**BEHAVIORAL HEALTH PROFESSIONAL WORKING GROUP**
**MEETING MINUTES**
**JULY 28, 2010**

**IN ATTENDANCE:**

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| **LA State Board of Examiners of Psychologists** | Joseph E. Comaty, Ph.D, M.P. |
| | Tony R. Young, Ph.D. |
| **LA Licensed Professional Counselors Board of Examiners** | Gloria Bockrath, Ph.D., LPC, LMFT |
| | June M. Williams, Ph.D., LPC, LMFT |
| **LA Counselors Association** | Michael H. Gootee, LPC, LMFT |
| | Cindy Nardini, LPC, LMFT |
| **LA Psychological Association** | Jessica Brown, Ph.D. |
| | Darla M.R. Burnett, Ph.D., M.P. |
| **LA State Board of Social Work Examiners** | Jacqueline Shellington, LCSW |
| **LA State Board of Medical Examiners** | Robert L. Marier, M.D. |

1. Introductions
2. Procedural Issues:
    a. The following documents were distributed to the group:
        i. Proposed agenda as posted for public notice;
        ii. Public notice announcement;
        iii. Suggested discussion topics submitted by Mr. Gootee;
        iv. Contact information for all members;
        v. SCR 100
    b. Dr. Comaty submitted the following recommendations for consideration:
        i. Review SCR 100 to remind members of the goals to be accomplished and the deadlines for meeting the stipulated requirements:
            1. First meeting by August 1st (accomplished);
            2. Final report by February 1, 2011;
        ii. Need for group to decide on schedule of meetings;
        iii. Mechanism for recording minutes, distributing minutes, approving minutes;
        iv. Dr. Marier also reminded the group about need to publically post approved minutes;
        v. Need to develop agendas for subsequent meetings;
        vi. Need to review history of current legislation to place current task within the historical context;
        vii. Review of open meetings law which apply to this workgroup;
    c. Dr. Comaty recommended that a leadership be established for the workgroup and suggested that it be a co-leadership with a representative from psychology and a representative from counselors. He recommended that Dr. Young be the psychology co-lead and the counselors recommended that Mr. Gootee be the co-lead from the counselor group. Members concurred and the floor was turned over to the co-leads.

d. By consensus, it was decided that the members may distribute information for review via email, but no decisions can be made outside of a called open meeting.
e. By consensus it was decided to establish a quorum for meetings and that members could participate in meetings via conference call, but could not vote on issues. However, a quorum of the members must be physically present at a meeting to conduct business. The quorum was determined to be a simple majority of the core members of the group (members=LSBEP (2); LPA (2); LaLPCBE (2); and LCA (2)) = 5.

3. The members discussed how to approach the task at hand. Several areas for discussion were identified that the group felt would be helpful to the process:
    a. Just having an open discussion about issues from each perspective will be instructional;
    b. Providing the group with educational materials re: training and experience of each profession;
    c. Rather than discussing from the perspective of each profession, it may be helpful to broaden the discussion to the level of how the two professions can work together to establish something more than simple language change;
    d. Examining differences in training as a means of clarifying scope of practice;
    e. Also need to look at areas of overlap;
4. Approaches to the task:
    a. Consider listing areas of agreement on the issue and areas of disagreement;
    b. Look at professional practice issues:
        i. Working in similar settings;
        ii. Performing similar duties;
        iii. Working as members of a multidisciplinary team;
    c. Refer back to the stipulated goals in the resolution, one of which is legislative language development for LPC scope of practice, particularly in the area of diagnosis;
    d. Using existing models:
        i. MP model;
        ii. Podiatric model;
        iii. Models from other states, KS for example;
        iv. 'Superboard', examples in other states, CA for example. Has pluses and minuses.
5. Discussion of how each of the professional boards regulate their members:
    a. The medical board regulates 17 other professions and physicians make up only about half of the number of professionals regulated. Dr. Marier explained the advantage to MPs of being regulated by the medical board which included a pathway for the development of enhanced practice (independent practice). But, to do this required them to meet numerous requirements: training, experience, national exam, etc. Dr. Marier stressed that it would be important to think about where we are going with healthcare in the future and how we would develop areas of practice that would meet the needs of the community as we move forward.
    b. The counselor board regulates two professions: LPCs and LMFTs.
    c. A question was raised as to how the LPC board regulates what their members are able to do or are they permitted to do anything, in essence regulating themselves; and do they have rules to deal with 'bad actors'; and how does the LPC board regulate LPCs who get involved in areas they are not supposed to. The answer is that LPCs are expected to practice in their area of competency, broadly stated. It is incumbent on the LPC to practice only in areas where they have received adequate training. Degree and training are just the beginning. When the LPC

board gets a complaint, they look at training and experience to determine the validity of the complaint.

d. LPCs are required to pass a national exam as are psychologists.
e. Dr. Marier cited the example of the podiatrists wanting to gain privileges to work on the lower extremity above the ankle. The two parties agreed to allow the medical board to establish qualifications for podiatrists through rule-making to gain the privilege they sought.
f. There is a national model for licensing regulations for psychologists from APA and from ASPPB. There is no national licensing standard for counselors.

6. Discussion of what was expected by the legislature:
    a. The impression is that the legislature would like the groups to settle this in a way that would not require a repetition of what occurred this year in subsequent years. The members concurred.
7. Current issue of disagreement involves how the two disciplines interpret the LPC scope of practice language:
    a. Psychology interprets the language in the statute to limit diagnostic scope to non-Axis I disorders and maybe adjustment disorders and is based on level of competence of LPCs;
    b. Counselors interpret the current language to permit them to diagnose all mental and emotional disorders and addictive disorders within the scope of their competence.
    c. It was noted that recently the language in scope of practice for social workers and LPCs had to be changed to include 'psychotherapy' but that there was no change in requirements for training or experience, just a change in the language.
    d. Description of the practice of psychology is quite broad in the law and therefore, there is a lot of overlap with scope of practice of counseling.
    e. There was a question about how the LPC board interprets the diagnostic scope of practice. Can LPCs diagnose any disorder in the DSM? The LPCs responded that they could diagnose any disorder for which they had training and competence. The medical board indicated that they are moving toward establishing standards for scope of practice for physicians. The current concerns do not involve seasoned physicians who have been in practice for many years as they have proven their competence through their practice. The concern is with new graduates who may not know what they don't know and due to changes in training tracks, they may not gain insight into their limitations.
8. There is also a difference in what is considered to be the minimum required level of credential for independent practice and scope:
    a. Psychology establishes the doctorate as the minimum required entry credential;
    b. Counselors and social workers establish independent practice at the master's level.
    c. Dr. Comaty expressed the opinion that in an ideal progression, training, experience, and demonstration of competency would precede and support any change in scope of practice legislation. However, in the cases cited thus far (adding psychotherapy to scope for SW and LPCs) for example, the cart was put before the horse and the law was changed to expand scope based on fiscal and political expediency without any change in training, experience, or demonstration of competency to support the added scope. There would be a risk to the public to change scope without some way of insuring appropriate training and competence.

d. Some members felt that this was incorrect and that that language of the law is not clear leading to misinterpretation of the intent and unfairly limiting the intended scope of practice.
e. Recommendation to bring in the respective laws governing practice to examine differences in language. Some members did not think this would be fruitful and would lead to endless discussions of issues already discussed that would bog the process down. But, others felt that it was important to examine the language of the law in order to understand the differences and this was a key to this process as it leads directly to our goals.
f. A question was raised as to whether the LPC board requires candidates for licensure to declare competencies during examination. Neither the LPC board nor the Social Work board has this requirement. Psychology board does have this requirement. The Medical board indicated that the medical scope of practice is quite broad, but there is a process for privileging physicians to limit practice to areas of competency and that there must be rules to govern this so that appropriate measures can be taken if licensees engage in practice beyond their level of competence. LPC board certifies individuals for appraisal privileges. Dr. Marier suggested that education alone is not sufficient to establish competency. He believes that there must be some type of certification process (such as testing a skill in a certain area), because 'education' can be obtained on the internet, workshops, etc. and this is being used to claim competency, when it may not be sufficient or reasonable. Some of the regulated professions claim that they can do whatever their supervising practitioner delegates to them and this may not be in the best interest of protecting the public. There must be thresholds for practice that are established.
g. The psychology board grants a 'generic' license, but candidates are asked to state a specialty area (like clinical, counseling, etc.). The law governs not only the title of psychologist, or any derivation of the word psychology, but more importantly, the law governs the practice of psychology. No matter what you call yourself, if you are engaged in practice that is defined as psychology, then you are in violation of the law if you are not a licensed psychologist. There are exceptions that allow unlicensed doctoral level individuals who are members of the faculty of a psychology department to call themselves 'psychologists' but they cannot provide applied services to the public or they would be in violation of the law. Similarly, since the psychology license is generic, they could become licensed with a specialty in experimental psychology, but that would not allow them to offer applied clinical services to the public because they would not be competent to do so.
h. The medical board also defines both title and practice. But, all practice acts have exclusions within them to protect infringing on the practice of another licensed profession. It is important to have standards and having individuals define their own scope of practice is not a good practice. There needs to be some mechanism to establish real standards, competencies, testing, etc that will require someone to demonstrate that they have the competence to perform a skill.
i. The LPC board requires two years of supervised practice, like social workers, but they do not have to be full time; but they have to have the requisite number of hours. It was pointed out that in the regulations for supervision it states that the LPC clinical supervisor is not responsible for the work of the supervisee. It is the administrative supervisor who has responsibility. The LPC board noted that they have filed complaints against supervisors for failing to fulfill their supervisory responsibility.

9. Action items for next meeting:
    a. Dr. Young will develop briefing on the education, training, national standards, scope of practice, psychology board competency requirements and specialties for psychologists;
    b. Mr. Gootee will provide the same information for counselors;
    c. Ms. Shellington will provide same information for social work;
    d. Review the respective laws governing scope of practice both within this state and across other states;
    e. Next meeting will be August 10, 2010 starting at 2 pm at DHH HQ, Bienville Bldg., 628 N. Fourth St., Baton Rouge, LA 70802.

Respectfully submitted:

Joseph E. Comaty, Ph.D., M.P.
Recorder

***BEHAVIORAL HEALTH PROFESSIONAL WORKING GROUP***
Bienville Bldg (DHH), 628 N. Fourth St., Baton Rouge, LA 70802

***AGENDA***
***July 28, 2010***

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2:00 p.m. Call to Order

Introductions

Approval of Agenda

Presentation of ideas/discussion of administrative matters necessary for the proper function of the working group.

Discuss the manner and frequency of the group's meetings

Preliminary discussion on moving forward to accomplish the goals and objectives set forth in SCR 100

5:00 p.m. Adjourn