risk assessment, ethics, appropriate screening and referral, and Washington State law, and will have a written arrangement for supervision of their practice with an agency-qualified supervisor. The Secretary shall establish the details of the requirements by rule.

There are minority reports relevant to this recommendation. (Appendix A)

Recommendation 2: Change the Scope of Practice

The work group recommends that the scope of practice of the new credential for counselors in private practice be defined to ensure that the diagnosis and treatment of mental disorders are referred to appropriate health care providers. Under the new scope definition, individuals with this credential may provide counseling services, as defined in part two below, but will not diagnose mental disorders nor serve as the primary mental health provider in the treatment of clients with a mental disorder.

The recommended scope of practice definition for the new credential for counselors in private practice is:

“The practice of the individuals with this credential shall be limited to:

1. Appropriate screening of the client’s condition. Recognition of a mental or physical disorder requires that the credential holder recommend that the client seek diagnosis and treatment from an appropriate health care professional.
2. Counseling and guiding clients in adjusting to life situations, developing new skills, and making desired changes, in accordance with the theories and techniques of a specific counseling method and established practice standards.”

There are minority reports relevant to this recommendation. (Appendix A)

Recommendation 3: Establish Continuing Education Requirements

The work group believes credential holders and the clients they serve will benefit from a mandatory continuing education requirement. The work group recommends that this component should include at least 36 continuing education credits, with at least 6 credits in professional law and ethics and be completed every two years. This requirement should not apply to Agency Affiliated Counselors and Chemical Dependency Trainees.

There are minority reports relevant to this recommendation. (Appendix A)

Recommendation 4: Establish a Comprehensive Public Education Program

The work group recommends that a comprehensive public education program be developed and implemented to increase citizen awareness and knowledge to make informed choices in selecting counseling and mental health providers.

There are minority reports relevant to this recommendation. (Appendix A)

Recommendation 5: Create a DOH advisory committee to provide expertise for establishing, implementing, and maintaining standards related to the new credential for counselors in private practice

There are minority reports relevant to this recommendation. (Appendix A)

Work Group Process

The Department of Health contracted with Mr. Eric Svaren, GroupSmith, Inc., to facilitate the work group process. The department also contracted with Gilmore Research to conduct a new survey of registered counselors to provide reliable data to the work group on current registered counselors in the state, as well as information on expectations for the work group from key informant interviews with legislators.

Staff of the department served as staff to the work group, which included maintaining and updating a website regarding the proceedings of the work group.

At the beginning of the first meeting of the work group, Secretary of Health Mary Selecky briefly addressed the work group, thanking members for their participation and time commitment, and discussing the importance of their upcoming work and recommendations.

Staff provided the work group with an overview on the timeline for the work group process, and the history of the counseling credentials. The recommendations of the 2006 Registered Counselors Task Force were also presented to the group. (See Appendix H.)

The facilitator presented a draft process agreement and roles for the work group to review and comment. The process agreement covered discussion ground rules, decision-making, voting, communication, and meeting records. Group members provided comments and

amendments to the decision making and voting sections of the process agreement and adopted the agreement and roles documents. A two-thirds vote was adopted as the standard required to pass motions in the work group, including final recommendations of the work group.

As part of the initial work group process, factors of success and desired outcomes (wishes) for the work group process were identified by the group.

Success factors identified were:

- being open to hear differently
- respect for people who work differently from you
- sensitivity to cultural needs
- final product built on common ground
- structure questions that do not limit our outcomes in advance (limit preconceptions)
- listening
- nice combination of patience and tenacity
- hear and address all issues in the document
- careful crafting of survey
- open to our learning moments
- clear process and accountability to that process
- honest, non-political input and outcome that reflects it
- end product that meets the needs of everybody
- being here and having a voice
- department seen as giving its all to process
- be clear about where we're headed
- avoid polarization
- don't let time pressure compromise product
- group shares intention to produce a superior product
- clarify definition of "counseling" – profession vs. practice
- not compromise patient safety because we are looking for an end product
- be evidence-based in our decision making
- be clear on what we're focusing on (the problem) and look at complaint data
- trust
- don't "reinvent the wheel" by trying to come up with a new scope of practice – draw from established standards of care.

Desired outcomes for the process were:

- all voices are heard
- decisions by consensus
- maintain category for alternative forms of counseling
- respect apprentice/journeyman process as well as academic – focus on fundamentals
- remain focused on well-being of the client
- avoid "us vs. them" mentality
- clear outcome we can educate public about

- don't overly limit definition of "counselor"
- focus on consumer choice as well as safety
- strengths – based – build on what's good and improving it
- preserve the value of peer counseling
- this results in an educational effort by the Department
- data to compare different professions (registered counselors and licensed).

The research firm provided an overview of their proposed survey process, and the principles associated with random sampling and statistical significance.

The work group concluded the first meeting by identifying approximately forty topics and questions they desired to be included on the survey. Based on the input from the work group, a final list of survey questions to be asked by the research firm was developed the following week.

Opportunities for the audience members to provide comments to the work group were provided periodically at each meeting. Notes of those comments were recorded as part of the meeting notes, and were included on the work group website.

In the second meeting, the work group broke into smaller groups to discuss and identify the core issues that could serve as the problem statement to be addressed in their recommendations.

The following problems were identified by various subgroups:

- Core competencies of what registered counselors do, both academic and nontraditional.
- Accountability
- Continuing education
- Ethics / Standards
- Professional credentialing
- Consultation
- Agency follow-through on public education and consumer safety
- Current registered counselor registration allows unqualified and untrained individuals to practice
- Counseling independently and does not define credentialing guidelines.
- Public misunderstandings fueled by a lack of core competency requirements for registered counselors.
- Differentiate mental health counseling from other types of work being done by registered counselors.

Based on the work group discussion and analysis of the items, the following themes were identified:

- Internal / external public education core competencies need to be agreed upon
- Registered counselor category is too broad
- Registered counselors are not more of a risk than others
- Agency oversight / follow through

- Public protection
- Do not know public perception
- Agency is not adequately following through on mandate:- enforcement- public education
- Demonstration of two kinds of competencies- in field- ethics, education, etc.

At the end of this review session, the work group adopted the following primary problem statement: “Current registered counselor regulations do not set adequate minimum standards for registered counselors to practice counseling.”

To further focus the work of the group, preliminary questions were answered through voting.

The results of the preliminary votes were (15 members were in attendance):

1. Do we want a broad credential with higher standards?
(3 members agreed)
2. Do we want several credentials?
(6 members agreed)
3. Do we want several credentials with higher standards?
(5 members agreed)
4. How do we want core competency demonstrated?
 - _ degree (8 members agreed)
 - _ alternative education (12 members agreed)
 - _ continuing education (14 members agreed)
 - _ testing (12 members agreed)
 - _ national certification (9 members agreed)
 - _ current background check (8 members agreed)
5. Do we want grandparenting?
 - Yes (11 members agreed)
 - No (1 member agreed)
6. If yes, should there be requirements to grandparent?
(14 members agreed)
7. Allow equivalencies?
(14 members agreed)
8. What elements should be in regulations?
 - _ education (14 members agreed)
 - _ risk assessment / training (14 members agreed)
 - _ how to refer to licensed people (13 members agreed)
 - _ continuing education (15 members agreed)
 - _ ethics (15 members agreed)
9. Would it solve part of the problem to rename registered counselors?
 - Yes (6 members agreed)
 - No (5 member agreed)
10. When would new requirements go into effect?
 - Immediately (0 members agreed)
 - One year (5 members agreed)
 - Five years (5 members agreed)

11. Should we consider recommendations from before (2006 Task Force)?
Yes (11 members agreed)
No (2 member agreed)

At the third meeting of the work group, an overview of the results was presented by the research company. Survey results were presented for the random sample of 805 registered counselors interviewed. (See complete report in Appendix E.) The work group was presented data and analyses on the following questions and topics:

- How many years as Registered Counselor in Washington State?
- In what settings do you provide counseling?
- Peer counselors
- Populations Served
- General Types of Populations Served
- Special Types of Populations Served
- Settings where Skills and Knowledge Gained
- Type or Subject of Counseling Degree
- Other than Degrees, Certification in Counseling or Mental Health
- Other than Certification or Degrees, What Type of Experience
- Modality of Mentorship
- Being a Client Part of Mentorship
- Modality of Apprenticeship
- Being a Client Part of Apprenticeship
- Modality of Supervised Internship
- Being a Client Part of Supervised Training
- Modality of Supervised Internship
- Modality of Professional Training Program
- Being a Client Part of Professional Training Program
- Member of any Organizations
- Currently Work with Another Mental Health Professional
- Previously Worked with Another Mental Health Professional
- Assess, Diagnose, or Treat Mental Health Disorders
- Role in Providing Primary Mental Health Care
- Assess, Diagnose, or Treat Substance Abuse /
- Chemical Dependency Disorders
- Assess if Client is Danger to Self or Others
- Train or Teach Others
- Other Credentials
- Supervised Hours for License or Certification
- Client Referrals

In the final regular meeting of the work group, a number of recommendations were proposed by individual work group members and subgroups of work group members.

The recommendations on which votes were taken and the results of those votes were:

1. Create four new credentials for counselors in pre-licensure and training status.

Yes – 13, No – 0, Passed

2. Statutory requirements for the credentials for counselors in pre-licensure and training status should be in their respective chapters, rather than in RCW 18.19.

Yes – 13, No – 0, Passed

3. Continuing education requirements should be the same for all categories of counselor.

Yes – 13, No – 0, Passed

4. Future private practice counselors should complete courses in risk assessment, ethics, appropriate screening and referral, and Washington State law, and other subjects identified by a competency and skill standards study to be conducted by the department, and

- i. a Associate of Arts degree in counseling or related field

Yes – 5, No – 8, Failed

- ii. an Apprenticeship/Internship

Yes – 5, No – 8, Failed

- iii. a Associate of Arts degree in counseling or related field and a Apprenticeship/Internship

Yes – 9, No – 4, Passed

- iv. a Bachelors degree in counseling or related field

Yes – 10, No – 3, Passed

- v. a Masters degree in counseling or related field

Yes – 1, No – 12, Failed

5. Future private practice counselors should pass an examination in risk assessment, ethics, appropriate screening and referral, and Washington State law, and other subjects identified by a competency and skill standards study to be conducted by the department.

Yes – 10, No – 3, Passed

6. Future private practice counselors should have two years experience under an internship or supervision arrangement similar to the pre-licensure and trainee counselors.

Yes – 7, No – 6, Failed

7. Future private practice counselors should have a supervision requirement of:

- i. One hour of supervision per 100 hours of client contact, with up to half of the supervision in group settings, ending after 1500 hours of client contact.

Yes – 7, No – 6, Failed

- ii. One hour of supervision per 100 hours of client contact, with up to half of the supervision in group settings, ending after 3000 hours of client contact.
Yes – 2, No – 11, Failed
 - iii. Two hours of supervision per month, ending after two years.
Yes – 8, No – 5, Failed
 - iv. One hour per two hundred hours of client contact; after five years, a minimum of six hours of supervision would be required annually; up to half of the required hours in any year may be supervision of practice in a group setting
Yes – 10, No – 2, Passed
8. Current registered counselors can transition to the new private practice credential if they:
- i. Show evidence of having completed course work in risk assessment, ethics, appropriate screening and referral, and Washington State law, and other subjects identified by a competency and skill standards study to be conducted by the department.
Yes – 12, No – 1, Passed
 - ii. Have been registered for five years, and their credential is in good standing, they have no pending unresolved disciplinary actions or complaints, and they are compliant with any prior disciplinary orders.
Yes – 13, No – 0, Passed
 - iii. Pass an examination in risk assessment, ethics, appropriate screening and referral, and Washington State law, and other subjects identified by a competency and skill standards study to be conducted by the department.
Yes – 13, No – 0, Passed
 - iv. Are supervised by another mental health professional.
Yes – 8, No – 5, Failed
 - v. Have a consultation agreement with another mental health professional.
Yes – 13, No – 0, Passed

At the end of the process, a special meeting of the work group was held to refine the content of the work group report.

As part of the special meeting, two additional topics were discussed by the work group, the written disclosure statement provided to clients, and the title to be recommended for the new credential for counselors in private practice

The work group recommended that the written disclosure statement provided to all clients of counselors in private practice include the following notice: -“As a [new title], I am not credentialed to diagnose or treat mental disorders or to conduct psychotherapy.”

Yes – 13, No – 1, Abstain – 1, Passed

The work group brainstormed on a title for counselors in private practice. The following titles and terms were identified, and a straw-poll was conducted regarding each item. The members were asked to vote if they liked the title or term to be used in the name of the new credential for counselors in private practice.

<u>Title or Term</u>	<u>Number That Liked</u>
• certified counselor	8 out of 15
• counselor	8 out of 15
• independent counselor	6 out of 15
• human services counselor	1 out of 15
• advisor	1 out of 15
• assistant counselor	1 out of 15
• complementary and alternative counselor	4 out of 15
• independent	7 out of 15
• registered counselor	2 out of 15
• approved counselor	1 out of 15
• unaffiliated counselor	0 out of 15
• associate counselor	0 out of 15
• specialty counselor	5 out of 15
• counseling permit	1 out of 15
• certified complementary and alternative counselor	2 out of 15

The work group did not reach an agreement on the title because no title met the two-thirds majority to pass.

The work group approved a motion to provide the following four terms for the consideration of the Governor and Legislature. The vote of the work group on this motion was Yes – 11, No – 0, Abstain -3, Passed.

- certified counselor
- complementary and alternative counselor
- independent counselor
- specialty counselor

Minority reports were submitted by work group members. (See Appendix A.)

Detailed Recommendations

The work group finds that current registered counselor regulations do not set adequate minimum standards for registered counselors to practice counseling and should be modified to clarify registered counselor roles, establish different categories and minimum requirements, improve public understanding of state standards and consumer rights, and retain agency oversight.

The work group recommends creating new types of credentials that will, after a period of transition, result in the abolishment of the registered counselor credential. In addition, the work group recommends that the scope of practice of the new credentials be defined to ensure that the diagnosis and treatment of clients with mental disorders are referred to appropriate health care providers. Consistent with the other mental health professions, the new credentials should have continuing education requirements. The work group also recommends that a comprehensive public education program be developed and implemented to increase citizen awareness and knowledge to make informed choices in selecting counseling and mental health providers. Finally, the work group recommends the creation of an agency advisory committee to provide expertise to establish, implement, and maintain standards related to the new credential for counselors in private practice.

Recommendation 1: Create Seven New Credentials and Abolish the Registered Counselor Credential

The work group recommends the creation of the following seven new credentials:

Five New Credentials for Counselors in Pre-Licensure/Training Status:

- **Chemical Dependency Professional Trainee**
- **Marriage and Family Therapy Associate**
- **Mental Health Counselor Associate**
- **Clinical Social Work Associate**
- **Advanced Social Work Associate**

One New Credential for Counselors in State Regulated Facilities:

- **Agency Affiliated Counselor**

One New Credential for Counselors in Private Practice

(The work group did not reach agreement on a recommended title for this credential. Because no title was agreed upon by the work group, this credential will be referred to as the “new credential for counselors in private practice” in this report.)

Associate & Trainee Credentials For Those In Pre-Licensure/Training Status

Approximately 35 percent of registered counselors are individuals who are gaining required experience to become licensed social workers, mental health counselors, and marriage and family therapists, or certified chemical dependency professionals. Pre-licensure candidates in social work, mental health counseling, and marriage and family therapy have a graduate degree in their respective mental health field, and maintain the registered counselor credential while working under state approved supervisors as mandated in state laws. Similarly, individuals working toward

achieving the necessary experience and coursework to become a chemical dependency professional also maintain the registered counselor credential as it is required by Department of Social and Health Services laws.

The work group finds, as did the 2006 registered counselor task force, that the strong existing standards and regulatory framework inherent in the pre-licensure and trainee programs is sufficient to ensure patient safety in delivery of supervised counseling services by individuals in these categories. Consequently, the work group recommends the creation of these separate pre-licensure and trainee credentials under their respective chapters in statute, under the jurisdiction of the Department of Health.

Agency Affiliated Counselor Credential For Counselors In State Related Facilities

Approximately 30 percent of registered counselors are working in an agency or facility operated, licensed, or certified by the State of Washington. Agency counselors work in settings that have quality assurance standards set in law, including supervision requirements.

The work group finds, as did the 2006 registered counselor task force, that the existing standards and regulatory framework inherent in programs operated, licensed, or certified by the state are sufficient to ensure patient safety in the delivery of supervised counseling services by individuals employed in these facilities. Consequently, the work group recommends the creation of a separate agency affiliated credential to be issued and maintained by the Department of Health.

New Credential For Counselors In Private Practice

Approximately 28 percent of registered counselors have a full time or part time private counseling practice. On average, private practice registered counselors have been practicing for approximately nine years.

The work group finds that private practice registered counselors provide significant and important care to the citizens of Washington. In the survey conducted for the work group, private practice registered counselors were more likely than registered counselors in other settings to serve the populations of the elderly, couples, students, health care professions, and first responders.

The work group also finds that the public would be better served by creating a unique credential for those in private practice, and requiring minimum experience and education qualifications for this new credential. Having a specific credential for counselors in private practice will enable the department to establish and maintain specific professional standards for this category of providers. It will also assist the public in distinguishing the qualifications of and services provided by this group of counselors from the other mental health providers.

The work group recommends that the requirements for the new credential for counselors in private practice be as follows:

- A bachelors degree in a counseling related field, or the equivalent in education and supervised experience, that may, among other things,

include an associate degree in a counseling related field plus a supervised internship, to be determined by the department.

- Passing an examination in core knowledge including risk assessment, ethics, appropriate screening and referral, and relevant Washington State law and other subjects identified by a competency skills study to be conducted by the department.
- Establishing and maintaining a written agreement for the supervision of their practice with a qualified supervisor. The minimum hours of supervision during the first five years would be one hour per two hundred hours of client contact; after five years, a minimum of six hours of supervision would be required annually; up to half of the required hours in any year may be supervision of practice in a group setting. The Secretary shall establish the supervisor qualification standards and the requirements for the supervision agreement.
- Meeting continuing education requirements as discussed below in Recommendation 3.

The work group further recommends that for a phase-in period of one year, counselors registered for at least five years be permitted to grandparent into the new credential for counselors in private practice, provided that they:

- Have a registration that is in good standing, and that they are compliant with any disciplinary process and orders.
- Show evidence of having completed course work in risk assessment, ethics, appropriate screening and referral, and Washington State law and other subjects identified by a competency skills study to be conducted by the department.
- Pass tests in risk assessment, ethics, appropriate screening and referral, and Washington State law, as determined by the department.
- Have a written consultation agreement (as opposed to supervision agreement) with a qualified supervisor. The Secretary shall establish the details of the requirements by rule.
- Meet continuing education requirements as discussed below in Recommendation 3.

The work group believes that this new credential will help ensure the care provided to clients by the counselors in private practice is safe and competent.

There are minority reports relevant to Recommendation 1. (See Appendix A.)

Recommendation 2: Change the Scope of Practice

The work group recommends that the scope of practice of the new credential for counselors in private practice be defined to ensure that the diagnosis and treatment of mental disorders are referred to appropriate health care providers. Under the new scope definition, individuals with this credential may provide counseling services, as defined in part two below, but will

not diagnose mental disorders nor serve as the primary mental health provider in the treatment of clients with a mental disorder.

The recommended scope of practice definition for the new credential for counselors in private practice is:

“The practice of the individuals with this credential shall be limited to:

1. Appropriate screening of the client’s condition. Recognition of a mental or physical disorder requires that the credential holder recommend that the client seek diagnosis and treatment from an appropriate health care professional.
2. Counseling and guiding clients in adjusting to life situations, developing new skills, and making desired changes, in accordance with the theories and techniques of a specific counseling method and established practice standards.”

Consistent with the scope of practice change, the work group recommends that the written disclosure statement provided to all clients include the following notice: “As a [new title], I am not credentialed to diagnose or treat mental disorders or to conduct psychotherapy.”

Finally, related to the scope of practice, the work group agrees with the 2006 registered counselor task force that the existing exemptions in RCW 18.19.040 should be retained and should be extended to include the following settings as exempt from the credential requirement:

- Vocational counselors who give advice on employment or career development
- School counselors who are employed by or contracted with a school or college and work to promote the academic, career, personal, and social development of children and young adults
- Peer counselors and student peer counselors who use their own experience to help people with similar conditions
- Domestic violence treatment providers and crime victim advocates who help people respond to acts of violence and crime
- Camp counselors who supervise individuals in recreational venues
- Pastoral counseling, religious and spiritual counseling.

There are minority reports relevant to Recommendation 2. (See Appendix A)

Recommendation 3: Establish Continuing Education Requirements

Credential holders and the clients they serve will benefit from a mandatory continuing education requirement. The work group recommends continuing education of at least 36 continuing education credits, with at least 6 credits in professional law and ethics. It should be completed every two years. However, this requirement should not apply to Agency Affiliated Counselors and Chemical Dependency Trainees.

There are minority reports relevant to Recommendation 3. (See Appendix A)

Recommendation 4: Establish A Comprehensive Public Education Program

The work group recommends that a comprehensive public education program be developed and implemented to increase citizen awareness and knowledge to make informed choices in selecting counseling and mental health providers.

The work group strongly agrees and supports Finding 5 in the recently issued performance audit of the Department of Health which recommends significant improvements in public education and understanding of health professions, client rights, and protections afforded under state law.

The department should develop comprehensive education strategies that together will enhance the public's understanding of the qualifications of and services provided by each of the mental health professions. Public education is essential to promote informed decision making in the selection of the type of mental health care provider to meet the specific needs of each client, and to encourage the prompt reporting by clients to the department of any provider misconduct. We agree that the legislature should provide the department with the necessary resources to establish and maintain a permanent public education program.

There are minority reports relevant to Recommendation 4. (See Appendix A.)

Recommendation 5: Create a DOH advisory committee to provide expertise for establishing, implementing, and maintaining standards related to the new credential for counselors in private practice

If the above recommendations are adopted, there will be significant work and ongoing activities requiring professional expertise in implementing and regulating this new credential. For this reason the work group suggests a new advisory committee to assist the department in establishing and maintaining standards related to the new credential for counselors in private practice.

There are minority reports relevant to Recommendation 5. (See Appendix A.)

Concluding Remarks

In closing, the work group is unanimous in thanking the Governor and Legislature for the opportunity to provide our ideas for improving our state's system of regulating registered counselors and other mental health professionals.

The work group is also unanimous in thanking the facilitator Eric Svaren, Gilmore Research, and the staff of the Department of Health, for their helpful assistance and support throughout the work group process.

APPENDIX A:

Minority Reports Submitted by Work Group Members

MEMO TO: Registered Counselor Work Group

FROM: The Washington State Psychological Association

ABOUT: Minority Report to the final report of the 2007 Work Group

September 30, 2007

The Washington State Psychological Association (WSPA) would like to submit a “minority report” to the final report of the 2007 Registered Counselor’s Work Group (RC work group). There are several controversial recommendations in that report that did not receive unanimous support. We believe it to be in the best interest of all parties that all recommendations be made available to the Department of Health and ultimately to the Legislature for their consideration.

Overview:

In this section we list the recommendations and the WSPA position. In the next section, we will provide background and arguments in support of WSPA’s recommendations.

1. The report of the 2007 RC work group report recommends that the Registered Counselor category of health care provider as it currently exists, be abolished. WSPA supports this recommendation (Recommendation 1).
2. The report recommends the creation of six new categories of provider (Recommendation 1) . Four new categories represent providers who are currently actively receiving supervised training as a Chemical Dependency Professional, and for licensure as Masters level Marriage and Family Therapists, Mental Health Counselors, and Licensed Social Workers. This recommendation is based on the finding by both the 2006 and 2007 RC work groups that a significant number of currently registered counselors are in supervised training positions in order to apply for licensure in these categories. WSPA supports the creation of these new training credentials.
3. The 2007 RC work group report recommends the creation of a new category entitled Agency Affiliated Counselor (Recommendation 1). Providers practicing with this credential shall only work in state regulated or state operated agencies wherein minimum education, supervision, background checks, continuing education, and other requirements are addressed in statute and rule and are under the authority of the Department of Social and Health Services (DSHS). WSPA supports the creation this new credential. However, it should be clearly designated that this category of credential shall not be used for independent practice.
4. The 2007 RC work group report recommends the creation of a new credential, the title of which is yet to be determined (Recommendation 1). This credential would replace the category of currently Registered Counselors who practice independently, with the addition of requirements for minimum standards of education, continuing education, training and supervision. WSPA does not support this recommendation, but does recommend a method by which currently Registered Counselors practicing independently may choose to continue their careers until retirement or practice closure.

5. In Recommendation 2, the RC work group offers a scope of practice for the new credential. Since WSPA does not support the creation of the new credential, we do not support the scope of practice.

6. Recommendation 3 would establish continuing education requirements for the new categories of providers. WSPA wholeheartedly supports the notion of required continuing education. However, we support the establishment of such requirements through existing rule development procedures.

7. Recommendation 4 would establish a “Comprehensive Public Education Program.” WSPA supports this recommendation, with the addition of funds to provide such a program being made available through state funds.

8. Recommendation 5 would establish an advisory committee or board for mental health professions. WSPA does not support this recommendation as boards and advisory committees already exist for these professions.

WSPA Response:

WSPA has been an active participant in both the 2006 and 2007 work groups considering changes to the existing Registered Counselor credential in Washington State. This year, as in 2006, we support the creation of new credentials for providers who clearly establish that they are receiving supervised training and experience towards licensure. Additionally, we support the creation of a similar training credential for individuals working towards Chemical Dependency Counselor status. Finally, we support again, as we did in 2006, the creation of the Agency Affiliated Counselor credential for those providers who work in state regulated or state supported settings.

We must, however, be cognizant of the findings of the 2007 Performance Audit of HPQA by the State Auditor’s office (August 21, 2007). Of critical importance is the acknowledgement by the performance audit of severe and persistent staff shortages at HPQA (page viii Executive Summary). HPQA has taken laudable steps to address major challenges to its functioning brought on by the increased workload without concomitant staffing increases. However, we wonder how HPQA can be expected to license and discipline a new category of provider that replaces the existing Registered Counselor category, with the additional requirements recommended in Recommendation 1 of the RC work group final report (testing, continuing education, and the like), without additional state funding for staff and staff support services?

In addition, the performance audit highlights the concern of risk to the public that currently exists with the Registered Counselors. To quote the audit, “...while the number of registered counselors has increased by 5.2% between 1999 and 2005, the increase in formal disciplinary actions increased by 142%. The Seattle Times asserted in its ‘License to Harm’ investigative series that registered counselors represented the largest number of offenders with reported sexual misconduct.” Importantly, the audit report goes on to state that “HPQA has not established sufficient procedures and adequate internal controls to ensure credentials are issued only to qualified individuals. Inconsistent processes and a lack of internal controls mean that HPQA cannot be certain that applicants seeking a credential meet all qualifications and background criteria before receiving a credential” (page 6). If HPQA is currently experiencing

such significant difficulties in credentialing and disciplining existing registered counselors and other license holders, WSPA questions how it can then be expected to simply re-certify the same providers with a new name, but with more administrative work to be required of existing HPQA staff, without the potential for more risk to the public?

WSPA recommends instead that the category of Registered Counselor be terminated for all new applicants. However, currently registered counselors practicing independently who do not wish to apply for one of the training designations listed above may continue to practice as registered counselors if and only if they 1) have no outstanding complaints against them filed with the DOH, 2) agree to receive continuing education as recommended by the 2007 RC work group, with specific emphasis on training in ethics and risk assessment, 3) document with the DOH that they receive regular and ongoing supervision in their practice from a licensed mental health provider, 4) submit documentation of all office policies, procedures, and supervision contracts to the DOH, and 5) demonstrate knowledge of relevant Washington State law. All registrations in this category will be terminated upon a registered counselor's retirement or closure of practice.

WSPA recommends that the scope of practice (Recommendation 2) for the three new training categories of providers be identical to the scopes of practice as defined in the licensure statute for which they intend to apply. Additionally, scope of practice for Chemical Dependency Trainees should be defined by the Chemical Dependency Counselor statutes and rules, and the scope of practice for Agency Affiliated Counselor should be defined by state agency and state affiliated agency statute and rule.

WSPA has struggled with the notion of applying scope of practice language beyond the above statements. If counselors are not educated and trained to diagnose mental disorders, how can they then identify a mental disorder in order to refer the client to an appropriate mental health professional? If counselors advertise to the public that they are "life coaches," "assist in adjustment to life situations," "practice skill building," and the like, it should then be required that all such terms are operationally defined for the public, in plain English, in all office policy and procedure documents filed with the DOH.

WSPA supports a program funded by the State and administered by the Department of Health that can demonstrate increased citizen awareness and knowledge of available resources for access to and treatment of mental disorders, with direct input to the program by relevant provider groups. Indeed, Finding 5 of the performance audit highlights efforts to improve public education of the complaint process by HPQA to be insufficient. The audit goes on to state, "HPQA does not have a budget for public education on its role in patient safety" (page 26). WSPA urges the Legislature to fund completely the recommendations in the performance audit that address this problem (page 27-28).

Finally, WSPA would like to take this opportunity to compliment and thank the staff of the Department of Health that organized and supported the work of both the 2006 and 2007 Registered Counselors Work Groups. They are all unfailingly helpful, responsive and thoughtful, and they have brought a wonderful sense of humor to a difficult process.

If there are additional questions about the recommendations put forward by WSPA, please feel free to contact Dr. Lucy Homans, Director of Professional Affairs for WSPA at drluluh@aol.com. Thank you.

To: Robert Nicoloff, Department of Health
2007 Registered Counselor Work Group
From: The Washington Community Mental Health Council
Re: Final Report of the Registered Counselor Work Group
Date: September 22, 2007

The Washington Community Mental Health Council is submitting the following comments on the Report of the Registered Counselor Work Group (9/21/07 Draft) and requests that these comments be included in the final work group report as a minority report.

The Washington Community Mental Health Council is the professional association for licensed mental health agencies across the state. Our association strongly supports oversight of the mental health professions in our state, including clear credentialing standards and ongoing quality control. Our core recommendation, creation of a new credential – Agency Affiliated Counselor – is based on the assertion that such standards and controls already exist in licensed community mental health agencies and, therefore, that those (current) Registered Counselors employed by licensed and/or certified community mental health agencies should not be treated as though they are practicing independently.

Community mental health agencies operate as coordinated systems of care and are regulated by the state accordingly through specific mental health RCW's and WAC's. Every community mental health center employs psychiatrists and licensed masters level mental health counselors who provide regular clinical supervision to all direct service staff. Written job descriptions define direct service roles and functions, and agency supervisory structures ensure ongoing monitoring of employee performance. In addition, all community mental health agencies operate under federal Medicaid regulations, standards of care and state/federal contract requirements.

Specific Washington Community Mental Health Council (WCMHC) recommendations regarding Registered Counselors (some of which are in agreement with the majority report, and others of which are not) include:

WCMHC recommends creation of a new credential, Agency Affiliated Counselor for those current Registered Counselors working in state-regulated or state-operated settings. In the case of licensed and/or certified community mental health agencies, issues of scope of practice, minimum education, supervision, background checks and continuing education should remain under the authority of the Department of Social and Health Services, and be addressed under:

1. RCW 71.24. Community Mental Health Services Act.
Most directly relevant to this discussion, *RCW 71.24.037, Licensed service providers, residential services, community support services – Minimum standards*, states:
 - (1) The [DSHS] secretary shall by rule establish state minimum standards for licensed service providers and services, and
 - (2) Minimum standards for licensed services providers shall at a minimum establish:
Qualifications for staff providing services directly to mentally ill persons, the

intended result of each service, and the rights and responsibilities of persons receiving mental health services pursuant to this chapter.

2. WAC Title 388, Department of Social and Health Service, WAC 388-865, Community Mental Health and Involuntary Treatment Programs.

Most directly relevant, *WAC 388-865-0405, Competency requirements for staff:*

(a) Addresses qualifications specific to the job position, education, background checks, supervision, consultation with a psychiatrist or physician, specialty consultation for children, older adults, ethnic minorities or persons with disabilities, and annual staff training plans.

(b) Should be revised to incorporate the new category of Agency Affiliated Counselor, thereby ensuring continued accountability under the DOH Uniform Disciplinary Act.

3. The credential of Agency Affiliated Counselor should under no circumstances be used to practice in independent settings.

WCMHC recommends that Peer Counselors be exempt from DOH regulation and that they not exist as a separate regulated healthcare profession in independent practice settings. In licensed community mental health agency settings, peer counselors interact with clients in defined roles as outlined in WAC 388-865-0107 and WAC 388-865-0453.

WCMHC supports the work group recommendation to create four new credentials for pre-licensure candidates, 1) Chemical Dependency Professional Trainee, 2) Marriage and Family Therapy Associate, 3) Mental Health Counselor Associate, and 4) Social Work Associate.

WCMHC supports the work group recommendation to eliminate the current Registered Counselor credential for new applicants, and supports a DOH-regulated process to allow current Registered Counselors in independent settings to retain this credential and continue practicing under new minimum standards developed by DOH.

WCMHC supports a public education program, funded and administered by the Department of Health, that

1. Provides user-friendly on-line information regarding the qualifications of and services provided by each of the various counselor credential categories,
2. Incorporates clear information about qualifications associated with the individual practitioner the meaning of their credential as part of the disclosure statement to clients, and
3. Focuses public education efforts on helping the public to better understand available DOH information resources and complaint processes regarding health care professions.

The Washington Community Mental Health Council offers its commitment to work with the Department of Health, the Department of Social and Health Services and the Legislature to ensure oversight of mental health professions and community mental health services in our state.

Minority Report to the Registered Counselor Work Group 9/28/07

This Minority Report for the Recommendations of the Registered Counselor Work Group is being submitted by the Washington State Society for Clinical Social Work (WSSCSW), the Washington Association for Marriage and Family Therapy (WAMFT), and the Washington Mental Health Counselors Association (WMHCA.) These groups were represented in the Work Group by Laura Groshong, LICSW, Scott Edwards, LMFT, and Adrian Magnuson-Whyte, LMHC, respectively.

WSSCSW, WAMFT, and WMHCA commend the Work Group for completing a complex and arduous task. In almost all ways we are in support of the conclusions reached by the Work Group. These are summarized below, based on the RCWG votes taken which had at least a 2/3 positive majority.

RCWG Agreements

1. Create the following new categories for pre-licensure candidates: Licensed Social Worker-Associate; Licensed Marriage and Family Therapist-Associate; and Licensed Mental Health Counselor-Associate, which will be under RCW 18.225 for Licensed Independent Clinical Social Worker, Licensed Advanced Social Worker, Licensed Marriage and Family Therapist, and Licensed Mental Health Counselor. Create a new category for Chemical Dependency Professional Trainee which is under RCW 18.205 for Certified Chemical Dependency Professional.
2. All registered counselors who work in licensed and certified state agencies will be given a new title, i.e. "agency-affiliated counselor."
3. A public education campaign to explain the differences between the licensed mental health professions and the [new title for current registered counselor practicing independently] will be conducted.
4. The scope of practice definition for the [new title for current registered counselor practicing independently] is as follows: The practice of [new title for current registered counselors practicing independently] in these categories shall be limited to the appropriate screening of each client's mental condition based on a review of client information. Recognition of a mental disorder in a client requires that the [new title for current registered counselor practicing independently] recommend that the client seek a diagnosis and treatment from an appropriate mental health professional [New title for current registered counselors practicing independently] may provide counseling and guiding clients in adjusting to life situations, developing new skills, and making desired changes, in accordance with the theories and techniques of a specific counseling method and established practice standards.

5. The [new title for current registered counselors practicing independently] will have the following item in their Disclosure Statement: "As a [new title for current registered counselor practicing independently], I am not credentialed to diagnose or treat mental disorders, or to conduct psychotherapy."
6. The [new title for current registered counselors practicing independently] will have a written agreement with a licensed mental health professional who will consult with the [new title for current registered counselor practicing independently] on whether a mental disorder is present in all new and ongoing clients and whether there is cause for referral to a mental health professional.
7. The [new title for current registered counselors practicing independently] will be supervised by a licensed mental health professional, or a [new title for current registered counselors practicing independently] with experience and supervision requirements for [new title for current registered counselor practicing independently] to be determined by DOH with one supervision hour for every 200 clinical hours.
8. All [new title for current registered counselors practicing independently] will have to develop a knowledge base in risk assessment, ethics, relevant Washington law, and the elements which make up an appropriate screening and referral process.
9. All [new title for current registered counselors practicing independently] will be required to have a Baccalaureate degree or its equivalency by acquiring an Associate Arts degree, plus having a supervised experience/internship, with equivalency requirements to be determined by the Department.
10. The [new category for current registered counselors practicing independently] establish an advisory committee to establish, implement, and maintain professional standards for the [new category for current registered counselor practicing independently.]
11. All [new title for current registered counselor practicing independently] will be required to obtain 36 hours of continuing education, including 6 hours in ethics and law, every two years.

Recommended Additions to RCWG Agreements

In addition, WSSCSW, WAMFT, and WMHCA respectfully make the following two recommendations:

1. The title for pre-licensure candidates in social work (see #1 above) should be consistent with the two titles for licensed social workers. We recommend that the title for candidates for Licensed Advanced Social Worker be called Licensed Advanced Social Worker – Associate and that the title for candidates for Licensed Independent Clinical Social Worker be called Licensed Clinical Social Worker – Associate, leaving out the word independent which it is not part of the scope of practice for candidates.

2. Several votes were taken on a proposed title for current registered counselor practicing independently, but no majority was reached. Of the four titles being proposed by the RCWG, WSSCSW, WAMFT, and WMHCA recommend the title “Registered Complementary and Alternative Counselor.” This description is used in several states for health care practices which are recognized but outside the medical model and medical methodology. The term “Complementary and Alternative” is recognized by the Center for Complementary and Alternative Medicine, part of the National Institutes of Health (<http://nccam.nih.gov/>). This title most accurately describes the “alternative” approach to counseling which many registered counselors who practice independently have used to describe their work.

WSSCSW, WAMFT, and WMHCA wish to thank the Department of Health for creating and providing administrative support to the Registered Counselor Work Group.

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**Minority Report: Addendum to DOH Registered
Counselor Workgroup Final Report**

Comments regarding proposed changes in the Registered Counselor credential,
as they relate to independent non-licensed counselors.

NASW-WA has been pleased to participate in the 2007 Department of Health Workgroup regarding Registered Counselors. We support the resulting majority report, and submit this addendum to underscore issues we find particularly important regarding public health and safety.

We deeply appreciate the support this process has received from the Governor, her office, the Department of Health, the Attorney General's office, and the Legislature. We hope the workgroup's considerable effort, the increased understanding the process generated for all participants, and the report this accompanies contribute to shaping legislation that will ensure the quality of counseling service offered to the public, and will also ensure public access to a diversity of competent providers, at costs affordable to all sectors of our community.

NASW represents social workers in a wide range of work settings, and values broad access to affordable services, a diversity of providers, ethical and competent practice, clarity of professional roles, and above all, the health and safety of the public.

Some of our observations with regard to the workgroup report and consideration of the registered counselor credential are as follows:

1. The system of registering counselors needs substantial improvement, but not because RCs represent a greater source of harm to the public than do licensed counselors. We have seen no accurate data to suggest that Registered Counselors commit a greater percentage of boundary violations or other abuses of the public than the licensed counselors or licensed clinical psychologists in Washington State. We are aware that there has been publicity given to a number of cases of abuse by registered counselors, and that coupled with the Auditor's report, changes in how non-licensed counselors are credentialed and monitored must occur. We do not support any effort to justify those changes based on presumptions that the RC pool is in fact a higher risk pool of providers. We advocate changes in the requirements in order to properly define their scope of practice, and increase the education, knowledge and experience level of that

group of providers, while recognizing the difference between what is needed for them to perform in their role, as contrasted with licensed providers.

Related to the question of accurate and useful statistics, we recommend that the Department of Health require sufficiently detailed information with each application for credentialing and renewal of counselor credentials of every type, in order that they can maintain a profile of service providers covered, their clientele, and their work settings. The Gilmore Research survey commissioned to assist this workgroup should provide a valuable basis for determining what information to elicit.

2. One danger in believing that RC's are the source of more risk to the public is that we may miss the opportunity to determine what *does* cause risk, and to effectively address those factors. We believe a portion of the answer to abuse of clients lies in greater consumer education about counseling and appropriate professional conduct, as well as coordination with educational programs to enhance the teaching of ethics, and of counseling skills with risk prone populations. As an example of public education, we would point to a brochure the State of California makes available, entitled *Professional Therapy Never Includes Sex*. www.psychboard.ca.gov/pubs/proftherapy.pdf

a) Among other things, we recommend that information to that effect be required in all disclosure statements provided to new clients by licensed and non-licensed counselors.

b) We also respectfully recommend that a workgroup or committee be assembled to review scholarly, DOH, and board data on abuse of the public, as well as strategies employed by other states, and to determine how we might effectively increase public safety, looking at changes needed for *all* credentialed and regulated mental health professions.

3. Non-licensed providers are an important source of affordable care to lower income, rural and minority members of the public. Community mental health centers concentrate their limited funding on service to the most gravely disordered clients, those who are suicidal, psychotic and otherwise high priority, and in many cases can not provide ongoing counseling even to those clients. Citizens with more ordinary but pressing concerns find fewer and fewer low cost sources of counseling. Elimination of, or severe restriction on the service provided by non-licensed providers in private practice will damage a major source of less costly service. The current RC provider pool is often the primary resource in rural, low income, minority and other less advantaged communities. DOH survey results suggest that approximately 4750 RC's are in at least part-time independent practice, and if we estimate their client load per year at fifteen per week, with turnover and clients with less frequent sessions, it is realistic to think that between 71,000 and 240,000 individuals and families in the State rely on their services each year.

4. Requirements should be adequate but realistic, given the reduced scope of practice permitted by the proposed new independent credential. We support the workgroup view that experienced registered independent practitioners in good standing should not be pushed out of practice, and that there be realistic, affordable & practical requirements for future independent non-licensed practitioners. They will operate under a more restricted scope of practice, and will not need the same level of education as those who engage in the diagnosis and primary treatment of mental disorders.

5. The proposed supervision requirement is a highly effective means to closely evaluate and increase the skill of practitioners. Along with other professional training traditions, social work has historically emphasized the value of supervised internship, and we support the proposal that future non-licensed providers have completed a substantial number of hours of supervised practice, whether they obtain a Bachelors degree or higher level of education. A similar, substantial supervision requirement is a major component of the requirements for licensure. It ensures that a qualified professional has become directly familiar with all aspects of an applicant's counseling practice.

6. Registered counselors do not currently have a continuing education requirement, but the proposed new independent credential would remedy that. The proposed addition of a continuing education requirement, similar in amount to that required of licensed counselors is an additional means to ensure that non-licensed counselors, whether in or out of agency settings, stay current in their field, as well as regularly satisfying the ethics and law hours requirement.

7. The title of the proposed new credential for non-licensed independent practitioners should be simple, informative, parallel to other related credentials, and be in the most appropriate regulatory category. While the workgroup did not settle on one proposed credential title, they made some recommendations. Of the considerations below, some were carefully discussed in the workgroup, and are among the factors we deem important in making the decision regarding the title.

a) It should be self-explanatory: the term 'counselor' should be included. The term is quite familiar to the public in an array of arenas in business, law, education and therapy. There is a body of research based, legally affirmed national standards and practice theory related to counseling, and Washington State statutes already contain an appropriate definition of the term.

b) Should it be a certification or registration?

Certification: Leaving aside the regulatory implications of this voluntary category, the term "Certified Counselor" would signal to the public that the counselor had presented sufficient credentialing information to gain the credential. Accompanied by a public education campaign to be sure the public knew the meaning and value of determining if their counselor was certified (or

licensed), the title would convey that a standard of preparedness had been set and met.

Registration: As a mandatory category, it offers the advantage of spreading a broader regulatory net. The term "Registered Counselor" is in use, and has no scope of practice associated with it. The addition of the term "independent," as in "Registered Independent Counselor" would be what we recommend, again, if the regulatory issues pointed to the need for registration as opposed to certification.

c) Discussion: Concerns were expressed in the workgroup regarding a credential that specified location of practice, but the workgroup has recommended a credential be created for "Agency Affiliated Counselor." Registered Independent Counselor would be a parallel construction, informative and simple. The term "independent" would not forbid the holder from working in agency settings – it is used in the credential Licensed Independent Clinical Social Worker (LICSW), and again, while it does not restrict those social workers to being in independent practice, it does indicate that they have qualified to work in such settings, under the related scope of practice (which is of course rather different from the scope proposed for this new counselor credential.)

Several proposals were made to include terms in the title that might indicate the type of counseling offered by the holder of the credential: "specialized modality," and "alternative and complementary" were both discussed, and found favor in some quarters. We observe that not all counselors are specialized, and not all adopt either alternative (non-standard) or complementary (adjunctive) models for the work they do. We would advise against a credential title that specifies the field unduly since we hope a broad range of counselors will meet the qualifications and adopt the credential, and do not see value in specifying the approach they will take, beyond that specified by the scope of practice. Again, that would parallel the other credentials already offered – social work, marriage and family therapy, and mental health counseling are all terms clear to the public, and related to established standards of care.

We would recommend either the title Certified Counselor, or Registered Independent Counselor.

In conclusion, we very much appreciate the tireless support and assistance the Department of Health provided this workgroup, and the warm and expert assistance given by the workgroup's professional facilitator, Eric Svaren, Principal, Groupsmith, Inc. We very much valued the effort, collaboration, dedication, mutual education and good spirit of the participants and members of the public, all of which greatly contributed to this workgroup's results.

Submitted on behalf of the Washington chapter of NASW,
Respectfully,

Joan C. Golston, DCSW, LICSW

Chair of Ethics, Washington Chapter, NASW
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**Minority Report: Addendum to DOH Registered
Counselor Work Group Final Report**

Washington Professional Counselors Association (WaProCA) was pleased to participate in the 2007 Department of Health Work Group regarding change in the regulation of those practitioners currently registered by the state as counselors. Since WaProCA represents the most controversial sub-group of registered counselors, those in private practice, it was especially important that our voice be included in determining how currently registered and future private practice counselors will be regulated.

WaProCA very much appreciates the contribution of our colleagues who dedicated their time and effort to serving on the work group. We are proud to say that despite our differences, we succeeded in coming to understanding and agreement on a number of challenging issues including scope of practice, grandfathering, and educational requirements. On the whole, WaProCA strongly supports the general report of the DOH Registered Counselor Work Group. We hope that these recommendations will contribute to drafting and passing legislation that will increase consumer safety while protecting the public's access to the diverse and affordable services private practice registered counselors have provided to our communities for the past 20 years.

In addition to our general support of the work group report, we would like to submit the following minority report to provide our perspective regarding key issues of title, scope of practice, education, and supervision. We will also add a few brief comments regarding the "background information" included with the work group report.

Regarding a title for the new category of non-licensed counselors in private practice:

(Those counselors who are currently in private practice and are registered with the state.)

Washington Professional Counselors Association is in strong support of the title,
"Washington State Certified Counselor."

“Certification” is a regulatory term that is commonly understood to mean that individuals who are certified by the state or another credentialing agency have met a meaningful set of minimum qualifying standards. This is very different from "registration" which indicates the individual has listed themselves with the state but has not met significant qualifying standards.

The workgroup has recommended considerably higher standards for entry and continued practice than those of the previous twenty years under the title of “Registered Counselor.” For this reason certification seems to be the logical next step. In addition, "Certified Counselor" was the title that had the strongest support of the work group. In fact, it came within one vote of being passed as the official recommendation of a title for the new class of independent non-licensed counselor. No other suggested titles came close to the support given for the title of "Certified Counselor.”

Because there is a National Board of Certified Counselors, we want to be very clear that this credential is for Washington State only and not to be confused with counselor certification in other states.

WaProCA is strongly in favor of maintaining a title that is easily understood by the public as offering-essential general counseling services. This is particularly important because we represent a very diverse group of counselors using a wide variety of counseling modalities. The title of "Registered Counselor" has twenty years of precedent using a simple regulatory term without unnecessary qualifiers to align it to a specific philosophy or school of thought. Adding limiting qualifiers at this time, would be very difficult with such a diverse group. Also, our state's history of having a regulatory designation that allows for a wealth of professional diversity in counseling is something that the public has come to expect. *It is this diversity of counseling practices available to our state's citizens that WaProCA is committed to protect.*

The title of "Washington State Certified Counselor" would provide a clear indication that the Department is requiring appropriate minimum standards, and that anyone practicing without the credential of "Washington State Certified Counselor" would be offering an unknown quality of service. The Department would no longer be in the position of endorsing counselors who had not met these higher standards of knowledge and professionalism. Adopting the title of "Washington State Certified Counselor" would provide the public with a clear statement that the rules and standards have changed.

Anyone else using the title of "counselor" would not be operating under the DOH. There have always been a small number of people that have practiced counseling without regulatory sanction. However, there are practical issues that would provide incentive for individuals to obtain the new credential of "Washington State Certified Counselor."

In order for counselors to advertise, obtain malpractice insurance, or join professional organizations it is necessary to have a regulatory number from the State. The few individuals who might initially choose to operate without a "Washington State Certified Counselor" number would be unable to obtain these essential components for building and maintaining a viable private practice and small business. These individuals would also be cast an unfavorable light within their professional circles with other counselors. These economic and professional pressures often prove to be strong incentives for regulatory compliance.

If, as the Workgroup has recommended, there is clear public education regarding the various regulatory classifications of counselor, the use of the title "Washington State Certified Counselor" will work very well to inform and protect the public.

Regarding the recommended change in scope of practice:

WaProCA is in full support of the work group's proposed restriction in scope of practice for this new category of private practice counselors, provided we keep the understanding reached in the work group that it is *the diagnosis and treatment of mental disorders* that is outside the scope of the new class of private practice counselors.

It is our understanding of the work group's intent that counselors working under this new scope of practice must screen and refer clients with mental disorders to licensed care. As long as the counselor does not serve as the primary mental health care provider *with regard to the*

diagnosis and treatment of the mental disorder, he or she can continue working with the client. Additionally, as long as the counselor screens and refers appropriately, he or she is not liable if the client refuses to use the referral.

Regarding basic education requirements for the new category of non-licensed counselor:

WaProCA supports the work group's recommendation that an AA degree plus a supervised internship be a recognized equivalent to the basic education requirement for the new class of non-licensed counselor.

It is essential that any education requirements for this newly credentialed class of counselor be appropriate to the new limited scope of practice that is being recommended for this credential. WaProCA is very concerned that there be opportunities for vocational as well as theoretical training, and that these be as affordable as possible. For this reason, we are very glad that the work group has recommended a bachelor's degree or its equivalent for this category.

There are very few bachelor's degrees in counseling related fields that give any practical vocational training in counseling. For this reason we feel that the recommended equivalent of an AA degree plus a supervised internship will actually better prepare students to become counselors than will most bachelor's degrees.

WaProCA also recommends an additional equivalency to the bachelor's degree requirement. We support a recommendation that individuals who have previously completed a bachelor's or graduate degree in any field be able to qualify for the new non-licensed counseling credential through completing additional vocational training in counseling.

Many people move into counseling as a second career. They often have a previous bachelor's or graduate degree in a non-counseling related field. These are exactly the kind of mature, experienced, educated people we want in the profession. These individuals could easily add a Vocational Technical diploma or equivalent certification program in counseling plus supervision to their existing degree. This would allow them to achieve a cost effective equivalency to a bachelor's in counseling in a reasonably short amount of time and not require them to go back and get a second college or graduate degree.

Regarding supervision requirements for the new category of non-licensed counselor:

WaProCA strongly recommends that supervision requirements for new counselors coming into the new credential be appropriate to the limited scope of practice for this category.

WaProCA believes that supervision is a very valuable part of a counselor's ongoing training and contributes greatly to safety and the quality of client care. We support the work group's recommendations for supervision in the new category as long as these requirements are reasonable and do not put an undue financial burden on non-licensed private practice counselors.

Given that the scope of practice will ensure that non-licensed counselors will not diagnose or treat mental disorders and that the treatment of these disorders will be referred to licensed mental health professionals, it would make no sense to require supervision that is equal to or exceeds what is required of licensed mental health professionals.

WaProCA also recommends that supervision be provided by a DOH qualified supervisor and that non-licensed counselors in the new category be allowed to meet the DOH requirements and qualify as supervisors.

We clearly understand the value of supervision by licensed counselors with regard to how to better identify mental disorders and make referrals. However, given the restricted scope of practice proposed by the workgroup, there is less and less reason for limiting supervision to only licensed providers.

Opening supervision to senior level counselors in the new private practice category who have met the DOH requirements for becoming a supervisor would greatly strengthen the quality of care available to clients. These supervisors would be able to offer guidance to junior level counselors *in the modality they use*. Permitting supervision to also come from non-licensed DOH qualified supervisors would allow counselors to receive ongoing specialized supervision in their preferred modalities of practice.

Timeline for compliance deadlines:

In the proviso instructing the Department of Health Registered Counselor Work Group, the group was directed to create guidelines that include "deadlines for compliance." Unfortunately, the Work Group had so many other pressing issues to consider, compliance deadlines did not make it onto the agenda and were not voted on.

Compliance deadlines need to be considered for all the new categories of counselors. WaProCA is making recommendations in this minority report for only the new category of "Washington State Certified Counselors." This category breaks down into three subcategories:

1. Registered Counselors who meet the requirements for grandfathering into the new category
2. Registered Counselors who do not meet the requirements for grandfathering, but who want to become Washington State Certified Counselors
3. New counselors who meet the requirements for certification

The Department of Health needs to set up the required courses and standardized exam before the first category of counselors can comply with the requirements for grandfathering into the new category. Once the courses and exam are available, there should be a one year time frame for compliance with the new law. WaProCA would hope the Department of Health could meet a six month deadline for providing the courses and exam. This would establish a deadline of a year and a half for compliance by counselors grandfathering into the new certified category.

For the second category of counselors who do not qualify for grandfathering, there needs to be enough time allowed so that they can fulfill the educational requirements to become certified. Given that they would need to complete either a 2 year degree and internship or a four year degree program, there should be *at least* 3 years from the enactment of the new law to allow for compliance.

Once the new law is enacted, it is the intent of the workgroup that the title of "registered counselor" will be terminated and there will be no new registration of counselors into the

old category. New graduates of bachelor's programs in psychology would immediately become eligible to complete requirements for certification. Consequently, it is important that the Department of Health have in place the required courses in ethics; WA law as it relates to counseling; risk assessment; screening and referral as well as the standardized exam, as soon as possible with a 6 month deadline as a proposed target.

Key changes to background information:

In general WaProCA finds the background information provided in the work group report to be informative and accurate. However, we would like to respectfully point out that there is no statistical evidence that registered counselors have a higher record of abuse of clients than the licensed mental health professions. The background information as it is written would seem to skew the perspective somewhat so as to leave an impression with the reader that there is a greater problem with this class of counselor. This is simply not true.

The background information section also fails to mention that *The Seattle Times* ran an article in April of 2006 which was the catalyst for changing the regulation of registered counselors. However, the statistical data presented in this article was not accurate, and we have had to work to correct the subsequent misperception of registered counselors as being unprofessional, unqualified, and a danger to the community.

Lastly, there is an essential piece of information missing from the background information included with this report regarding the task force that met in the summer of 2006. It is crucial to note that the task force membership did not include any registered counselors in private practice. Legislation that was formulated out of the task force recommendations subsequently failed to pass in large part because the class of counselors most adversely affected was not included in the process. This problem was remedied in the 2007 work group through WaProCA's representation of private practice registered counselors.

In conclusion we would like to express our gratitude and appreciation to the Department of Health for providing the work group with such thorough and efficient support. We would also like to recognize them for coordinating our efforts with Gilmore Research to provide critical information necessary for our decision making process. We also very much appreciate the expert leadership of our professional facilitator, Eric Svaren, Principal, Groupsmith, Inc.

We also thank Rep. Richard Curtis for his involvement in the work group and for his advocacy regarding the role of community colleges in the vocational training of counselors. Many legislative staff members contributed their time and attention to this process, and many members of the public contributed valuable testimony that helped the group reach a more in-depth understanding of the implications in real life of the regulatory changes being proposed.

We are also very thankful for support from Governor Gregoire and members of her staff. To a great degree it is because of the Governor's understanding of mental health care and her concern for the safety of clients that we have been involved in this important process. We applaud the Governor's request for a Health Professions Quality Assurance Audit, and we are in agreement with many of the audit findings. We are especially encouraged by the auditors' recommendation that "Washington needs to develop a public education strategy." It is critical that consumers be made aware of both the differences among credentials and of their recourse when counselors behave unethically. In order for the recommendations and reforms to the credentialing of counselors to succeed, it will be essential that we develop and implement more effective education of the public as outlined in the Health Professions Quality Assurance Audit.

Submitted on behalf of Washington Professional Counselors Association,
Respectfully,

Miriam Dyak, BA, RC

President, Washington Professional Counselors Association
DOH Registered Counselor Workgroup member (2007)
Registered Counselor in Private Practice

Kate Abbott, MA, RC

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APPENDIX B:

Work Group Directive from the Legislature

2007-2009 Operating Budget Enacted 5/15/07
SHB 1128, Section 222(31), page 111

\$147,000 of the health professions account--state appropriation is provided solely for the department of health to convene a work group to develop recommendations regarding the need to regulate those individuals currently registered with the department of health as counselors. The department of health shall submit recommendations of the work group to the legislature and governor by November 15, 2007. Based on the recommendations of the work group, the department of health shall draft credentialing guidelines for all registered counselors by January 1, 2008. Guidelines shall include education in risk assessment, ethics, professional standards, and deadlines for compliance.

APPENDIX C:

Work Group Members

Members
Registered Counselor Work Group

Kate Abbott, MA, RC, Secretary, Washington Professional Counselors Association

Ann Christian, MSW, CEO, Washington Community Mental Health Council

Deb Cummins, BA, CDP, Division of Alcohol & Substance Abuse, Department of Social & Health Services

Miriam Dyak, BA, RC, President, Washington Professional Counselors Association

Scott Edwards, Ph.D., LMFT, Washington Association for Marriage and Family Therapy

Katie Evans, BA, Certified Hypnotherapists, National Guild of Hypnotists, Washington State Chapter

Joan Golston, DCSW, LICSW, National Association of Social Workers, Washington State Chapter

Laura Groshong, LICSW, Washington State Society for Clinical Social Work

Raymond Harry, MA, Public Member

Lucy Homans, EdD, Director of Professional Affairs, Washington State Psychological Association

Carl Kester, BA, President, Association of Alcoholism and Addictions Programs

Adrian Magnuson-Whyte, MA, LMHC, NCC, CCHP, Washington Mental Health Counselors Association

Pete Marburger, LICSW, Mental Health Division, Department of Social & Health Services

Richard Miles, MA, Washington Professional Counselors Association

Cheryl Raleigh-DuRoff, MN, ARNP, Association of Advanced Practice Psychiatric Nurses

Representative Richard Curtis, Washington State Legislature

APPENDIX D:

Letter To All Registered Counselors Regarding Work Group and Survey



To: All Registered Counselors

**From: Tracy Hansen
Registered Counselor Program Manager**

Subject: Phone Call You May Receive For Registered Counselor Survey

Hello. I'm Tracy Hansen, manager of the registered counselor program with the Department of Health.

I wanted to let you know that a new work group will be reviewing the registered counselor credential, and as part of that review, you may be contacted and asked to participate in a telephone survey. The Department of Health has asked the Gilmore Research Group in Seattle to conduct the survey. Gilmore will randomly select names from the complete list of registered counselors to complete the surveys. If you are contacted, we encourage you to participate, as the survey will provide important information for the work group. Your individual responses will be confidential and will be used only in aggregate when findings are reported to the work group.

The new work group was established by the state legislature. The goal of the work group is to develop recommendations about regulating registered counselors. The recommendations will be reported to the legislature and governor by November 15, 2007.

The dates and location of work group meetings are listed at the bottom of this letter.

You can read updates about the registered counselor work group at our website. Our website can be accessed as follows:

1. Go to website <http://www.doh.wa.gov/>
2. Click on Topics A-Z item in the left column
3. Click on letter R at the top of the page
4. Click on Registered Counselors

You can receive updates by email by subscribing to the registered counselor listserv at the following website:
<http://listserv.wa.gov>

Questions about the survey or work group can be addressed to me, Tracy Hansen, Program Manager at (360) 236-4915 or at email address Tracy.Hansen@doh.wa.gov

Thank you for your assistance.

Registered Counselor Work Group Meeting Dates & Locations

(Note: Please let Tracy Hansen know if you will be attending a work group meeting. This will help us plan for sufficient space for all attendees.)

Friday, July 13th from 8:30am to 4:00pm - Pelligrino's Tyee Event Center
Thursday, August 9th from 8:30am to 4:00pm - Comfort Inn, Tumwater
Thursday, August 23rd from 8:30am to 4:00pm - Comfort Inn, Tumwater
Thursday, September 6th from 8:30am to 4:00pm - Comfort Inn, Tumwater
Friday, September 7th (if necessary) from 8:30am to 4:00pm - Comfort Inn, Tumwater

**Location Addresses: Pelligrino's Tyee Event Center, 5757 Littlerock Road SW, Tumwater, WA 98512
Comfort Inn, 1620 74th Ave SW, Tumwater, WA 98501**

APPENDIX E:

**Results of Registered Counselor Survey
Conducted By Gilmore Research**

Department of Health Survey of Registered Counselors

Prepared for:

State of Washington
Department of Health

August 2007

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Introduction

The Washington State Department of Health has convened a work group to develop recommendations on the need to regulate registered counselors. Based on the recommendations made by this work group, the Department of Health (DOH) and State legislators will draft credentialing guidelines for all registered counselors by January 1, 2008. Guidelines, as defined by Washington State legislators, shall include education in risk assessment, ethics, professional standards and deadlines for compliance.

As part of the development of these guidelines, the DOH work group commissioned Gilmore Research Group to conduct a random survey of counselors registered with the State of Washington in order to assess the extent of their current credentialing. This report summarizes the results of that survey.

Key Findings

Years of Professional Experience: A majority of respondents (56%) said they have been registered counselors with the State of Washington for five years or less. The average for all respondents was 6.6 years. Among respondents with advanced degrees (Masters / Ph.D.), the average was significantly greater (7.6 years).

Time Spent in Counseling/Counseling Related Activities: The overall average percentage of time spent in counseling or counseling related activities was 60%. The average was significantly higher for respondents with two-year degrees (Associates degrees) – 74%.

Counseling Settings: About one quarter of respondents (24%) said they worked in *private practice*, among other settings. About one fifth (19%) said they worked in *community mental health agencies*, and an equal proportion said *home visits*. Fifteen percent (15%) reported working in *healthcare clinics, nursing homes or hospital settings* and 8% said *community substance abuse agencies*.

Populations Served: Respondents with advanced academic degrees (Masters / Ph.D.) were more likely than all other respondents to counsel individuals (97%), families (66%), sexually abused teens and adults (63%) and couples (49%). Respondents with two-year degrees were more likely than all other respondents to serve clients with substance abuse/chemical dependency disorders (81%). Almost half of all respondents (46%) said they provide counseling to people living in rural, remote or underserved areas.

Peer Counselors: Sixteen percent (16%) said they serve as peer counselors. Males were more likely than females to serve as peer counselors. Among respondents who are peer counselors, a large majority (86%) said they have neither state nor national certification to be peer counselors.

Settings Providing Skills and Knowledge Used in Counseling Services: About three out of five respondents (59%) said they gained skills and knowledge to provide counseling services in both credit-granting academic settings and non-academic settings.

Respondents with four-year degrees (Bachelors degrees) were particularly likely to say they have both academic and non-academic training (67%).

Academic Backgrounds: Half of all respondents said they had advanced education - either a Masters degree in counseling or a closely related field (46%) or a Doctoral degree (4%). Just over one fifth (22%) said they had a Bachelors degree (four year degree) and 8% said they had an Associates degree (two-year degree) in counseling or a closely related field. Twenty percent (20%) of the registered counselors reported having taken some courses in counseling or a closely related field, but no academic degree in counseling.

Primary Subject Areas of Academic Degrees: Many (37%) said they received academic degrees in Psychology or Applied Behavioral Science. Degrees in Social Work were also fairly common (19%). About one in thirteen respondents (8%) said they had degrees in Counseling.

Respondents who have advanced academic degrees (Masters / Ph.D.) were more likely than those who have two-year degrees and four-year degrees to name Social Work as their primary subject area (23%). Respondents who have two-year degrees were more likely than those who have four-year degrees and those who have advanced degrees to name chemical dependency counseling as the subject area of their degrees (31%).

Certifications in Counseling or Mental Health Modality: A majority of respondents (58%) said they had *no* certifications in counseling or a mental health modality. Subgroups that were more likely than others to say *yes*, they have certifications include those who have advanced degrees and those who have more than 10 years of counseling experience.

Additional Training Experiences: Two thirds of respondents (66%) said they have had supervised internships, 37% have had professional training programs and 35% have had counseling mentors. Respondents with advanced academic degrees were more likely to say they have had supervised internships (84%). Twelve percent (12%) of respondents said they have had none of these additional training experiences. Those who have no academic degrees in counseling or related fields were more likely than others to say they have had *none* of these additional experiences.

For any given type of additional training, practice modalities occurred more often with individual therapies, followed by group counseling and family counseling. Respondents who were mentored and those who had supervised internships were more likely to counsel individuals. Those who had professional training programs were more likely to work with groups.

Professional Organizations: A majority of respondents (63%) said they *do not* belong to any organizations, certification bodies or certification organizations that are related to their fields of counseling. Those who have advanced academic degrees were more likely than all others to say *yes*, they do belong to these types of organizations. Females were more likely than males to belong to these organizations. Of those who belong to professional organizations, nearly all (95%) said their organizations had codes of ethics.

Current Professional Associations and Relationships: Most respondents (56%) said they *do not* presently maintain any relationships with associates who serve as mentors, consultants or trainers. Among those who have these professional relationships 17% named consultants, 16% said mentors and 9% said professional trainers. Respondents who have one year or less of counseling experience were more likely than those with more experience to say they currently work with trainers.

Length of Current Professional Associations and Frequency of Meetings: Results found a significantly larger proportion of respondents having year long or shorter-term associations with trainers (61%) than with mentors or consultants (40% and 39%, respectively). Additionally, those who work with trainers were more likely to have more frequent meetings. Seventy-four percent (74%) of those who worked with trainers met with them at least once a week. In comparison, 60% of those who worked with mentors and (59%) of those who had consultants met this often.

Previous Professional Associations and Relationships: Over half of the counselors (52%) said they have previously worked with other mental health professionals who served as their mentors, consultants or trainers. They more often said they worked with mentors (23%) than with other types of mental health professionals.

Length of Previous Professional Associations and Frequency of Meetings: Previous work with trainers was more likely than previous work with consultants and mentors to be short term (one year or less), with frequent meetings (at least once a week).

Assessment, Diagnosis and Treatment of Mental Health Disorders: Overall, respondents more often said they *treat* mental health disorders (45% said *yes*), than said they assess or diagnose these illnesses. Less than half the respondents said they *assess* mental health disorders in their practices (40%) and even fewer said they *diagnose* disorders (24%).

Among those who provide mental health assessments, diagnoses and treatments, large majorities said they had training in these areas (94%, 97% and 96%, respectively).

Respondents who have advanced degrees (Masters and Doctorates) were significantly more likely than those with less education to both *assess* mental health disorders (57%) and *diagnose* disorders (41%). Respondents who have Bachelors degrees and advanced degrees were more likely than those who have less education than four-year degrees, to *treat* mental health disorders (61% and 41%, respectively).

Role in Provision of Primary Mental Health Care Treatment: Most respondents who provide treatment for mental health disorders are either the client's primary mental health provider (43%) or are aligned with the primary mental health care provider as part of a treatment team (46%). Five percent (5%) said they *sometimes* work as part of a treatment team, and 6% indicated that they never do.

Assessment, Diagnosis and Treatment of Substance Abuse or Chemical

Dependency Disorders: Respondents more often said they *assess* substance abuse or chemical dependency disorders (38%), than *diagnose* (24%) or *treat* (32%) these illnesses. More than 9 out of 10 of those who diagnose and treat these disorders indicated that they have training to do so (93%, each service), and 89% of those who assess the disorders said they have training in assessment. Respondents who have two-year degrees were more likely than all others to say they assess (64%), diagnose (49%) and treat (67%) substance abuse/chemical dependency disorders

Role in Provision of Primary Mental Health Care Treatment for Substance

Abuse/Chemical Dependency Clients: Most respondents who provide treatment for substance abuse or chemical dependency disorders are either the client's primary mental health provider (33%) or are aligned with the primary mental health care provider as part of a treatment team (55%). Four percent (4%) said they *sometimes* work as part of a treatment team, and 8% indicated that they never do.

Training in Assessment of Risk Factors: Eighty-two percent (82%) of respondents said they assess whether or not clients are dangers to themselves or others. Those who have advanced academic degrees were more likely than other respondents to say they have this responsibility (90%). A large majority (88%) of those who assess clients as risk factors said they have specific training in risk factors and assessments. Counselors with two-year degrees were more likely than others to say they have this training (98%).

Leadership: The survey found respondents more likely to serve as career models than leaders. Thirty percent (30%) said they acted as mentors, consultants or supervisors to their associates. Less than one fifth (18%) said they taught courses in their fields and 12% said they authored magazines, journal articles or books. Respondents who have advanced degrees were more likely than others to develop their careers in all three areas (mentors/consultants/supervisors, teachers and authors).

Other Credentials: Although most respondents (76%) said they do not hold another Washington State credential, 40% said they are either currently working toward meeting qualifications for another state credential, or planning to obtain a license or certification for another mental health profession. Respondents who have advanced degrees (Masters/ Ph.D.) were more likely than those with less education to be working towards licensure as mental health counselors (18%) and/or advanced or independent clinical social workers (13%).

Respondents who have no academic degree in counseling were more likely to say that they are not working for other credentials (71%).

Of those working for additional credentialing or licensure, 51% are working with other professionals who oversee their counseling. Half (50%) have been working with supervisors for 1 to 3 years, and 12% have been working to achieve supervised hours for 4 years or longer. Meetings with supervisors occur frequently: 55% said they meet with supervisors weekly and 15% said they meet more often than once a week.

Referrals: More respondents said they refer clients to other health professionals (86%) than said they receive client referrals from others (65%).

Conclusions

This survey of registered counselors finds a substantial majority having the academic training that might be expected among those in practice. Half (50%) said they have advanced degrees and more than one fifth (22%) said they have four-year degrees in counseling or a closely related field. Level of experience tracks closely to level of academic training, with counselors having advanced degrees registered with the State for a significantly longer period of time than those with less education.

Counseling settings for the most part seem adequately matched to academic training and experience. Respondents who have the most academic training more often cluster into private practice and school settings. Those with two-year degrees tend to locate within community substance abuse agencies. It is worth noting that the survey found evidence that some who lack academic degrees work in private practice more often than would be expected as compared to those who have four-year degrees.

Counselors who have Masters degrees and Doctorates more often serve the mental health needs of individuals, families, sexually abused teens or adults, couples and adolescents. They more often work in the assessment, diagnosis and treatment of mental health disorders in these populations. They are also more often charged with the responsibility of assessing clients as risk factors to themselves and others.

Counselors who have Associates degrees more often serve the mental health needs of clients with substance abuse disorders or chemical dependencies. They more often work in the assessment, diagnosis and treatment of disorders in this population.

Whether counselors are assessing, diagnosing or treating mental health disorders or substance abuse/chemical dependency disorders, a *very* large majority says they have the training to provide these services.

The survey determined that only a minority of respondents belongs to professional organizations. Only a minority has certifications in counseling or mental health modality. Those who do belong to organizations and/or have certifications are more likely to have advanced academic degrees. Of the four out of ten who are currently working toward meeting qualifications for another state credential or licensure, significantly more have four-year degrees or advanced education.

Results of this survey suggest that if there are any weaknesses to be identified in the current credentialing held by registered counselors they are likely to be discovered in the lack of professional certifications, organizational memberships and current professional associations found among respondents who have less than four-year academic degrees and to some extent among some of those who have these degrees.

Detailed Findings

Introduction

The report is organized into several sections. Each section includes a discussion of graphics or tables that display specific results for the total group of respondents and for respondents as classified by their reported academic degrees: (1) Have coursework but no

degree, (2) Have a two-year degree (Associates Degree), (3) Have a four-year degree (Bachelors Degree) and (4) Have an advanced degree (Masters Degree or Ph.D.).

The report discusses significant differences between groups based on these academic achievements, as well as any differences that may occur based on gender and years of experience as a registered counselor in the State of Washington. Analysis of results also provides comparisons of respondents based on the types of settings in which they provide counseling.¹ These settings include (1) private practice, (2) work within agencies and (3) counseling provided in other settings (including hospitals, home visits, religious settings, tribal settings, prisons and detention facilities, and schools).

Methodology

Gilmore Research Group conducted a telephone survey of 805 registered counselors in the State of Washington beginning July 26, 2007 and ending August 9, 2007. Seventy percent (70%) of interviews were conducted with females and 30%, with males. The average length of the survey was 16.1 minutes, and it had a completion rate was 55%. DOH provided a population database of counselors who are registered with the State of Washington. This database served as sample for the study.

The confidence limit of findings are +/-3.37 percentage points at the 95% confidence level for the total of 805 interviews completed with sample randomly drawn from the given population of 17,280 registered counselors. For smaller sized subgroups, the confidence limit of findings is larger.

Years of Professional Experience, Counseling Modalities, Working Hours and Counseling Settings

Fifty-six percent (56%) of respondents said they had been registered counselors in the State of Washington for 5 years or less. (Table 1) Overall, respondents averaged 6.6 years as registered counselors.

The average number of years as a registered counselor was significantly higher for respondents with advanced degrees (Masters / Ph.D. – 7.6 years), than for those with less education.

The average was also higher among respondents in private practice (mean - 7.5 years) and those who counsel in other settings (6.6) than for those who counsel in agencies (mean - 5.8 years).

¹It is very common for counselors to provide therapy in a number of different settings. Therefore, when respondents were asked to name settings in which they provide counseling they were given up to 11 opportunities to name various kinds of settings. Answers to these “multiple response” questions cannot be tested to determine whether they are statistically different from one another. This is because the test that is used to determine statistical significance (the Z-test) requires response categories to be mutually exclusive. (The same respondent cannot answer in more than one response category.) When the report discusses differences between respondents based on settings in which they provide counseling, it does not refer to statistically significant differences. Instead it points out differences because they are of key interest in the study.

Asked to give an estimate of the percentage of time they spend in counseling activities compared to the time they spend in an alternative job or field, respondents specified an average of about 60%. Those with two-year degrees gave a higher average estimate (74%) than those with more education, and those with less education.

Counseling Settings

Table 1					
Experience, Counseling Modalities and Working Hours					
	Total	No Degree	Associates	Bachelors	Masters/Ph.D.
	(805)	(159)	(67)	(173)	(401)
Years as registered counselor					
1 year or less	21%	29%	22%	25%	16%
2 to 5 years	35	43	36	32	33
6 to 10 years	22	13	28	20	24
More than 10 years	22	14	13	22	26
Don't know	1	1	-	1	1
<i>Average</i>	<i>6.6</i>	<i>4.8</i>	<i>5.6</i>	<i>6.1</i>	<i>7.6</i>
Percentage of time spent in counseling/related activities					
Less than 20%	19%	30%	6%	20%	16%
20% up to 50%	16	16	16	17	15
50% to 75%	23	20	18	23	24
More than 75%	40	30	54	36	43
Don't know	3	4	6	4	2
<i>Average</i>	<i>59.7%</i>	<i>49.2%</i>	<i>73.6%</i>	<i>57.4%</i>	<i>62.4%</i>
Questions 1, 2, 3A: How many years have you been a registered counselor in the State of Washington? What kinds of counseling do you do? What percentage of your working hours would you say you spend in counseling or counseling related fields?					
Proportions may not sum to 100% because of rounding.					

Nearly one-quarter of respondents (24%) said they worked in private practice, among other settings. Counselors who have advanced academic degrees were more likely to work in private practice (30%) than were those with two-year and four-year degrees (15% and 13%, respectively). They also were more likely than all other respondents to work in school settings (12%).

Respondents who have two-year degrees were more likely than all other respondents to work in community substance abuse agencies (22%).

Respondents who have coursework in counseling, but no academic degree were more likely than those who have four-year degrees to say they work in private practice (25% compared to 13%). Additionally, these respondents were more likely than those with advanced academic degrees to say they are not currently providing counseling (7% compared to 2%).

Table 2					
Counseling Settings					
	Total	No Degree	Associates	Bachelors	Masters/Ph.D.
	(805)	(159)	(67)	(173)	(401)
Private practice	24%	25%	15%	13%	30%
Community mental health agency	19	15	12	21	20
Home visits	19	16	10	22	20

Healthcare clinic, nursing home or hospital	15	8	13	14	18
Other human service or counseling agency	12	12	12	12	13
Community substance abuse agency	8	6	22	9	5
School setting	7	3	2	5	12
Spiritual, religious settings	5	6	6	3	6
Government agency	5	4	9	5	5
Prison, jail, correction facility	3	2	2	6	2
Some other setting	1	1	2	1	1
Not currently providing counseling	4	7	5	8	2
Some other setting	12	13	9	14	11
Don't know	1	1	2	1	1
<p>Question 4: In what settings do you provide counseling?</p> <p>Responses gathering less than 3% of total response are not shown.</p> <p>Multiple response question; proportions may add to more than 100%.</p>					

Private Practice

About three quarters of respondents (76%) *did not* name private practice as a setting in which they provide counseling. To clarify the number of counselors who work in a private practice setting these 615 respondents were asked in a follow up question whether they were (employed) in private practice.

Of the 615 respondents asked the question, 39 responded *yes*. Results therefore found a total of 229 registered counselors, or 28%, who work at least some of the time in private practice. Overall, respondents who said they worked in private practice said they worked an average of 8.9 years in this capacity. The average among respondents with advanced degrees (n=137) was 9.98 years. Among those having coursework in counseling, but no academic degrees (n=49), the average was 6.86 years.

Populations Served

Interviewers read respondents a list of populations that commonly require the service of counselors. From this list they were asked to select those primary populations that they serve as a counselor. Table 2 displays results that show a very wide range of populations counseled by respondents at every level of educational training.

Respondents with advanced academic degrees (Masters/Ph.D.) were more likely than all other respondents to serve individuals (97%), sexually abused adolescents or adults (63%), families (66%) and couples (49%).

Respondents with two-year degrees were more likely than all others to serve clients with substance abuse problems or chemical dependencies (81%).

Additional significant differences between sub-groups include those based on *years of experience as a counselor* and *gender*.

- Respondents having more than 10 years of experience were more likely than those having 5 years or less to serve:

- Doctors, nurses and other health care professionals (40%, compared to 25%)
- Other counselors (34%, compared to 22%)
- Counselors having 6 to10 years of experience were more likely than those having 2 to 5 years, and those having 10 or more years of experience, to serve post traumatic stress victims.
- Males were more likely than females to serve these populations:
 - Substance abuse or chemical dependency clients (70% versus 62%)
 - Doctors, nurses and other health care professionals (36% versus 27%)
 - Other counselors (32% versus 24%)
 - Military personnel and their families (31% versus 22%)
 - Police, firefighters and paramedics (24% versus 16%)

Table 2 Primary Populations Served					
	Total	No Degree	Associates	Bachelors	Masters/Ph.D
	(805)	(159)	(67)	(173)	(401)
Individuals	93%	91%	84%	92%	97%
Socio-economically disadvantaged	79	62	73	83	85
Substance abuse/chemically dependent clients	65	56	81	67	64
Specific culture, ethnicity, race	64	50	63	65	69
Post traumatic stress / trauma victims	64	50	58	64	71
Gay, lesbian, bisexual, transgender	58	47	55	61	62
Adolescents	58	44	49	57	65
Domestic violence	58	47	61	58	61
Sexually abused teens, adults	56	45	48	53	63
Families	56	35	43	57	66
Students	55	45	42	57	61
Elderly	48	47	55	42	49
Children	44	29	27	44	52
Couples	42	32	30	38	49
Medical / hospital care patients	34	30	24	31	39
Health care professionals	30	26	30	27	33
Sexually abused children	30	19	13	32	36
Other counselors	26	26	27	27	26
Military, military families	25	18	25	27	27
Police, firefighters, paramedics	18	17	18	17	20
Businesses	10	12	9	8	11
Other	19	18	22	21	18
Don't know	1	1	3	1	1

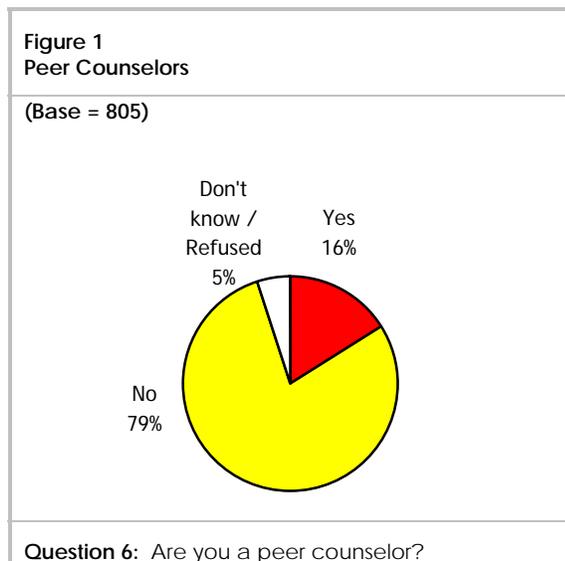
Question 7: We are interested in the primary populations you serve as a counselor. I will read a list and would like you say *yes* or *no* to each population.

Multiple response question; proportions may add to more than 100%.

Differences noted between subgroups based on *counseling settings* include the following:

- Respondents who counsel in private practice more likely than those who counsel in agency settings and in other settings to serve these populations:
 - Individuals (private practice - 99%, compared to agencies – 95% and other settings – 96%)
 - Students (private practice - 66%, compared to agencies – 54% and other settings – 55%)
 - Elderly (private practice - 53%, compared to agencies – 44%)
 - Couples (private practice - 59%, compared to agencies – 37% and other settings – 45%)
 - Doctors, nurses and other health care professionals (private practice - 49%, compared to agencies and other settings – 27%, each)
 - Other counselors (private practice - 35%, compared to other settings – 22%)
 - Police, firefighters, paramedics (private practice - 19%, compared to agencies – 9% and other settings – 8%)
- Respondents who counsel in agency settings were more likely than those who counsel in private practice and in other settings to serve these populations:
 - Substance abuse or chemical dependency clients (agencies - 75%, compared to private practice – 56% and other settings – 66%)
 - Specific cultures, ethnicities, races (agencies - 70%, compared to private practice – 59%)
 - Clients with post traumatic stress disorders (agencies - 73%, compared to private practice – 62% and other settings – 65%)
 - Gay, lesbian, transgender or bisexual clients (agencies - 66%, compared to other settings – 53%)
 - Domestic violence victims (agencies - 67%, compared to private practice – 54% and other settings – 58%)

- Respondents who counsel in other settings were more likely than those who counsel in private practice and agency settings to serve these populations:
 - Socio-economically disadvantaged clients (other settings - 85%, compared to private practice – 71%)
 - Substance abuse or chemical dependency clients (other settings - 66%, compared to private practice – 56%)
 - Families (other settings - 65%, compared to agencies - 57%)
 - Elderly (other settings - 53%, compared to agencies - 44%)
 - Children (other settings - 51%, compared to agencies - 42%)
 - Couples (other settings - 45%, compared to agencies - 37%)
 - Medical, hospital care patients (other settings - 43%, compared to agencies - 34% and private practice – 23%)
 - Sexually abused children - (other settings - 37%, compared to private practice – 26%)



Asked whether they served as a peer counselor to others, one in six (16%) said *yes*. (Figure 1) Males were more likely than females to answer *yes* (23% compared to 13%).

Most respondents who said they were peer counselors said they had *neither* state nor national certification as a peer counselor (86% said they were not certified).

Figure 2 shows that nearly half the respondents (46%) said they provide counseling to people living in rural, remote or underserved areas.

The most experienced counselors (more than 10 years of experience) were more likely than others to say they do not provide counseling to the underserved (64%).

Education and Training

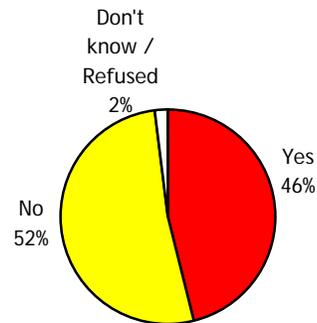
The majority of counselors indicated that they were degreed and qualified to provide service to clients.

Nearly 3 out of 5 (59%) said they gained skills and knowledge to provide counseling services in both credit-granting academic settings and non-academic settings. (Figure 3)

Respondents who have four-year degrees were particularly likely to say they have both academic and non-academic training (67%).

Figure 2
Provide Counseling Services to the Underserved

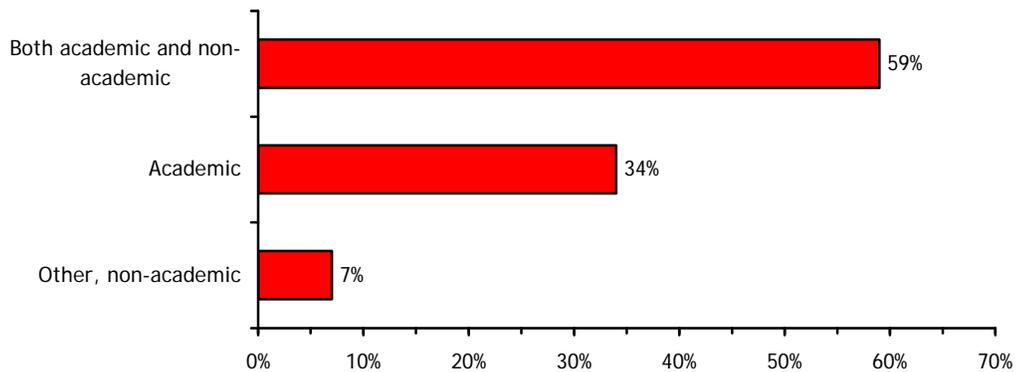
(Base = 805)



Question 29: Do you provide counseling to people living in rural, remote or underserved areas?

Figure 3
Settings Providing Skills, Knowledge Used in Counseling Services

(Base = 805)



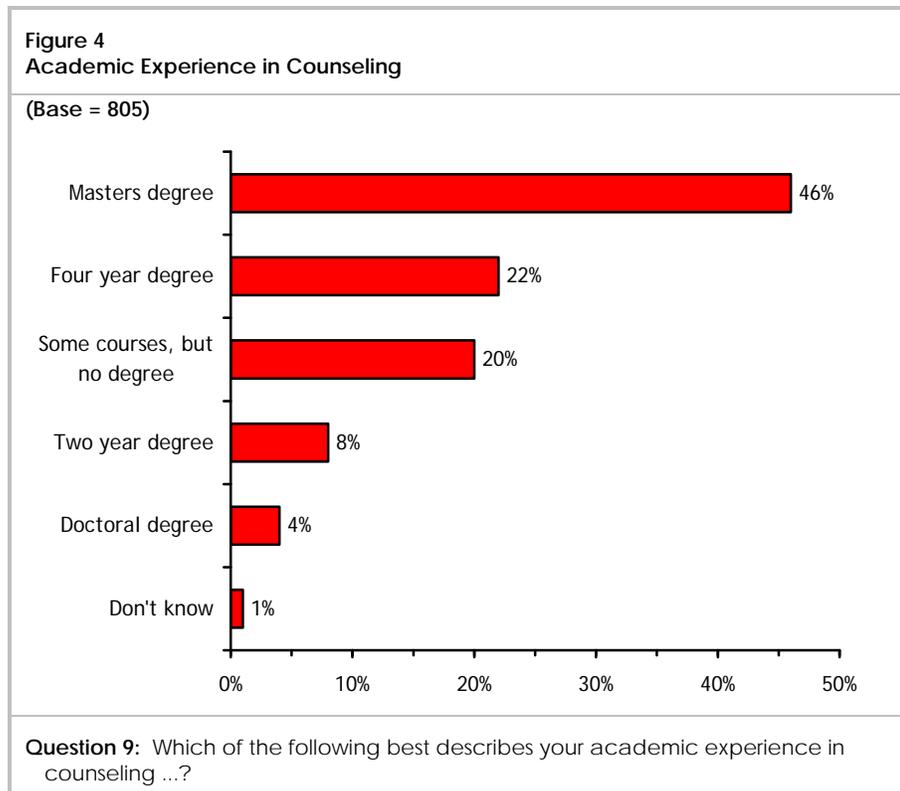
Question 8: We would like to know about the settings in which you gained the skills and knowledge you use in providing counseling services. Did you get your counseling education and training in credit-granting academic settings, other settings or both?

Half of all respondents said they had advanced education in counseling - either a Masters degree in counseling or a closely related field (46%) or a Doctoral degree (4%). (Figure 4) Just over one fifth (22%) said they had a Bachelors degree (four year degree) and 8% said they had a two-year degree in counseling or a closely related field.

Twenty percent (20%) of the registered counselors reported having taken some courses in counseling or a closely related field, but no academic degree in counseling.

Respondents having one year or less of experience and those having 2 to 5 years were more likely to say they have taken courses, but have no degree (27% and 25%, respectively). This is in comparison to those who have 6 to 10 years of experience (12%) and those who have 10 or more years of experience (20%).

Males were more likely than females to say they have two-year degrees (12% compared to 7%).



Differences based on counseling settings include these:

- Those who counsel in private practice were more likely than those who counsel in agencies and in other settings to say that they have a Doctoral degree (private practice – 10%; agencies – 2%; other settings – 4%).
- Respondents who counsel in agencies were more likely than those who counsel in private practice and in other settings to say they have a two year degree (agencies – 10%; private practice – 5%; other settings – 6%).
- Those who counsel in agencies were more likely than those who counsel in private practice to say they have a four year degree (agencies – 23%; private practice – 11%).
- Respondents who provide counseling in other settings were more likely than those who counsel in private practice to say they have a four year degree (other settings – 22%; private practice – 11%).
- Respondents who provide counseling in other settings were more likely than those who provide counseling in agencies to say they have a Masters degree (other settings – 53%; agencies – 44%).

Respondents who said they had academic degrees were asked to name the primary subject area of the degree. Many said they received degrees in Psychology or Applied Behavioral Science (37%). Degrees in Social Work were also fairly common (19%). About one in thirteen respondents (8%) said they had degrees in Counseling.

Respondents who have advanced academic degrees were more likely than those who have two-year degrees and four-year degrees to name Social Work as their primary subject area (23%, compared to 8% and 14%, respectively). Respondents who have two-year degrees were more likely than those who have four-year degrees and those who have advanced degrees to name chemical dependency counseling (31%, compared to 3% and <1%, respectively).

Table 3				
Subject Areas of Academic Degrees				
	Total	Associates	Bachelors	Masters/Ph.D
	(641)	(67)	(173)	(401)
Psychology/Applied Behavioral Science	37%	19%	45%	37%
Social Work	19	8	14	23
Counseling (subject not specified)	8	-	1	13
Human services	6	19	13	1
Education and Guidance Counseling	6	3	4	7
Liberal Arts	4	9	10	1
Chemical Dependency Counseling	4	31	3	<1
Marriage and Family Counseling	4	-	2	6
Mental Health Counseling	3	1	1	4
Other	20	24	23	18

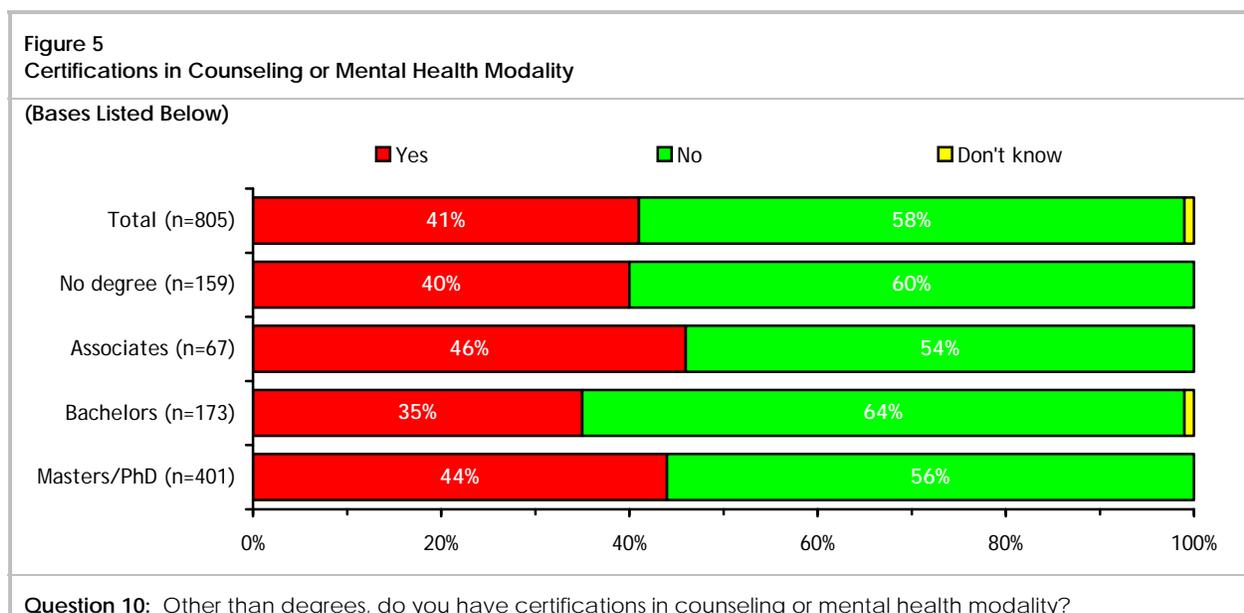
Question 9A: What type or subject is that degree?
 Multiple response question; proportions may add to more than 100%. Responses gathering less than 3% of total response are shown as "Other."

The following differences were noted between subgroups based on settings in which respondents provide counseling:

- Private practice - more likely to have degrees in Psychology (46%) than those in agencies (35%);
- Private practice - more likely to have degrees in Counseling (15%) than those in agencies (7%) and other settings (8%);
- Agencies – more likely to have degrees in Social Work (21%) than those in private practice (7%);
- Agencies – more likely to have degrees in Human Services (8%) than those in private practice (3%);
- Agencies – more likely to have Liberal Arts degrees (5%) than those in private practice (1%);

- Agencies – more likely to have degrees in Mental Health Counseling (5%) than those in private practice (1%) and those in other settings (1%);
- Other Settings – more likely to have degrees in Social Work (14%) than those in private practice (7%); and
- Other Settings – more likely to have Liberal Arts degrees (4%) than those in private practice (1%).

A majority (58%) said they had *no* certifications in counseling or mental health modality. (Figure 5)



These subgroups were more likely than others to say they have certifications:

- Respondents who have advanced degrees (44%), compared to those who have Bachelors degrees (35%).
- Those who have more than 10 years of experience (50%); compared to those who have 1 year or less (30%) and those who have 2 to 5 years (39%).

Additionally, respondents who counsel in private practice more often said yes, they do have certifications (51%), than did respondents who counsel in agencies (39%) and those who counsel in other settings (42%).

Additional Training Experiences

All respondents were asked whether or not they had any additional training experiences, specifically, mentorships, apprenticeships, supervised internships, professional training programs or other preparation for careers in counseling. (Table 4)

Results found two-thirds (66%) having supervised internships and 37% having taken professional training programs. Over one third (35%) reported having involvement with a counseling mentor. Twelve percent (12%) said they had none of these experiences, or any other type of preparation to be a counselor.

Respondents who have Masters degrees / Doctoral degrees were more likely than all others to say they have had supervised internships (84%). Respondents who have no academic degrees were more likely than those who have an Associates degree and those who have Masters degrees / Doctoral degrees to say they have had none of the experiences shown in Table 4 (23%).

Table 4					
Types of Training Experienced to Provide Basis for Work in Counseling					
	Total	No Degree	Associates	Bachelors	Masters/Ph.D
	(805)	(159)	(67)	(173)	(401)
Supervised internship	66%	25%	70%	59%	84%
Professional training program	37	38	27	33	39
Mentorship	35	31	34	32	38
Apprenticeship	11	9	13	11	12
Something else	9	13	9	7	9
None of these	12	23	12	19	5
Don't know	<1	-	2	1	-

Question 11A: Other than courses, certifications or degrees, have any of these types of experiences provided a basis for your counseling work? Have you had ...?

Multiple response question; proportions may add to more than 100%.

Subgroups also varied on the basis of *years of experience* and *gender*.

- Counselors who have 10 or more years of experience were more likely than those who have 5 years of experience or less to have had professional training programs (47%, compared to 31%) and mentorships (43%, compared to 30%).
- Respondents who have 6 to 10 years of experience were more likely than respondents who have less experience to say they have had supervised internships (73%, versus 62%).

Respondents who counsel in private practice were more likely to say they have had mentorships (45%) than were those who counsel in agencies (29%) and other settings (34%).

The survey asked respondents having any of these additional training experiences to explain the modality of the experience and the length of the experience. The survey also asked whether *being a client* was part of the experience. (Table 5)

Table 5 Additional Training Experiences: Modalities, Length of Experience and Involvement in Role as Client					
	Mentorship	Apprenticeship	Supervised Internship	Professional Training Program	Some Other Experience
	(279)	(90)	(529)	(294)	(75)
Modality of Experience					
Individual	61%	54%	60%	49%	41%
Group	27	28	33	40	34
Collaborative	12	6	9	12	1
Family	11	10	17	16	11
Relationship / couples	6	3	4	7	4
Chemical dependency	6	4	9	7	7
Conjoint	5	6	4	5	-
Concurrent	4	7	5	7	7
Intergenerational	4	2	4	4	7
Other	26	28	33	35	45
Don't know	1	1	2		9
Length of Experience					
Less than 1 year	17%	26%	27%	17%	9%
1 year	29	24	37	16	12
2 years	19	19	15	17	13
3+ years	27	21	12	29	32
Ongoing/continuous	4	4	2	4	11
Other	2	4	6	12	17
Don't know	1	1	1	4	7
Experience Involved Being a Client					
Yes	31%	23%	24%	28%	25%
No	68	76	75	71	70
Don't know	1	1	1	1	5
Questions 11B – 11F3: On what modality was your mentorship/apprenticeship/supervised internship/professional training program/other experience? For how long was that? Was being a client a part of your mentorship/apprenticeship/supervised internship/professional training program/other experience?					

Results found that for any given type of training, practice modalities occurred more often with individual therapies, followed by group counseling and counseling with families.

A comparison of modalities of experience across types of experience found these notable differences:

- Respondents who were mentored and those who had supervised internships were particularly likely to counsel *individuals* (61% and 60%, respectively).
- Those who had professional training programs were especially likely to work with *groups* (40%)

A comparison of length of training experience by type of experience found these differences:

- Respondents who were apprenticed and those who had supervised internships were more likely to have the experiences for less than one year (26% and 27%,

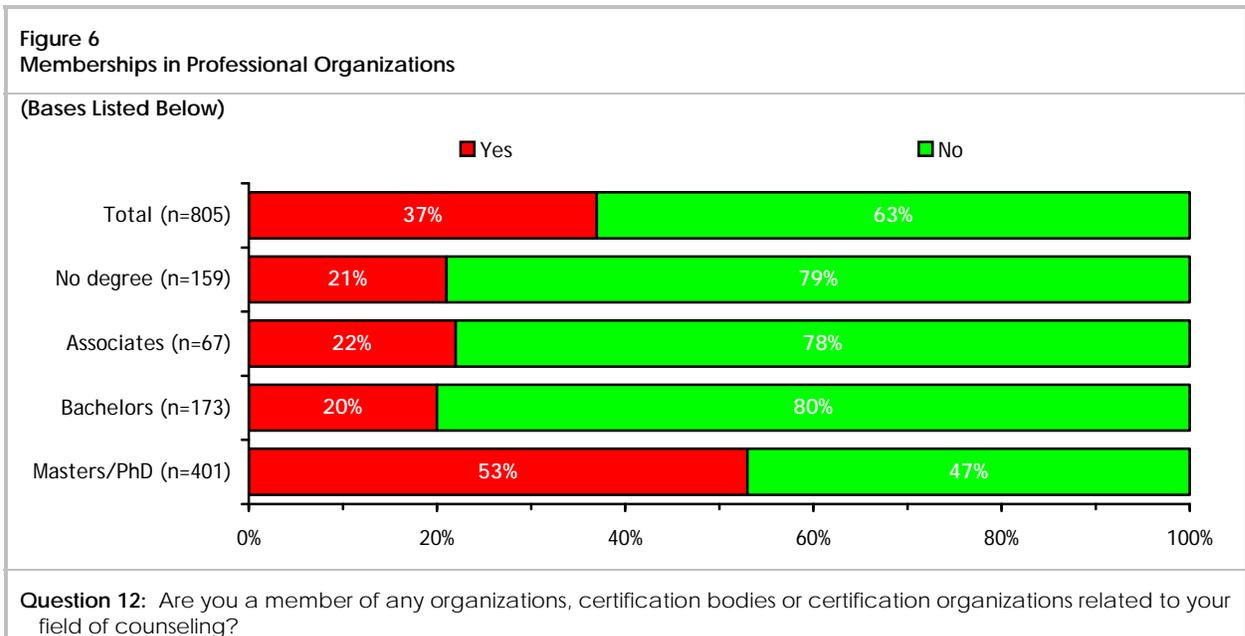
respectively); in comparison, those who were mentored and those who had professional training programs were more likely to be involved for 3 or more years (27% and 29%, respectively).

Respondents who were mentored were more likely than those who were apprenticed to say they had the experience as a client (31% compared to 23%).

For each type of experience asked about, those who counsel in private practice more often said they were clients than did those who counsel in agencies and other settings.

Professional Organizations

Nearly two thirds of respondents (63%) replied *no* when they were asked whether they belonged to any organizations, certification bodies or certification organizations related to their fields of counseling. (Figure 6)



Respondents who have advanced academic degrees were more likely than all others to answer *yes* (53%). Females were more likely than males to answer *yes* (39%, compared to 31%). Respondents who counsel in private practice more often answered *yes* (50%).

Counselors who said they belonged to professional organizations were asked to name them. Their responses are included in verbatim remarks found in the Appendix.

Nearly all respondents who have memberships in professional organizations said that the organizations had codes of ethics (95% said *yes*).

Current Professional Associations and Relationships

The survey asked whether respondents had any current associations with mentors, consultants or trainers. If so, they were also asked to specify the duration of the associations, the frequency of their meetings with associates and to specify professional training, background and/or credentials held by the associates.

As Figure 7 indicates, a majority of respondents (56%) said they *do not* maintain any current relationships with others who serve as mentors, consultants or trainers. Those who have these types of associations were more likely to have mentors (16%) or consultants (17%), rather than have professional trainers (9%).

Respondents who have one year or less of counseling experience were more likely than respondents who have more experience to say that they currently work with trainers (19%, compared to 7%).

Respondents who counsel in agencies more often said they worked with trainers (14%) than respondents who counsel in private practice (6%) and those who counsel in other settings (8%).

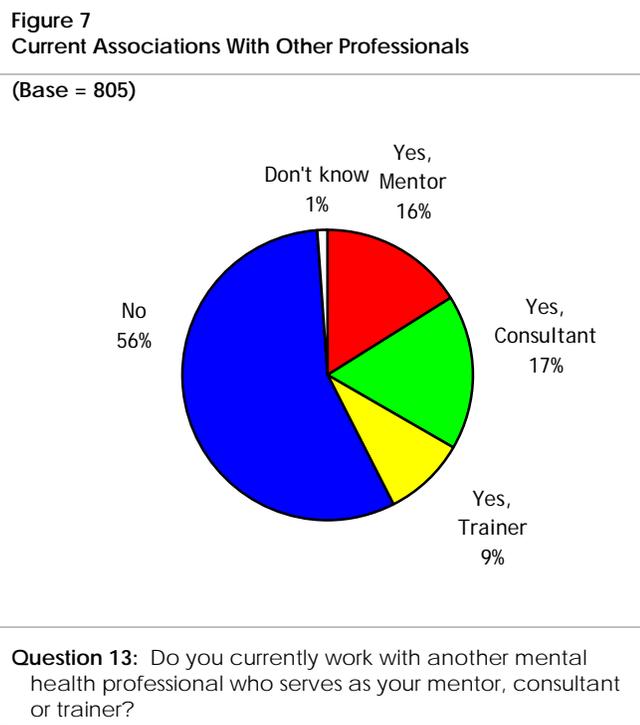


Table 6 shows the length of time respondents said they worked with each type of associate, and also the frequency of their meetings.

Results found a significantly larger proportion of respondents having year long or shorter-term associations with trainers (61%) than with mentors or consultants (40% and 39%, respectively). Conversely, associations with mentors and consultants were more likely to be longer term (more than 5 years) than associations with trainers.

Respondents who said they who work with trainers were more likely to have more frequent meetings – at least once a week (74%) than were those who work with mentors (60%) or consultants (59%).

Table 6 Current Work With Other Professionals			
	Mentor (132)	Consultant (138)	Trainer (74)
Length of association			
1 year or less	40%	39%	61%
2 to 5 years	34	38	30
More than 5 years	24	20	5
Other	1	2	4
Don't know	1	1	-
Frequency of meeting			
At least once a week	60%	59%	74%
Less often than at least once a week	37	36	15
Other	3	4	11
Don't know	-	1	-
Questions 13A & 13B: For how long a period have you worked with (your mentor, consultant, trainer)? How frequently do you meet?			

Respondent verbatim descriptions of training and credentials held by current mentors, consultants and trainers are included in the Appendix to the report.

Previous Professional Associations and Relationships

Over half of the counselors (52%) said they have previously worked with other mental health professionals who served as their mentors, consultants or trainers. (Figure 8) They more often said they were associated with mentors (23%) than with other types of mental health professionals.

Subgroups differed on the basis of their previous associations with other professionals.

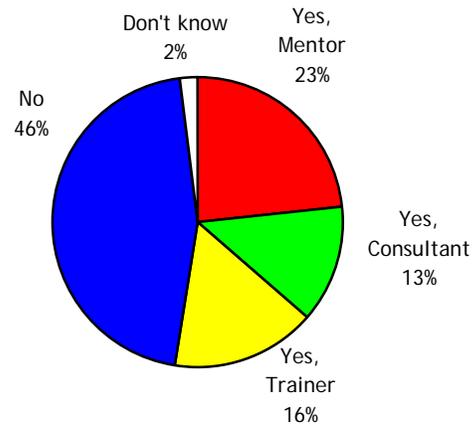
Counselors who have four-year degrees and those who have advanced degrees were more likely to have previous associations with mentors, than were counselors who have no academic degrees and those who have two year degrees.

Respondents with at least 6 years of counseling experience were more likely than those with less experience to have previous associations with mentors.

Table 6: Results found a significantly larger proportion of respondents having *previous* year long or shorter-term associations with trainers (57%) than with mentors or consultants (36% and 32%, respectively). This relationship is similar to the relationship found for length of association among *current* mentors,

Figure 8
Previous Associations With Other Professionals

(Base = 805)



Question 14: Have you previously worked with another mental health professional who served as your mentor, consultant or trainer?

	Mentor (184)	Consultant (108)	Trainer (131)
Length of association			
1 year or less	36%	32%	57%
2 to 5 years	47	43	31
More than 5 years	14	23	7
Other	2	1	4
Don't know	1	1	1
Frequency of meeting			
At least once a week	73%	56%	82%
Less often than at least once a week	23	41	13
Other	2	4	5
Don't know	2	-	-

Questions 14A & 14B: For how long a period did you work with (your mentor, consultant, trainer)? How frequently did you meet?

consultants and trainers.

Respondents who previously met with trainers met with them more frequently than respondents who met with mentors and consultants (at least once a week). The proportion of respondents who met with trainers at least once a week (82%) was significantly greater than the proportion that met with consultants this often (56%).

This relationship is also similar to the relationship found for frequency of meetings among *current* mentors, consultants and trainers.

Respondent verbatim descriptions of training and credentials held by former mentors, consultants and trainers are shown in the Appendix to the report.

Assessment, Diagnosis and Treatment of Mental Health Disorders

Overall, respondents more often said they *treat* mental health disorders (45% said *yes*), than said they assess or diagnose these illnesses. (Table 7) Less than half the respondents said they *assess* mental health disorders in their practices (40%) and even fewer said they *diagnose* disorders (24%).

However, among those who provide mental health assessments, diagnoses and treatments, large majorities said they had training in these areas (94%, 97% and 96%, respectively).

Respondents who have advanced degrees (Masters and Doctorates) were significantly more likely than those with less education to both *assess* mental health disorders (57%) and *diagnose* disorders (41%). Respondents who have Bachelors degrees (41%) and advanced degrees (61%) were more likely than those who have less education than four-year degrees, to *treat* mental health disorders (no degree – 23%; two year degree – 21%).

Those who counsel in private practice and in agencies more often said they diagnose mental health disorders (34% and 31%, respectively) than those who counsel in other settings (22%).

Table 7					
Assessment, Diagnosis and Treatment of Mental Health Disorders					
	Total	No Degree	Associates	Bachelors	Masters/Ph.D
	(805)	(159)	(67)	(173)	(401)
Assess disorders					
Yes	40%	16%	21%	31%	57%
No	60	84	79	69	42
	<1	-	-	1	1
(Among those who assess)	(322)	(25)*	(14)*	(53)	(230)
Have training in assessment					
Yes	94%	76%	86%	87%	98%
No	6	24	14	11	2
	<1	-	-	2	-
Diagnose disorders	(805)	(159)	(67)	(173)	(401)
Yes	24%	8%	5%	10%	41%
No	75	91	96	90	59
Don't know	1	1	-	-	1
(Among those who diagnose)	(196)	(13)*	(3)*	(17)*	(163)
Have training in diagnosis					
Yes	97%	85%	100%	88%	99%
No	3	15	-	12	1
Treat disorders	(805)	(159)	(67)	(173)	(401)
Yes	45%	23%	21%	41%	61%
No	54	75	79	57	39
Don't know	1	2	-	2	1
(Among those who provide treatment)	(364)	(36)*	(14)*	(71)	(243)
Have training in treatment					
Yes	96%	94%	93%	93%	98%
No	3	6	7	7	1
Don't know	1	-	-	-	1
Questions 15, 15A, 16, 16A, 17, 17A: Do you assess/diagnose/treat mental health disorders in your practice? Do you have training in the assessment/diagnosis/treatment of mental health disorders?					
*Very small sample size; interpret with caution.					

Role in Provision of Primary Mental Health Care Treatment

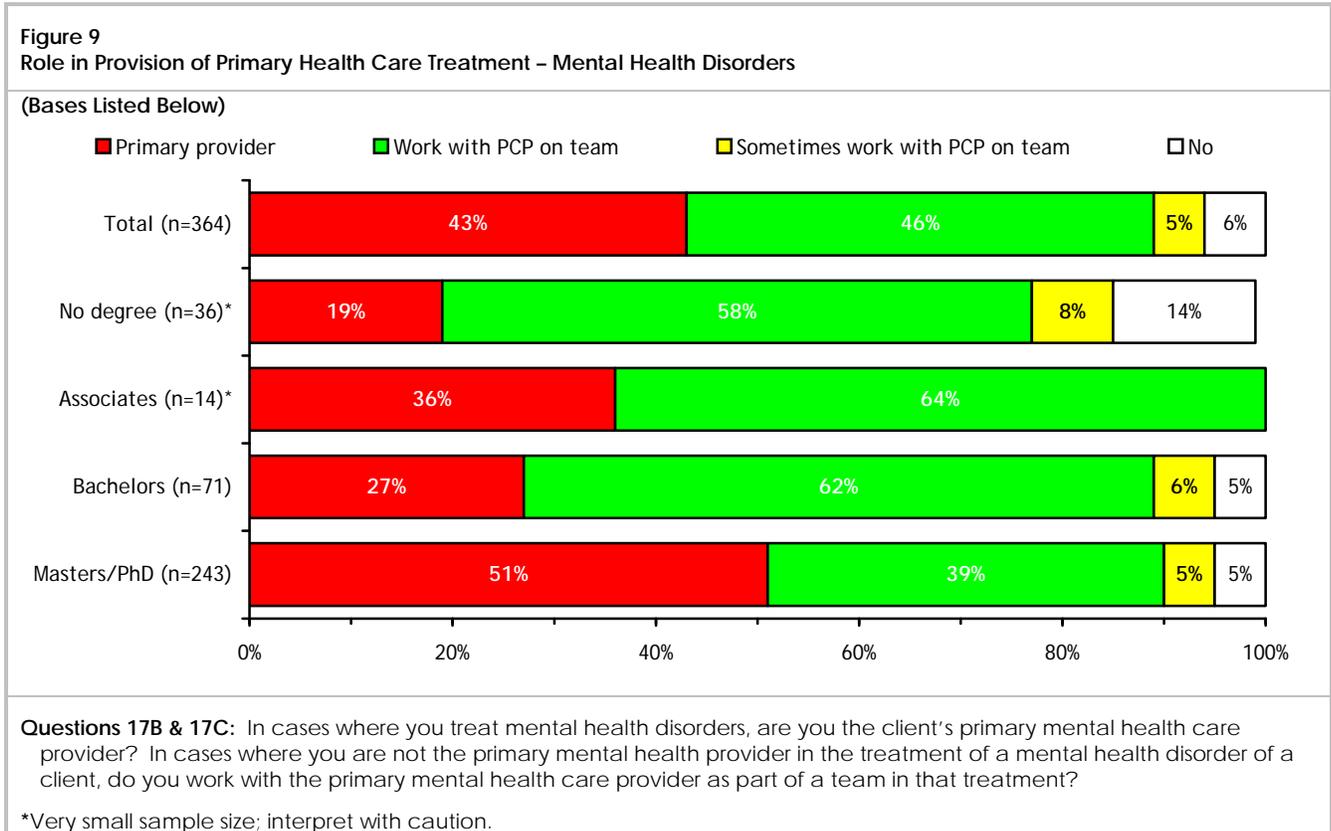
Respondents who said they provide treatment for mental health disorders were asked about their role in the provision of treatment. They were asked first, whether or not they were the client's primary mental health care provider, and *if not*, whether they worked with the primary mental health care provider as part of a treatment team, either sometimes or not at all.

Results found that most of those who provide treatment are either the client's primary mental health provider or are aligned with the primary care provider as part of a treatment team. (Figure 9)

A comparison of response proportions shown in Figure 9 found respondents with advanced degrees more likely to be the client's primary health care provider (51%) than

respondents with Bachelors degrees (27%) and respondents without academic degrees (19%).

Additionally, although the sample size is extremely small, it notable that respondents who have no degree were especially *unlikely* to provide primary mental health care, or work with the primary mental health care providers to these clients on a team, even sometimes. (Fourteen percent fell into this category.)



Assessment, Diagnosis and Treatment of Substance Abuse or Chemical Dependency Disorders

Respondents more often said that they *assess* substance abuse or chemical dependency disorders in their practices (38%) than *diagnose* (24%) or *treat* (32%) these types of disorders. (Table 8)

A majority of counselors who engage in these activities said they have training to do so. More than nine out of ten of those who diagnose and treat indicated that they have training in these areas of service (93%, each service). Eighty-nine percent (89%) of those who said they assess substance abuse or chemical dependency disorders in their practices said they have training in assessment.

Respondents who have two-year degrees (Associates degrees) were more likely than all other respondents to *assess* (64%), *diagnose* (49%) and *treat* (67%) substance abuse/chemical dependency disorders. They were also more likely than all others to say they have training in the *assessment* of these disorders (100%).

Additional subgroup differences include:

- Males, more likely than females to say they *assess* substance abuse/chemical dependency disorders in their practice (44% compared to 36%); and
- Respondents with 2 to 5 years of counseling experience more likely to say they *treat* substance abuse/chemical dependency disorders (37%) than those with more than 5 years of experience (26%).

Those who counsel in agencies more often said they *assess* substance abuse and chemical dependency disorders (47%) than those who counsel in private practice (31%). They more often said they *diagnose* these disorders than those who counsel in other settings (32% versus 18%). They more often said they *treat* substance abuse and chemical dependency disorders (42%) than those who counsel in private practice (29%) and those who counsel in other settings (29%).

Table 8 Assessment, Diagnosis and Treatment of Substance Abuse or Chemical Dependency Disorders					
	Total	No Degree	Associates	Bachelors	Masters/Ph.D
	(805)	(159)	(67)	(173)	(401)
Assess disorders					
Yes	38%	30%	64%	37%	39%
No	61	70	34	62	61
Don't know	1	1	2	1	1
(Among those who assess) Have training in assessment	(309)	(47)*	(43)*	(64)	(155)
Yes	89%	87%	100%	92%	86%
No	10	11	-	8	13
Don't know	1	2	1	-	1
Diagnose disorders	(805)	(159)	(67)	(173)	(401)
Yes	24%	16%	49%	20%	25%
No	75	84	51	79	74
Don't know	1	-	-	1	1
(Among those who diagnose) Have training in diagnosis	(196)	(26)*	(33)*	(35)*	(102)
Yes	93%	92%	97%	97%	91%
No	7	8	3	3	9
Treat disorders	(805)	(159)	(67)	(173)	(401)
Yes	32%	26%	67%	34%	28%
No	67	74	33	66	71
Don't know	1	1	-	1	1
(Among those who provide treatment) Have training in treatment	(258)	(41)*	(45)*	(58)	(113)
Yes	93%	93%	98%	88%	95%
No	7	7	2	12	5
Questions 18, 18A, 19, 19A, 20, 20A: Do you assess/diagnose/treat substance abuse or chemical dependency disorders in your practice? Do you have training in the assessment/diagnosis/treatment of substance abuse or chemical dependency disorders?					
*Very small sample size; interpret with caution.					

Role in Provision of Primary Mental Health Care Treatment

Respondents who said they provide treatment for substance abuse or chemical dependency disorders were asked about their role in the provision of treatment. They were asked first, whether or not they were the client's primary mental health care provider, and *if not*, whether they worked with the primary mental health care provider as part of a treatment team, either sometimes or not at all.

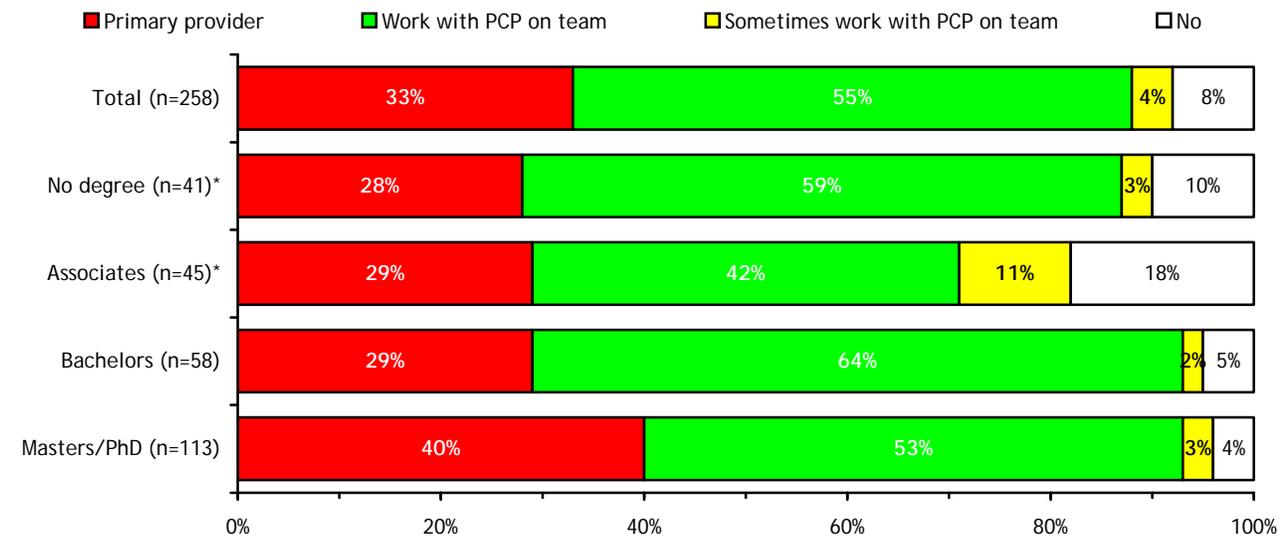
Results found that most of those who provide treatment are either the client's primary mental health provider (33%) or are aligned with the primary care provider as part of a treatment team (55%). (Figure 10)

Respondents with two-year degrees were more likely to than respondents with four-year degrees and advanced degrees to *neither* provide primary mental health care to their substance abuse /chemical dependency disorder clients, nor work with the primary

mental health care providers to these clients on a team, even sometimes (18% - Associates; compared to 5% - Bachelors degrees and 4% - Masters/Ph.D. degrees). This fact should be considered in view of the fact that respondents with two-year degrees were more likely than all others to *treat* substance abuse /chemical dependency disorders in their practices. This suggests that these respondents are often treating clients without the help of others.

Figure 10
Role in Provision of Primary Health Care Treatment – Substance Abuse/Chemical Dependency Disorders

(Bases Listed Below)



Questions 20B & 20C: In cases where you treat substance abuse or chemical dependency disorders, are you the client's primary mental health care provider? In cases where you are not the primary mental health provider in the treatment of a substance abuse or chemical dependency disorder of a client, do you work with the primary mental health care provider as part of a team in that treatment?

*Very small sample size; interpret with caution.

Among all respondents who treat substance abuse or chemical dependency disorders, 2 said they *did not know* whether or not they worked with the primary mental health care provider as part of a team in the treatment of the disorder. These were respondents who said they had coursework in counseling, but no academic degree.

Training in Assessment of Risk Factors

More than 8 out of 10 respondents (82%) said that they assess whether or not clients are dangers to themselves or others. (Table 9) Respondents who have Masters or Doctorates were more likely than other respondents to say they have this responsibility (90%).

Among those who said they assess clients as risk factors, a large majority (88%) reported having specific training in risk factors and assessments. Counselors who have two-year degrees were more likely than others to say that they have this specific training (98%).

Respondents who counsel in agencies more often said they have had this specific training (92%) than did those who counsel in private practice (82%).

Table 9
Training in Assessment of Clients as Risks to Self, Others

	Total	No Degree	Associates	Bachelors	Masters/Ph.D
	(805)	(159)	(67)	(173)	(401)
Assesses clients as risks					
Yes	82%	65%	78%	83%	90%
No	17	32	22	17	10
Don't know	1	3	-	-	-
(Among those who assess)	(663)	(104)	(52)	(143)	(360)
Have training in assessment					
Yes	88%	78%	98%	88%	91%
No	11	20	2	12	9
Don't know	1	2	-	-	1

Questions 21 & 21A: In your counseling practice, do you assess if a client is a danger to themselves or others? Have you gone to specific training or courses in risk factors and assessment?

Leadership

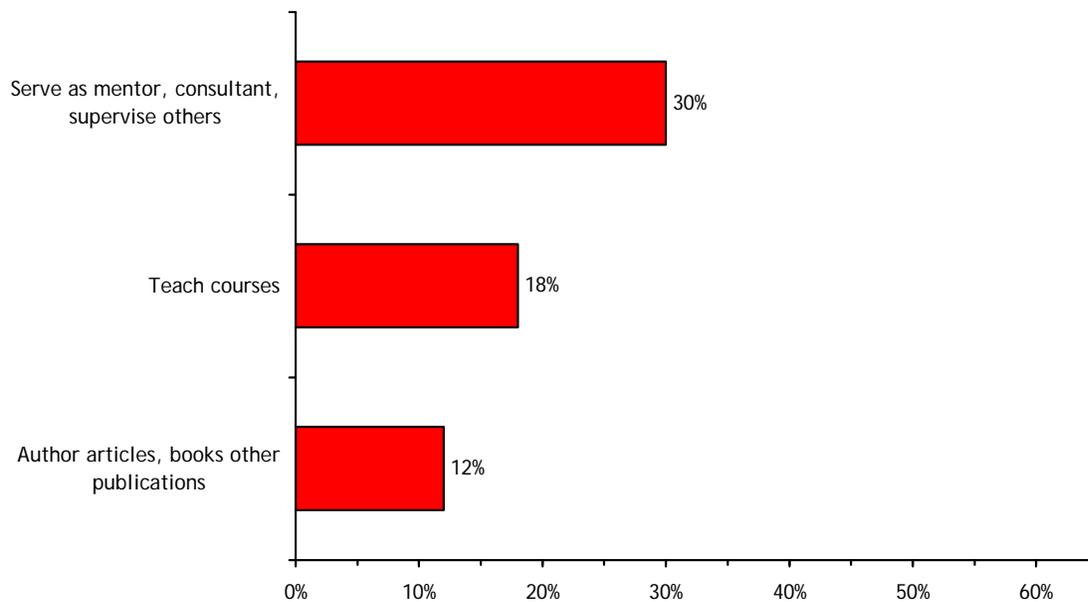
The survey found respondents more likely to serve as career models than leaders. Three in ten (30%) said they acted as mentors, consultants or supervisors to others in their fields of counseling. Fewer than two in ten (18%) said they taught courses in their fields and about one in ten (12%) said they authored magazine or journal articles, books or other publications. (Figure 11)

Respondents who have advanced academic degrees were more likely to develop their careers in all three areas shown in Figure 11. Respondents who counsel in private practice more often said they taught, and also authored books and magazine articles, than did those who counsel in agencies and in other settings.

Among those who said they taught courses, 23% said they held faculty positions in the field of counseling, or some related field. (This equates to about 4% of all respondents surveyed.) Of those who hold faculty positions, 47% (or 15 out of 32 respondents) said attendees of their courses earn continuing education credits in a mental health profession.

Figure 11
Career Achievements

(Base = 805)



Questions 22, 23 & 24: Do you currently provide mentoring, consultation or supervision to others in your field of counseling? Do you teach courses in your field of counseling? Are you an author in your field of practice?

Other Credentials

Although about three quarters of counselors (76%) said they do *not* hold another Washington State credential, 40% said they are either currently working toward meeting

the qualifications for another state credential, or planning to obtain a license or certification for another mental health profession. (Table 10)

Respondents who have advanced degrees (Masters / Ph.D.) were more likely than those with less education to be working towards licensure as mental health counselors (18%) and advanced or independent clinical social workers (13%).

Respondents who have no academic degree in counseling were more likely to say that they are not working for other credentials (71%).

Table 10 Additional Credentials					
	Total	No Degree	Associates	Bachelors	Masters/Ph.D
	(805)	(159)	(67)	(173)	(401)
Hold another WA State credential (besides registered counselor)					
Yes	24%	24%	33%	23%	24%
No	76	75	67	78	76
Don't know	-	1	-	-	-
Working toward another WA State credential or planning to obtain license for another mental health profession					
Licensed mental health counselor	12%	7%	5%	7%	18%
Licensed advanced or independent clinical social worker	9	3	2	7	13
Certified chemical dependency professional	6	4	12	10	3
License or certification no specified	5	1	6	1	8
Licensed marriage and family therapist	3	2	-	5	4
Licensed psychologist	3	2	5	4	2
Other	7	12	8	11	3
Not working for another credential	58	71	64	55	52
Don't know	2	3	-	5	1
Question 25: In addition to registered counselor, do you currently hold another state credential?					
Question 26: Are you currently working toward meeting the qualifications for another credential in the State of Washington or are you planning to obtain a license or certification for another mental health profession? Multiple response question; proportions may add to more than 100%.					

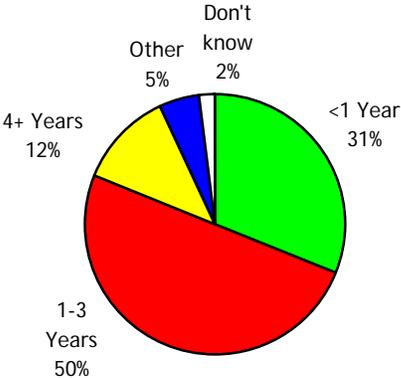
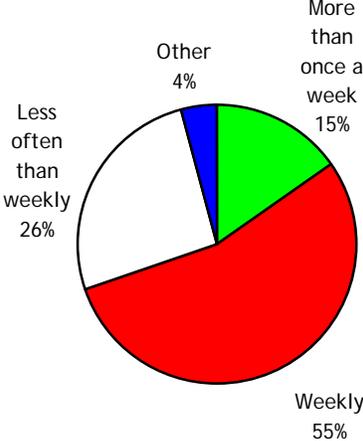
Counselors who said they were working toward another Washington State credential or planning to obtain a license for another mental health profession were asked additional questions:

- Whether they were currently working with another mental health professional who oversees their work to achieve a licensing requirement for completed supervised hours, and if so,
- How long they have worked with the professional, and
- How often they meet.

Results found that 51% of the respondents who are working for additional credentials or licensure are working with other professionals who oversee their counseling to satisfy credentialing or licensure requirements.

Respondents who have advanced degrees (Masters / Ph.D.) were more likely than respondents with less education to be working with supervisors (70% of respondents with advanced degrees answered *yes*).

Half of the counselors who are working with supervisors have done so for a lengthy period of time: 50% specified an interval of time stretching from 1 year to 3 years. An additional 12% said they have been working to achieve supervised hours for four years or

<p>Figure 20A Length of Time Working Toward "Supervised Hours" Requirement Counselors Seeking Additional Credentialing/Licensure</p>	<p>Figure 20B Frequency of Meetings With Supervisor for "Supervised Hours" Requirement Counselors Seeking Additional Credentialing /Licensure</p>																						
<p>(Base = 170)</p>  <table border="1"> <caption>Data for Figure 20A</caption> <thead> <tr> <th>Length of Time</th> <th>Percentage</th> </tr> </thead> <tbody> <tr> <td><1 Year</td> <td>31%</td> </tr> <tr> <td>1-3 Years</td> <td>50%</td> </tr> <tr> <td>4+ Years</td> <td>12%</td> </tr> <tr> <td>Other</td> <td>5%</td> </tr> <tr> <td>Don't know</td> <td>2%</td> </tr> </tbody> </table>	Length of Time	Percentage	<1 Year	31%	1-3 Years	50%	4+ Years	12%	Other	5%	Don't know	2%	<p>(Base = 170)</p>  <table border="1"> <caption>Data for Figure 20B</caption> <thead> <tr> <th>Frequency</th> <th>Percentage</th> </tr> </thead> <tbody> <tr> <td>Weekly</td> <td>55%</td> </tr> <tr> <td>Less often than weekly</td> <td>26%</td> </tr> <tr> <td>More than once a week</td> <td>15%</td> </tr> <tr> <td>Other</td> <td>4%</td> </tr> </tbody> </table>	Frequency	Percentage	Weekly	55%	Less often than weekly	26%	More than once a week	15%	Other	4%
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<p>Question 26B: For how long a period (have you met)?</p>	<p>Question 26C: How frequently do you meet?</p>																						

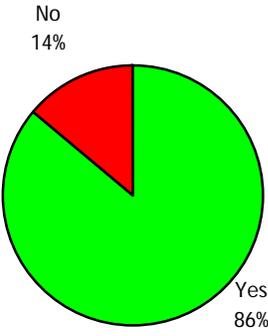
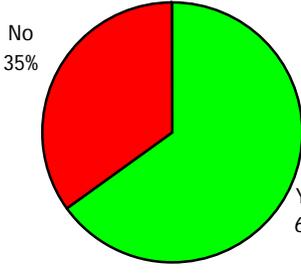
longer. (Figure 20A)

Meetings occur frequently: over half (55%) said they meet with supervisors weekly, and 15% said they meet more often than once a week. (Figure 20B)

Referrals

Although most respondents both refer clients to other health professionals and receive client referrals, more said they refer clients (86%) than said they receive referrals (65%). (Figures 21A and 21B)

Respondents who have advanced degrees (Masters / Ph.D.) were more likely to provide referrals (93%), and they were also more likely to receive referrals (70%). Counselors who work in private practice were more likely to provide referrals (95%), as well as receive referrals (79%).

<p>Figure 21A Provide Referrals to Other Counselors/Health Professionals</p>	<p>Figure 21B Receive Referrals from Other Counselors/Health Professionals</p>												
<p>(Base = 805)</p>  <table border="1" data-bbox="414 388 682 724"> <thead> <tr> <th>Response</th> <th>Percentage</th> </tr> </thead> <tbody> <tr> <td>Yes</td> <td>86%</td> </tr> <tr> <td>No</td> <td>14%</td> </tr> </tbody> </table>	Response	Percentage	Yes	86%	No	14%	<p>(Base = 805)</p>  <table border="1" data-bbox="941 451 1242 724"> <thead> <tr> <th>Response</th> <th>Percentage</th> </tr> </thead> <tbody> <tr> <td>Yes</td> <td>65%</td> </tr> <tr> <td>No</td> <td>35%</td> </tr> </tbody> </table>	Response	Percentage	Yes	65%	No	35%
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<p>Question 27: As a part of your counseling practice, do you refer clients to other counselors and/or other health professionals?</p> <p>(Not shown: 2 respondents said <i>don't know</i>; proportions are rebased to include only those who gave a response).</p>	<p>Question 28: As part of your counseling practice, do you receive client referrals from other counselors and/or other health professionals?</p> <p>(Not shown: 5 respondents said <i>don't know</i>; proportions are rebased to include only those who gave a response).</p>												

APPENDIX F:

**Mental Health Professions Currently
Regulated by Department of Health**

Mental Health Professions Regulated By The Department Of Health

Profession *	Regulated Since	Minimum Education Requirements	Minimum Experience Requirements	Examination Requirements
	1987	None	None	None
	1987	None	None	None
	1987	Masters or Doctoral Degree	3000 Hours Of Supervised Experience	National Examination
	1987	Masters or Doctoral Degree	3 Years Of Supervised Experience or 3000 Hours of Supervised Experience	National Examination
		Masters or Doctoral Degree	4000 Hours Of Supervised Experience	National Examination
	1987	Masters or Doctoral Degree	3200 Hours Of Supervised Experience	National Examination
	1955	Doctorate	1 Year Of Supervised Experience	National Examination
		AA Degree	2500 Hours Of Supervised Experience	National Examination
		Baccalaureate Degree	2000 Hours Of Supervised Experience	National Examination
	1998	Masters or Doctoral Degree	1500 Hours Of Supervised Experience	National Examination
		Licensed as Adv. Registered Nurse	1500 Hours Of Supervised Experience	National Examination
		Licensed as Psychologist	1500 Hours Of Supervised Experience	National Examination
		Masters or Doctoral Degree		
	1990	Medical Doctor or Osteopathic Doctor (board certified/eligible psychiatrist)	2000 Hours Of Supervised Experience	State Examination
		Bachelors, Masters or Doctoral Degree		
		Medical Doctor or Osteopathic Doctor (board certified/eligible psychiatrist)	None	State Examination

*MDs who are Psychiatrists are also regulated, but they do not have a separate license

APPENDIX G:

Survey Information Submitted by Work Group Members

Survey Information Submitted by Task Force Members

Washington Professional Counselor's Association is taking a survey of Registered Counselors. The survey is posted on our website and has also been mailed out to about 2000 RC's so far. You can read the survey at <<http://www.waproca.org>>, but a current registration number with the DOH is required to complete and submit the survey. This ensures that only RC's answer the survey and that no one answers more than once. So far we have 85 respondents – here is a summary of the results:

- 65.5% of registered counselors responding to the survey are in private practice. The average length of time in private practice was 10.85 years. These private practice registered counselors are more likely to have master's and Ph.D. degrees. They complete a significantly greater number continuing education credits per year, and they are more likely than their agency-employed counterparts to have completed non-academic certification programs in counseling.
- Private practice registered counselors have a higher rate of membership in professional organizations that hold their members accountable to a code of ethics. 86.3% refer to licensed counselors, psychologists, psychiatrists, and 82.8% receive referrals from these professionals.
- Almost all respondents who replied that they teach continuing education classes for licensed mental health professionals, teach in college or university settings, lead local, national and international trainings and seminars, or have published books, articles and other educational materials in their field, are private practice registered counselors.
- Our findings on populations served were the same as Gilmore's.

To: Registered Counselor Work Group
From: Ray Harry, Public Member

I had mentioned at the meeting on August 23rd that I was thinking of ways to seek some input from citizens regarding registered counselors. Working with Washington AARP, the below questionnaire was emailed to their email membership list.

I haven't received many responses yet, only 13, but I thought I would share the results so far:

Question 1: Yes - 1, No - 12
Question 2: Yes - 1, No - 12
Question 3: Yes - 2, No - 11
Question 4: Experience: Yes - 13, No - 0
Education: Yes - 13, No - 0

Thanks,

Ray

=====

Hello all,

I'm writing with a quick request for just a couple minutes of your time and input. Long time AARP friend and volunteer Ray Harry has been appointed to a state work group charged with developing recommendations regarding "registered counselors." Harry is the lone member of the group representing consumers, and would like to provide input regarding what the public understands and thinks about this issue.

Harry would greatly appreciate it if you could send him an email with your answers to the following four questions. His email address is rharry1901@comcast.net.

Thank you for your time,

Jason Erskine
AARP Washington
206-517-9345
jerskine@aarp.org

1. "Do you know the difference between a registered counselor, licensed counselor, and licensed psychologist?"

Yes No

2. Have you used the services of a Registered Counselor?

Yes No

3. Do you know the qualification requirements for being a Registered Counselor?

Yes No

4. "Do you think there should be a requirement for counseling experience and/or education in counseling before a person can become a registered counselor?"

Experience: yes no

Education: yes no

APPENDIX H:

2006 Registered Counselor Task Force Summary

Information Summary and Recommendations

Review of Registered Counselors

September 1, 2006



For more information or additional
copies of this report contact:

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

Phone: (360) 236-4612
Fax: (360) 236-4626

Mary C. Selecky
Secretary of Health



Health Systems Quality Assurance

Executive Summary

Governor Gregoire directed the Department of Health to review existing statutes and regulations for registered counselors by September 1, 2006. Mary Selecky, Secretary of the Department of Health, convened a short-term task force to assist in this review.

The department took a comprehensive approach to exploring the issues. The department consulted with the Board of Psychology, the Mental Health Counselors, Marriage and Family Therapists, and Social Workers Advisory Committee and the Chemical Dependency Certification Advisory Committee. The Registered Counselor Task Force met three times and identified issues, shared expertise, and discussed recommendations. The department invited all registered counselors to participate in a Web-based survey about their education and experience levels. Department staff and task force members conducted independent research on a number of subjects, including regulation in other states. Stakeholders also submitted written comments.

The department identified the following categories of registered counselors.

- Registered Counselors with Master's Degrees - Some registered counselors have a master's degree in the mental health field and use the registered counselor credential to acquire the necessary experience for licensure. Some registered counselors have master's degrees and are not pursuing licensure for a variety of reasons, including the difficulty in obtaining the required supervised experience.
- Chemical Dependency Trainees - Some registered counselors intend to become certified chemical dependency professionals. They register while obtaining a college degree and counseling experience.
- Agency and Facility Practice - Individuals who work as registered counselors in agencies and facilities operated, licensed, or certified by Washington State government.
- Private Practice - Some registered counselors work in private or group practice. They may have a PhD., master's, bachelor's, or associate's degree, or no formal degree.
- Peer Counselors - Typically individuals who have experienced mental illness or substance abuse and use that experience to help people with similar conditions.
- Wellness Practitioners - Individuals who teach wellness and life coaching. They do not attempt to diagnose or treat mental illness.

Recommendations

The department finds that existing laws regulating registered counselors should be modified to protect the public and restore public confidence in the profession. The department recommends eliminating the existing registered counselor category and creating three new categories for all existing registered counselors and future applicants. The recommendations are summarized below, please refer to page nine for the complete recommendations.

Recommendation 1: Pre-Licensure or Trainees

Individuals who are gaining experience to become a licensed social worker, licensed mental health counselor, or licensed marriage and family therapist would obtain an associate license created in the licensed counselor law, Chapter 18.225 RCW. Individuals who are gaining the training necessary to become a certified chemical dependency professional (CDP) should obtain a CDP-Trainee credential created in the CDP law, Chapter 18.205 RCW. Neither group would register as counselors under Chapter 18.19 RCW.

Recommendation 2: Agency Affiliated Counselor

Registered counselors employed by an agency or facility operated, licensed or certified by Washington State would become agency-affiliated counselors. Agency counselors work in settings that already have quality assurance standards set in law, including supervision requirements. Agencies should notify the department when an agency-affiliated counselor commits misconduct or leaves the agency. This will help the department take appropriate disciplinary action and prevent counselors who have committed misconduct from moving to another agency or into private practice.

Recommendation 3: Unaffiliated Counselor

Registered counselors who counsel in private or group practices would be required to:

- Have a high school diploma or GED and obtain the following education from an accredited college: ethics of counseling, psychology, or social work; counseling theory; human growth and development; and abnormal psychology. They would need education on assessing risk for suicide and homicide; the duty to warn; and duty to report abuse. Current registered counselors would have three years to meet these requirements.
- Annually complete a self-assessment to identify areas of ongoing proficiency, take 20 hours of continuing education directed at those areas, and complete an evaluation of their professional development.
- Have a written consultation agreement with a licensed mental health care provider. Current registered counselors would have one year to meet this requirement.

Recommendation 4: Scope of Practice

Counseling should be defined more clearly in Chapter 18.19 RCW and require individuals who provide counseling be credentialed by the Department of Health. The definition of counseling should clarify what constitutes therapeutic counseling and what is excluded. Individuals who diagnose and treat mental illness would need to be credentialed. Counselors who work in exempt settings, such as schools, would not need to be credentialed. Counseling can be defined as:

Therapeutic counseling means employing a recognized theory with a deliberate and defined therapeutic technique, for a fee, that offers to assist, or attempt to assist, an individual or individuals in the amelioration or adjustment of mental, emotional, or behavioral problems. Counseling includes using therapeutic techniques to improve a client's mental health, achieve sensitivity and awareness of self and others and the development of human potential. Counseling does not include vocational counseling,

school counseling, peer counselors, domestic violence treatment providers and crime victim advocates, camp counselors or supportive services such as case management activities, human services, residential support, or administering tests unless therapeutic techniques are used. Counseling does not imply proficiency in the practice or competencies of licensed Marriage and Family Therapy, Mental Health Counselor, Social Work, Psychiatric Nurse Practice, Psychology, or Psychiatry.

Recommendation 5: Disclosure and Public Education

Augment existing disclosure requirements by adding a statement regarding any disciplinary action taken by the department, other agency, or jurisdiction and referral resources. The registered counselor disclosure statement should include a statement that the counselor does not hold a license to practice social work, marriage and family therapy, mental health, psychology, or psychiatric nursing.

Fund a public education campaign to educate consumers about counseling. The department will continue to promote its web-based resources to identify practitioners and counseling laws.