STATE OF MAINE
129th LEGISLATURE
FIRST REGULAR SESSION

WORKING GROUP ON MENTAL HEALTH
FINAL REPORT
JANUARY 2020

MEMBERS:
Senator Cathy Breen, Falmouth, Senate Chair
Representative Charlotte Warren, Hallowell, House Chair
Senator Kimberly Rosen, Bucksport
Representative Beth O'Connor, Berwick
Karen Evans, Consumer
Sheriff Kevin Joyce, Cumberland County and Maine Sheriff's Association
Commissioner of the Department of Health and Human Services or designee
Commissioner of the Department of Corrections or designee
Simonne Maline, Consumer Council System of Maine
Tom McAdam, Kennebec Behavioral Health
Jenna Mehnert, National Alliance on Mental Illness Maine
Chief Leonard MacDaid, Newport Police
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Kevin Voyvodich, Disability Rights Maine
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I. BACKGROUND

The Working Group on Mental Health was established out of LD 1602, Resolve 2019, Chapter 100, Resolve, Establishing the Working Group on Mental Health. The resolve directed the Working Group as follows:

> [T]he working group shall review the State's mental health system and propose a mental health plan for the State. As part of its review, the working group shall examine:
>
> 1. Information on total state and federal dollars spent on children's and adult behavioral health care as coded by Medicaid and where those dollars are currently spent;
> 2. Access to mental health care in the State, including issues associated with waiting lists, geographic barriers to access and lack of adequate reimbursement to community-based programs that prevents those programs from reaching optimum capacity;
> 3. The quality of outcomes;
> 4. The costs required to provide mental health services in emergency rooms, inpatient settings, homeless shelters, jails and prisons as compared with the costs required to provide mental health services such as medication management, daily living support, peer support and other therapies provided in community-based settings;
> 5. An assessment of assets and deficits; and
> 6. The projected effect of MaineCare expansion on the provision of mental health services.

Members of the Working Group were appointed by the Senate President and the Speaker of the House; the Commissioner of Health and Human Services and the Commissioner of Corrections, or their designees, were ex officio members. The Department of Health and Human Services provided staffing with support from the Office of the Senate President.

In addition to formal appointees, several interested parties attended and participated in the Working Group, including but not limited to Community Housing of Maine, Maine Association of Psychiatric Physicians, Shalom House, Volunteers of America, Maine Hospital Association, the Maine Judicial Branch, District Attorneys, the Department of Public Safety, Riverview Psychiatric Center and several members of the public.

The Working Group met five times in Augusta from September to December 2019. Agendas, minutes, and meeting materials from the working group are available online at: www.maine.gov/mentalhealthworkgroup.

II. SUMMARY OF MEETINGS

At the meeting on September 20, the working group read and acknowledged the statute and reviewed the scope of its work. The main objective of the group was identified as keeping people with mental health and/or substance abuse needs from being housed in the wrong places: jail or prison, the emergency room, or homelessness.

Before addressing gaps in the system, the group identified the ways in which the system is succeeding. These successes included NAMI's Crisis Intervention Training (CIT), which diverts individuals to resources other than jail; mandatory mental health first aid as part of the Criminal Justice Academy's training; Maine's status as a leader in early detection of psychotic illnesses; Medicaid expansion; the Bridging Rental Assistance Program (BRAP) program which issues housing vouchers to transitioning clients; high answer rate for crisis hotline calls; and the Behavioral Health Home program.

Opportunities for improvement were identified as: concerns that BRAP reimbursement is too low and income thresholds are too high and limit its effectiveness; lack of flow of information between hospitals and the criminal justice system; better matching of services to clients; a centralized source of information between relevant departments; the need to overcome the stigma and discrimination related to SUD/MH, and to defeat legislation that proposes increasing penalties for this population; increasing continuity of care, ie from PNMIs to shelters; attracting psychiatrists and other MH professionals to Maine, which affects medication management services ond other relevant services; and providing law enforcement with a more robust menu of options for mental health crisis management.

The working group identified the need for more data on certain components of its work, including but not limited to: waiting lists for medication management, number of providers' open staff positions, and available housing. The working group also directed staff to gather information on other states' approaches to managing the mental health population.

Current practices of the Department of Health and Human Services and the Department of Corrections related to mental health and substance use disorder were reviewed, and items for discussion for the next meeting were established.

At the meeting on October 4, Court Master Daniel Wathen updated the working group on the status of the AMHI consent decree. Key issues were identified as lack of housing and employment opportunities; lack of timely access to quality services; problems with contract management and the grievance process, and excessively severe punishments. Judge Wathen also stated that the enactment of LD1822, "An Act To Protect Access to Services for Adults with Serious and Persistent Mental Illness," a bill from DHHS and sponsored by Rep. Drew Gattine (D-Westbrook) would begin to change certain elements of the consent decree.

Judge Wathen said that one problem with Maine is that the state spends more than the national average on mental health care and does not have the results to show for it. He stated that the state's problem is one of management, not resources, but this was challenged by members who pointed out that states have different methods of determining cost.

With regard to medication management, Judge Wathen said that reimbursement rates are out of step with the market, the wait lists are long and most providers operate at a loss. Medication management is a trial-and-error process that takes time; it can't be administered quickly.

Finally, Judge Wathen said that Maine was correct to provide an expansive menu of mental health services under the consent decree because it prohibited potential cuts during an economic downturn.

Jenna Mehnert from the National Alliance on Mental Illness (NAMI) in Maine provided a status update on NAMI's activities. She stressed stepping up police activities as a main priority, with a goal of 20% of police officers trained to be part of a Crisis Intervention Team (CIT) and 100% trained in mental health first aid. She proposed a certificate program at the Maine Criminal Justice Academy for officers with an interest in handling mental health-related calls. She also stressed the need to share information regarding available resources, citing that Crisis Stabilization Units often have space but law enforcement is unaware. She suggested working with PEW Research Center to centralize data and information.

Sheriff Kevin Joyce listed his priorities as shoring up the medication-assisted treatment (MAT) program, saying that the county jails are slowly implementing MAT programs and training their staff. He also mentioned lack of widespread "first offender" programs that would send inmates to work in the community instead of going to jail.

The working group expressed the need for a flowchart showing a client's possible routes through the state's various systems. Worst case scenarios were identified as jail, the hospital or homelessness, and it was suggested that the working group start with those categories to find out how people got there.

While attempting to develop this flowchart, it became clear that there is no methodological, predictable pathway for consumers. So the working group broke the work into subgroups, each with a focus on a specific area: mapping, workforce, administrative rules, bureaucracy, crisis services, resource allocation, and housing.

At the meeting on October 18, Beth Connolly from the Pew Research Center presented a summary of her work mapping behavioral health services for DHHS. Among the main points of the presentation were that mental health and substance abuse often go hand in hand; Maine is tied for 16th nationwide in suicide rate (2016); Maine is increasing MAT providers but needs better data on prescription rates; and Maine needs to improve its ability to connect people to care. In New Jersey, for instance, people in crisis can call one number and be directed to the appropriate level of care. Other states use online tools like Open Beds to connect people with services.

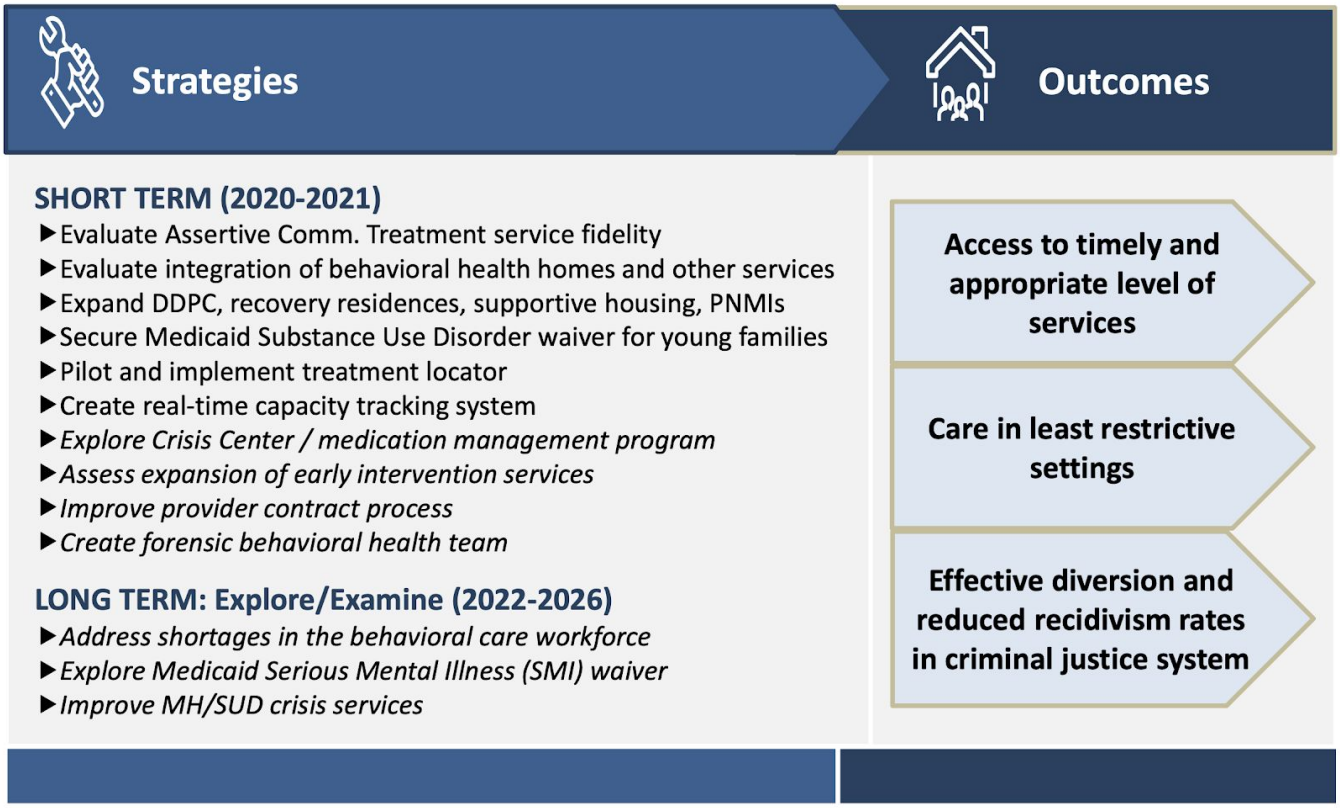
During the discussion after the presentation, the working group reviewed the mental health system maps that had been submitted by members. Karen Evans, representing the client perspective, outlined the optimal order of services: a warm line to talk through any issues; crisis mobile; peer respite; crisis stabilization; police. She stressed that the least restrictive option is always best, and that the hospital or police are last resorts.

The group reviewed subgroup report backs. The crisis services subgroup's recommendations included mobile assessment centers like the Living Room Project; police ride-alongs with a mental health liaison; a streamlined MaineCare application process and presumptive eligibility; more agents of continuity such as Intensive Case Managers (ICM); and early intervention in schools.

The bureaucracy subgroup suggested that Assertive Community Treatment (ACT) not be administered within Section 17; that bureaucratic duplication has become a burden and consumes too big a percentage of the state's mental health resources; and that quarterly meetings to review regulations should be mandated. The housing subgroup discussed barriers to service such as lack of transportation to available housing and the need for better dissemination of information regarding housing options to landlords and providers.

At the meeting on November 1, Dr. Jessica Pollard, Director of the DHHS Office of Substance Abuse and Mental Health Services (SAMHS), updated the group on her efforts to rebuild SAMHS, citing its decline in staffing during the previous administration and the high level of demand as evidenced by high rates of suicide, schizophrenia, bipolar disorder.

The following was shared with the group about SAMHS' long and short term goals.



The mapping subgroup presented a table detailing the stages where a consumer moves through the system and demonstrating that there is no linear path through the system for anyone. Gaps in transition from one level of service to another, misinformation and lack of clarity from service providers regarding how to access help and an unnecessarily difficult process were identified as barriers preventing the system from operating smoothly.

The housing subgroup highlighted the need for clearer information for clients on available options upon discharge from the hospital or jail; the need to ensure that private non-medical institutions provide effective treatment so space becomes available for other individuals to access those services; the need for apartments with supportive services, not just congregate living options; increased value for BRAP vouchers, and the cessation of transfers from hospitals to homelessness, among others.

The crisis services subgroup cited lack of resources and lack of available information about existing resources. Needs were identified as more peer support, more telehealth and a warm handoff during crisis. The subgroup questioned the true vision for crisis services: a first responder system with therapeutic resources or a risk assessment for other services, or both.

The bureaucracy subgroup speculated that legislation may be required to reduce administrative redundancy and mandate quarterly meetings with stakeholders. The communications and collaboration subgroup recommended asking DHHS for a comprehensive plan for ongoing multi-stakeholder communication and bringing back case managers, liaisons and navigators.

The working group discussed funding levels for mental health services, acknowledging that the state can do more with less by adopting a smarter approach to providing services. The working group then reviewed preliminary areas of agreement on recommendations and formed a new subgroup to consolidate all of the existing subgroups' recommendations.

At the meeting on December 2, the subgroups were instructed to workshop their initial recommendations. Discussion centered on jails tracking mental health spending; the need for an ombudsman of efficiency to reduce paperwork; the need to address and track adverse childhood experiences (ACE), and possibly include ACE-related questions on the Maine Integrated Youth Health Survey; the lack of handicap-accessible housing stock; attracting workers to Maine by overhauling licensing requirements, paying livable wages and through loan forgiveness programs; the adverse effects of the fee for service model; the constitutionality of the blue paper process; and the potential for specialized mental health probation officers.

At the final meeting on December 16, the working group focused on shoring up draft recommendations and discussed the timeframe for the final report.

III. CONSENSUS RECOMMENDATIONS

The Working Group developed the following guiding principles for reform of the mental health system in Maine, as well as more specific recommendations that are presented below in categories that generally correspond to the topics addressed by each subgroup of the full Working Group.

Guiding principles for the mental health system in Maine

- Build a system that encourages early screening, diagnosis and evidence-based treatment for Mainers at risk of mental health problems in the least restrictive environment

- Promote services close to consumers' homes and jobs through robust community providers that operate as network, preserving consumers choice of treatment modalities
- Include consumers, providers, and community partners in planning and providing mental health services
- Align resources with services at the earliest stages of intervention, and reducing in the more acute, severe stages
- Create a first response mental health system that relies on therapeutic intervention and does not default to criminal justice intervention
- The Department of Health and Human Services is best positioned to influence change in the mental health system; it should take the lead on driving innovative and forward-thinking reforms through larger-scale policy initiatives
- Ensure that data is being tracked for individuals with serious mental illness experiencing homelessness; and ensure serious mental illness information is collected upon entry into hospitals, emergency rooms, jails and prisons, and use that data to inform efforts to end homeless for individuals with serious mental illness

Specific recommendations

Recommendations related to resources and resource allocation

- Devise a method for tracking and reporting what county jails are spending on mental health services
- Endorse the recommendations of the Committee on Criminal Justice and Public Safety to amend LD 973 to require annual reporting of county jail costs and to make state funding contingent upon recordkeeping and reporting requirements; and to require county jails to provide substance use and addiction recovery treatment, medication assisted treatment (MAT), increased spending on programs and services, and community corrections programs including pretrial and conditional release, alternative sentencing and housing programs and electronic monitoring
- Enact stronger parity legislation and enforcement to address reimbursement rate gap between commercial payers and MaineCare
- Determine behavioral health rates that are most out of line with actual costs of providing the service and then align those rates with actual costs
- Direct DHHS to determine the availability of and apply for federal resources available including, but not limited to, grants, matching funds and block grants
- Develop resources for under-insured individuals who have health insurance but high deductibles that pose a barrier to accessing care
- Consider requiring commercial insurers to cover all evidence-based children's behavioral health services that are covered by MaineCare, as other states, including Illinois, require
- Distribute copies of DHHS service array ("spending pyramid") for education with superimposed distribution of current spending (with the goal of aligning spending with community-based and least-restrictive services, which are the most effective and lowest cost)
    - The DHHS service array is attached as **Appendix A**

- Increase access to community integration services, behavioral health homes and other community case management services and make eligibility more focused on functional need rather than clinical diagnosis
- Increase critical incident training (CIT) so that 100% of police officers have been trained in mental health first aid and 20% of police officers have been CIT trained
- Establish the position of Mental Health Specialist in the Department of Public Safety to respond or provide guidance to law enforcement on responding to situations where a therapeutic response may be the most appropriate and effective action and divert individuals from hospitals or the criminal justice system and toward behavioral health care

Recommendations related to the management of the mental health system

- Regular stakeholder meetings to assess where barriers to access to meaningful mental health services exist
    - Frequent regional-level meetings and less frequent statewide meetings
    - Stakeholders to involve include: the Department of Health and Humans Services, the Department of Corrections, the Department of Public Safety, the Department of Education, the Consumer Council System of Maine, Disability Rights Maine, the National Alliance on Mental Illness, providers of mental health services, housing advocacy groups, homeless advocacy groups, county sheriffs, police associations, prosecutors, judges, defense attorneys, the court system, hospitals, the State hospital system, and a significant representation of consumers of mental health services
- Require that cumulative effect of laws and regulations be considered when new regulations are adopted to avoid adding new rules and requirements of stakeholders without discarding outdated rules and requirements
    - A cross-agency review by the Office of the Governor or the Attorney General would:
        - Eliminate multiple requests for reporting the same data
        - Ensure that the licensing requirements, Kepro requirements and DHHS program requirements are as similar as possible and are satisfied with a single reporting mechanism
        - Provide a single point of review of program integrity and for maintaining MaineCare eligibility
        - Allow coordination of MaineCare and licensing audits
        - Include stakeholders when developing any new reporting requirements and provide adequate notice of both the requirement, the reason it is necessary, and how it will be utilized
- Re-invigorate the Consumer Council System of Maine by:
    - Including an Office of Consumer Affairs at management level within DHHS to provide internal expertise in consumer affairs
    - Reestablishing regular meetings between CCSM and DHHS where CCSM has an opportunity to fulfill its statutory obligation of advising “the [Department of Health and Human Services], the Governor and other state agencies”
    - Improving contact between the Commissioner of Health and Human Services, the Office of Substance Abuse and Mental Health Services

- Track adverse childhood experiences (ACES) by adding ACES questions to the Maine Integrated Youth Health Survey, which is already completed by students in public schools and administered by the Maine CDC and the Department of Education
- Require prior authorization for treatment of chronic and persistent mental health conditions at an interval greater than the current 90 days, such as 6 or 12 months as other states require
- Ensure consistent application by MaineCare of the standard for presumptive eligibility through:
    - Clearly established standards for eligibility for each service
    - Communication and education from the Department of Health and Human Services to all providers about presumptive eligibility standards

Recommendations related to workforce needs in the mental health system

- Support legislation or rulemaking to allow for licensing reciprocity for individuals who are licensed and in good standing in other states as licensed clinical social workers (LCSWs) or licensed professional counselor (LPC)
    - Draft recommended legislation is attached as **Appendix B**
- Create a waive-in process within the Department of Health and Human Services for individuals to achieve mental health rehabilitation technician/community (MHRT/C) certification
- Track proposed federal Health Resources and Services Administration changes to loan repayment qualification guidelines under the National Health Service Corps that may make Maine less competitive for healthcare providers to offer loan repayment, especially for mental health
- Establish a fund administered by the Finance Authority of Maine to provide up $10,000 per individual in tuition reimbursement and twenty $5,000 signing bonuses for individuals who work in a bachelor's degree-level position with a community-based mental health services provider or as a LCPC or LCSW with a community-based mental health services provider for at least 3 years
- Communicate more effectively between all stakeholders in the mental health system with the goals of:
    - Increasing access to care
    - Improving outcomes of services, including by sharing and disseminating best practices
    - Removing administrative barriers to services

Recommendations related to housing and the relationship of housing to the mental health system

- Achieve no discharges to homelessness, while respecting an individual's liberty to choose among discharge options
- Review DHHS recommendations on housing from innovation accelerator program, which are expected to be released spring 2020
- Expand availability of Housing First for individuals with serious mental illness by:
    - Expanding availability of housing for highest users of services provided to individuals with serious mental illness, such as through LR 3086, which is being introduced to the Second Regular Session of the 129th Legislature by Representative Victoria Morales and would create the Frequent Users Systems Engagement (FUSE) Collaborative to provide housing targeted toward the 1 percent who use 30 percent of mental health

system resources and redirect dollars spent on criminal justice and emergency departments for those individuals into housing with psychosocial and rehabilitative services

- Create 200 units of housing for individuals with mental illness over a four-year period by:
    - Including scoring incentives on MaineHousing's qualified allocation plan for site-based permanent supportive housing that qualifies for the Low Income Housing Tax Credit
    - Increasing resources available to develop small multifamily apartment buildings that is permanent supportive housing
    - Supporting development of 50 units of low-barrier permanent supportive housing through low-barrier PNMIs, including small multifamily developments and traditional group homes, using BRAP or PNMI rates
    - Reintroducing LD 970 (128th Legislature): An Act To End Homelessness by Expanding Housing Support Services (veto sustained), which established the Housing First Assistance Program at the Maine State Housing Authority to work with emergency shelters and other crisis responders in the neediest areas of the State to provide permanent housing and support services for chronically homeless individuals and families and to homeless individuals addicted to opiates
- Respect the limitations and objectives of the AMHI Settlement Agreement (or "Consent Decree") to allow individuals with serious mental illness to live: independently in their own homes without the need for any supportive services, with increased levels of services and supervision; in housing that is not an independent home but is fully staffed and supported and, in most cases, does not exceed eight beds; and with services, if necessary, that can be initiated, increased or discontinued as an individual's needs change
- Ensure rules adopted pursuant to Resolve 2019, c. 60 (LD 613), Resolve, Concerning the Adoption of Rules To Carry Out the Purpose of the Bridging Rental Assistance Program, are promulgated to allow low barrier use of BRAP vouchers and to establish a fund to target and address problem areas as they become known after implementation of the regulations

Recommendations related to crisis services available in the mental health system

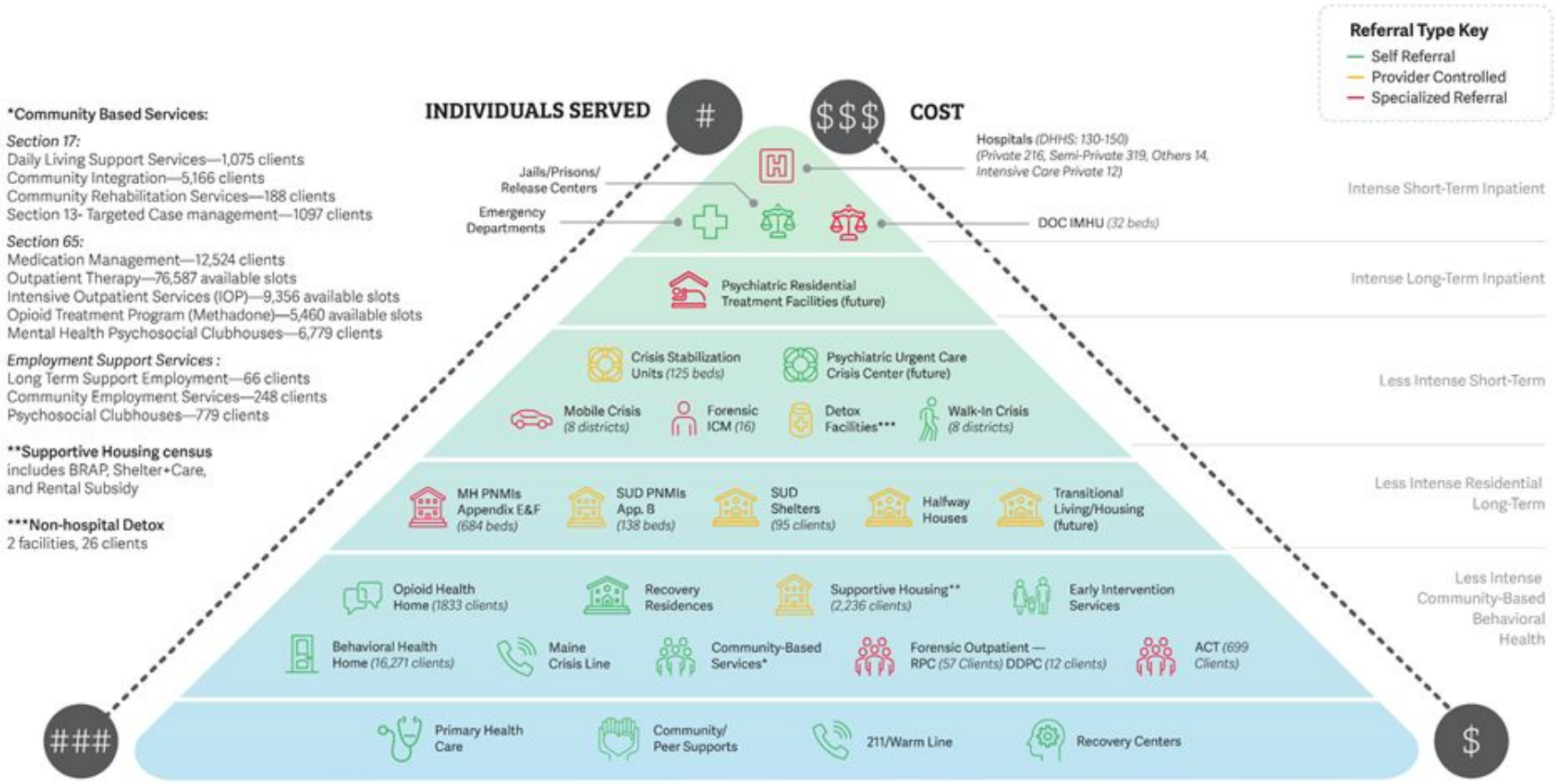
- Improve availability of warm line and peer services, including 211 phone and online systems
- Make non-jail options available for crisis situations as an alternative to jails
- Coordinate crisis response with law enforcement response to ensure a therapeutic response is available
- Fund mental health professional to either ride with law enforcement or assist dispatch; create option to dispatch a mental health professional instead of law enforcement
- Increase capacity of crisis stabilization units and peer respite services; integrate crisis stabilization unit options with law enforcement response
- Crisis stabilization units should be expanded to be regional and available 24/7, with peer support available, and where acceptance cannot be refused

Recommendations related to communication and coordination within the mental health system

- Create a comprehensive plan in the Department of Health and Human Services for ongoing multi-stakeholder communications and a flow chart of options to provide guidance when multiple responses to a mental health situation may be available
- Improve transitions of care and case management
- Implement a system of navigators and liaisons where navigators would be assigned to clients seeking mental health services and help direct them to the setting, type and level of care most appropriate for their needs and preferences, and where liaisons would be interface with various agencies, contractors and divisions within the Department of Health and Human Services to help bridge gaps and ensure that consumers have been directed to the most appropriate venue or service for treatment

Appendix A

Department of Health and Human Services Array or “Spending Pyramid”


*Community Based Services:
Section 17:
Daily Living Support Services—1,075 clients
Community Integration—5,166 clients
Community Rehabilitation Services—188 clients
Section 13- Targeted Case management—1097 clients
Section 65:
Medication Management—12,524 clients
Outpatient Therapy—76,587 available slots
Intensive Outpatient Services (IOP)—9,356 available slots
Opioid Treatment Program (Methadone)—5,460 available slots
Mental Health Psychosocial Clubhouses—6,779 clients
Employment Support Services :
Long Term Support Employment—66 clients
Community Employment Services—248 clients
Psychosocial Clubhouses—779 clients
**Supportive Housing census
includes BRAP, Shelter+Care,
and Rental Subsidy
***Non-hospital Detox
2 facilities, 26 clients
INDIVIDUALS SERVED
#
$$$
COST
Referral Type Key
Self Referral
Provider Controlled
Specialized Referral
Hospitals (DHHS: 130-150)
(Private 216, Semi-Private 319, Others 14,
Intensive Care Private 12)
Jails/Prisons/
Release Centers
Emergency
Departments
DOC IMHU (32 beds)
Intense Short-Term Inpatient
Psychiatric Residential
Treatment Facilities (future)
Intense Long-Term Inpatient
Crisis Stabilization
Units (125 beds)
Psychiatric Urgent Care
Crisis Center (future)
Mobile Crisis
(8 districts)
Forensic
ICM (16)
Detox
Facilities***
Walk-In Crisis
(8 districts)
Less Intense Short-Term
MH PNMIs
Appendix E&F
(684 beds)
SUD PNMIs
App. B
(138 beds)
SUD
Shelters
(95 clients)
Halfway
Houses
Transitional
Living/Housing
(future)
Less Intense Residential
Long-Term
Opioid Health
Home (1833 clients)
Recovery
Residences
Supportive Housing**
(2,236 clients)
Early Intervention
Services
Behavioral Health
Home (16,271 clients)
Maine
Crisis Line
Community-Based
Services*
Forensic Outpatient —
RPC (57 Clients) DDPC (12 clients)
ACT (699
Clients)
Less Intense
Community-Based
Behavioral
Health
###
$
Primary Health
Care
Community/
Peer Supports
211/Warm Line
Recovery Centers

Appendix B

Draft recommended legislation to allow for licensing reciprocity for an individual who is licensed and in good standing in another state as a licensed clinical social worker (LCSW) or licensed professional counselor (LPC)

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 32 MRSA §7053, subsection 1 is amended to read:

1. Licensed clinical social worker. To be qualified as a licensed clinical social worker, an applicant shall have demonstrated to the satisfaction of the board adherence to the ethics of the social work profession; shall have successfully completed the examination prescribed by the board; and shall have received either:

A. A master's or doctoral degree in social work or social welfare from an accredited educational institution in a clinical concentration and:

(1) Shall have subsequently completed 2 years of social work experience with 96 hours of consultation in a clinical setting; or

(2) Shall have demonstrated 2 years of full-time clinical social work experience or its equivalent and have completed the graduate degree prior to January 1, 1987 and have completed 2 years of subsequent social work experience with 96 hours of consultation in a private setting; ~~or~~

B. A master's or doctoral degree in social work in a nonclinical concentration from an accredited educational institution and:

(1) Shall have subsequently completed 4 years of social work experience with 192 hours of consultation in a clinical setting; or

(2) Shall have demonstrated 2 years of full-time clinical social work experience or its equivalent and have completed the graduate degree prior to January 1, 1987 and have completed 4 years of subsequent social work experience with 192 hours of consultation in a private setting~~.~~; or

C. A master’s or doctoral degree in social work from an accredited educational institution and shall, at the time of application, be licensed and in good standing to practice as a clinical social worker in another state in the United States of America.

Sec. 2. 32 MRSA §13858, subsection 2 is repealed and replaced with the following:

2. Licensed clinical professional counselor. To be qualified as a licensed clinical professional counselor, an applicant must demonstrate to the satisfaction of the board adherence to the ethics of the counseling profession, and either:

A. Successfully complete the examination prescribed by the board and have:

(1) A master's degree or a doctoral degree in counseling or an allied mental health field from an accredited institution or a program approved by the board. Such schooling must include a minimum core curriculum and total credit hours as adopted by the board; and

(2) Two years of experience after obtainment of a master's degree or a doctoral degree to include at least 3,000 hours of supervised clinical experience with a minimum of 100 hours of personal supervision; or

B. Have a master's degree or a doctoral degree in counseling or an allied mental health field from an accredited institution or a program approved by the board and, at the time of application, be licensed and in good standing to practice as a clinical social worker in another state in the United States of America.

Beginning January 1, 2020, an applicant under this subsection shall demonstrate to the satisfaction of the board successful completion of a minimum of 12 hours of course work in family or intimate partner violence, including course work in spousal or partner abuse that addresses screening, referral and intervention strategies, including knowledge of community resources, cultural factors, evidence-based risk assessment and same-gender abuse dynamics. An applicant may fulfill this requirement through course work taken in fulfillment of other educational requirements for licensure or through separate course work provided through contact hours, Internet hours or distance learning programs, as evidenced by certification from an accredited educational institution. The board shall accept certification from the accredited educational institution from which the applicant is a graduate that verifies the applicant's satisfaction of this requirement within the applicant's completed course curriculum. An applicant for initial licensure that is unable to demonstrate completion of the requirements of this paragraph at the time the initial application is submitted shall demonstrate to the board that these requirements have been fulfilled upon the applicant's first application for license renewal.

SUMMARY

This bill allows, as an alternative option to the requirements in existing law, an individual to become a licensed clinical social worker or a licensed clinical professional counselor when the individual holds a master’s or doctoral degree in the appropriate field and is in good standing as a licensed clinical social worker or licensed clinical professional counselor, as applicable, in another state.