2003 SUNSET REVIEW

Colorado Department of Regulatory Agencies
Office of Policy and Research

Division of Registrations, Mental Health Section:

Board of Psychologist Examiners
Board of Social Work Examiners
Board of Marriage & Family Therapist Examiners
Board of Licensed Professional Counselor Examiners
State Grievance Board
Addiction Counselors Program

October 15, 2003

STATE OF COLORADO

DEPARTMENT OF REGULATORY AGENCIES
Office of the Executive Director
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Bill Owens
Governor

October 15, 2003

Members of the Colorado General Assembly
c/o the Office of Legislative Legal Services
State Capitol Building
Denver, Colorado 80203

Dear Members of the General Assembly:

The Colorado Department of Regulatory Agencies has completed its evaluation of the Colorado Mental Health Statute. I am pleased to submit this written report, which will be the basis for my office's oral testimony before the 2004 legislative committee of reference. The report is submitted pursuant to section 24-34-104(9)(b), of the Colorado Revised Statutes (C.R.S.), which states in part:

> *The department of regulatory agencies shall conduct an analysis of the performance of each division, board or agency or each function scheduled for termination under this section...*
>
> *The department of regulatory agencies shall submit a report and supporting materials to the office of legislative legal services no later than October 15 of the year preceding the date established for termination….*

The report discusses the question of whether there is a need for the regulation provided under Article 43 of Title 12, C.R.S. The report also discusses the effectiveness of the Division of Registrations and staff in carrying out the intent of the statutes and makes recommendations for statutory and administrative changes in the event this regulatory program is continued by the General Assembly.

In addition, Appendix H of the report is submitted pursuant to section 24-34-901, C.R.S., which states, in part:

> *Before any bill is introduced in the general assembly that contains . . . a mandatory continuing education requirement for any occupation or profession . . . the group or association proposing such mandatory continuing education requirement shall first submit information concerning the need for such a requirement to the office of the executive director of the department of regulatory agencies. The executive director shall impartially review such evidence, analyze and evaluate the proposal, and report in writing to the general assembly whether mandatory continuing education would likely protect the public served by the practitioners.*

The professional associations described in Appendix H have requested that the General Assembly mandate continuing education for the indicated mental health professions and properly submitted information regarding that request to my office. Appendix H contains my department's analysis of this issue and the report required by section 24-34-901, C.R.S.

Sincerely,

Richard F. O'Donnell

Richard F. O'Donnell
Executive Director

2003 Sunset Review
Colorado Mental Health Boards

EXECUTIVE SUMMARY

Department of Regulatory Agencies

Bill Owens
Governor

Richard F. O'Donnell
Executive Director

Quick Facts

What is Regulated? Psychologists, social workers, marriage and family therapists, professional counselors, addictions counselors and unlicensed psychotherapists.

Who is Regulated?

- 2,005 psychologists
- 3,232 social workers
- 492 marriage and family therapists
- 2,652 licensed professional counselors
- 2,093 addictions counselors
- 1,655 unlicensed psychotherapists

How is it Regulated? The Director of the Division of Registrations regulates the addictions counselor program with the assistance of a four-member advisory committee. Each of the remaining mental health professions is regulated by its own seven-member board of examiners, comprising three mental health professionals and four public members. The Department of Regulatory Agencies, Division of Registrations administers the mental health boards.

What Does it Cost? The fiscal year 01-02 budget to oversee this program was $854,902. Currently, there are 5.0 full-time equivalent employees allocated to the program.

In fiscal year 01-02, license costs were:

	New License	Renewal
Licensed Addictions Counselors	$150	$165
Certified Addictions Counselors	$115	$165
All Others	$160	$146

What Disciplinary Activity is There? Between fiscal years 97-98 and 01-02, the boards' disciplinary proceedings consisted of:

Complaints Filed	1,133
Revocations	12
Suspensions	4
Probation	77
Other	146

Where Do I Get the Full Report? The full sunset review can be found on the internet at: http://www.dora.state.co.us/opr/2003MentalHealth.pdf

Key Recommendations

Continue the mental health boards until 2013
The current model of regulation, which includes independent boards with public member majorities, is more efficient, from a public protection standpoint, than an omnibus, multidisciplinary board, and it adequately protects the public.

Require each mental health board to fund itself by repealing the uniform fee requirement
With the exception of addictions counselors, the initial and renewal licensing fees for all mental health professionals are uniform. This has resulted in larger licensee groups subsidizing smaller licensee groups. This review recommends that initial and renewal licensing fees be established on a per-board basis, which will likely result in lower fees for larger licensee groups and higher fees for small licensee groups, thus eliminating subsidization.

Amend and repeal the appropriate statutes and rules to eliminate the existing jurisprudence requirements for all mental health professionals except unlicensed psychotherapists and addictions counselors
All six mental health boards impose on candidates for licensure, certification, registration or listing a jurisprudence requirement. Only unlicensed psychotherapists, however, possess a statutory requirement. This review recommends the repeal of all board rules relating to jurisprudence requirements for all mental health professionals except unlicensed psychotherapists and addictions counselors.

Reduce from four to one, the levels of licensure available to social workers, and attach protection of the title "social worker" to the attainment of a Master's of Social Work or higher degree
There are currently four levels of regulation available to social workers: Registered Social Worker, Licensed Social Worker, Licensed Independent Social Worker and Licensed Clinical Social Worker, each with its own requirements for education, examinations and supervision. This review concludes that four levels of regulation are not only unnecessary, but are confusing to both practitioners and the public. This review recommends eliminating all levels of social work regulation except for Licensed Clinical Social Worker.

…Key Recommendations Continued

Repeal the Psychology Board's rule requiring an oral licensing examination
The Board of Psychologist Examiners requires candidates for licensure to take and pass a written examination, a jurisprudence examination and an oral examination. However, the Psychology Board is statutorily authorized to require only a single examination. This review recommends that the General Assembly repeal the Psychology Board's rule mandating oral examinations.

Do not impose a continuing education requirement on mental health professionals
Several mental health professional associations filed with the Department of Regulatory Agencies (DORA) a request to impose a mandatory continuing education requirement on mental health professionals. Appendix H of this review contains DORA's statutorily required analysis and recommendation. The efficacy of mandatory, as opposed to voluntary, continuing education is questionable. Furthermore, a high proportion of Colorado's mental health professionals obtain continuing education without a statutory mandate to do so. This review finds that because it cannot be established that mandatory continuing education would enhance public protection and because a high proportion of mental health professionals in Colorado obtain continuing education voluntarily, mandatory continuing education is not justified.

Major Contacts Made In Researching the 2003 Sunset Review of the Mental Health Boards

Members of the mental health boards
Association of State and Provincial Psychology Boards
Colorado Association of Marriage and Family Therapists
Colorado Association of Psychotherapists
Colorado Council of Mediators
Colorado Counseling Association
Colorado Department of Education
Colorado Department of Human Services, Alcohol and Drug Abuse Division
Colorado Department of Public Safety, Division of Criminal Justice
Colorado Department of Regulatory Agencies, Division of Registrations
Colorado Judicial Department
Colorado Mental Health Counselors Association
Colorado Psychological Association
Colorado Society of School Psychologists
Denver Coach Federation
International Coach Federation
Mental Health Sunset Coalition
Metro Denver Interdisciplinary Committee
National Association of Social Workers, Colorado Chapter
National Register of Health Service Providers in Psychology
Practitioners
Society of Addictions Counselors of Colorado
Society for Clinical Social Work

What is a Sunset Review?

A sunset review is a periodic assessment of state boards, programs, and functions to determine whether or not they should be continued by the legislature. Sunset reviews focus on creating the least restrictive form of regulation consistent with the public interest. In formulating recommendations, sunset reviews consider the public's right to consistent, high quality professional or occupational services and the rights of businesses to exist and thrive in a highly competitive market, free from unfair, costly or unnecessary regulation.

Sunset Reviews are Prepared By:
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Background

The Sunset Process

The regulatory functions of the Board of Psychologist Examiners, Board of Social Work Examiners, Board of Marriage and Family Therapist Examiners, Board of Licensed Professional Counselor Examiners, the State Grievance Board and the licensing and disciplinary functions of the Addictions Counselors Program, all of which are administered by the Division of Registrations (Division), Mental Health Section (Section) in accordance with Article 43 of Title 12, Colorado Revised Statutes (C.R.S.), shall terminate on July 1, 2004, unless continued by the General Assembly. During the year prior to this date, it is the duty of the Department of Regulatory Agencies (DORA) to conduct an analysis and evaluation of the Division pursuant to section 24-34-104(9)(b), C.R.S.

The purpose of this review is to determine whether Article 43 of Title 12, C.R.S. (Statute), should be continued for the protection of the public and to evaluate the performance of the Division and staff. During this review, the Division must demonstrate that there is still a need for the Statute and that the regulation is the least restrictive regulation that is consistent with the public interest. DORA's findings and recommendations are submitted via this report to the legislative committee of reference of the Colorado General Assembly. Statutory criteria used in sunset reviews may be found in Appendix A on page 58.

Methodology

As part of this review, DORA staff attended board and advisory committee meetings; interviewed Division staff, and advisory committee and board members; reviewed Division records and minutes, including complaint files and disciplinary actions; interviewed officials with state and national professional associations; interviewed mental health care providers; reviewed Colorado statutes and Division rules; and reviewed the laws of other states.

Profile of the Profession

The Statute regulates six professions: psychology, social work, marriage and family therapy, professional counseling, addictions counseling and unlicensed psychotherapy. Notably, psychiatrists are not included in this list because they are regulated by the Colorado Medical Practice Act and come within the jurisdiction of the Board of Medical Examiners.

In a clinical sense, mental health professionals seek to help individuals, groups, families, communities, etc., resolve problems. Such problems may be psychological, emotional, societal, etc., in origin.

While there is considerable overlap in the practices of the mental health professions, there are also some distinguishing characteristics that can be generalized. Primary among these distinctions is the manner in which the various mental health professionals approach their clients' problems.

Psychologists typically hold either a Ph.D. or a Psy.D., and, according to the 2002-03 *Occupational Outlook Handbook*, "study the human mind and human behavior." Psychologists are typically trained as clinicians, researchers or scholars.

Clinical psychologists, more so than other mental health professionals, look to the inner individual first. They tend to look for medical-type diagnoses before commencing treatment. Then they move to look at the individual in wider context, such as familial, community, societal, etc.

The practice of social work is, by far, the most diverse among the licensed mental health professionals regulated by the Statute. Social workers may hold bachelor's, master's or doctoral level degrees and still practice social work. Those that practice independent of any supervision hold master's or doctoral level degrees.

Social work can essentially be broken down into two main areas of practice: indirect and direct. Indirect practice is more of a systems approach to practice. Social workers who engage in indirect practice are likely to work for community-based organizations such as schools and hospitals, and work to connect individuals, groups or communities with necessary services, or work as administrators in such organizations.

Direct social work practice, however, can be characterized as clinical work. That is, social workers that engage in direct practice tend to offer psychotherapeutic or counseling services to individuals or groups. Unlike the typical psychologist, the typical clinical social worker will first analyze the client in terms of the client's community and then look more towards the inner individual.

Marriage and family therapists typically hold master's or doctoral level degrees and most often engage in clinical work. The focus of marriage and family therapists, as the name implies, is familial. The typical marriage and family therapist is likely to first analyze the client in terms of that client's family or other relevant social group, and all the relationships and dynamics that such membership entails. The practice of marriage and family therapy is not confined to "couples counseling."

Professional counselors typically hold master's or doctoral level degrees and most often engage in clinical work. Professional counselors typically focus on a client's ability to cope with stresses and stressors. That is, the professional counselor does not view the client as ill. Rather, the professional counselor views the client in context and assists the client in developing the skills necessary to cope with everyday life or with specific situations. Professional counselors often work as guidance counselors in schools or in employee assistance programs.

Addictions counselors are quite different than the mental health professionals discussed thus far. As the name implies, addictions counselors assist their clients in coping with, or recovering from, addictions. In terms of the regulated community, these are addictions stemming from substance abuse, such as drugs and/or alcohol.

The educational background for addictions counselors is quite varied. No formal education beyond a high school diploma is required, although certain courses are required for certification. Additionally, a large number of addictions counselors are recovering addicts themselves. This status allows them to empathize with clients and to assist clients in successful recovery efforts.

Finally, the Statute regulates unlicensed psychotherapists. By far, this is the most diverse group of individuals regulated by the Statute. Like addictions counselors, their educational backgrounds are varied. Some hold high school diplomas, some hold graduate degrees in engineering or math, and still others hold doctorates in psychology and other areas. The basic premise of unlicensed psychotherapy is that formal education matters less than the practitioner's ability to help the client.

The approaches that unlicensed psychotherapists take with their clients is as varied as the population of unlicensed psychotherapists itself. Since many of the other mental health professions require a period of supervised practice prior to licensure, many unlicensed psychotherapists are such, simply because they are not yet licensed, and are in their period of supervised practice. These individuals tend to follow more traditional approaches to psychotherapy.

Some unlicensed psychotherapists begin as such because they were seeking licensure, but determine, for whatever reason, not to pursue licensure because they can continue to practice without a license. Again the reasons for not pursuing licensure are as varied as the population itself: some simply choose not to pursue licensure; some are unable to pass the licensing examinations; some practice in non-traditional areas, such as hypnotherapy or dream analysis, that are not recognized by the more traditional mental health professions; and, the list goes on.

The practice of unlicensed psychotherapy offers the public a viable alternative to the more traditional approaches to psychotherapy. It allows unlicensed psychotherapists to practice with minimal state sanction, but allows the state to hold them accountable for the therapeutic services they provide.

Finally, many Colorado Department of Education-licensed school psychologists practice outside of the public schools. Depending on their educational backgrounds and on whether they have taken the relevant mental health licensing examination, they may practice as psychologists, social workers, marriage and family therapists, professional counselors or unlicensed psychotherapists.

History of Regulation

The regulation of mental health professionals in Colorado seeks to protect the public health, safety, and welfare by identifying individuals who practice psychotherapy and by taking disciplinary action against those who, by act or omission, cause harm to their clients, and thus to the public. Mental health professionals provide, among other things, psychotherapy within a confidential and private setting, either one-on-one with clients or in groups.

The State Board of Psychology Examiners (Psychology Board) was created in 1961, within the Department of Regulatory Agencies (DORA), Division of Registrations (Division). The Psychology Board protected the public by certifying psychologists. In 1981, protection was enhanced with the advent of licensing psychologists. The Psychology Board's authority included examining candidates for licensing, renewal, and suspending or revoking licenses as needed. Since its inception, the law has provided title protection to licensed psychologists.

In 1975, the General Assembly created the State Board of Social Work Examiners (Social Work Board) within the Division. The Social Work Board's authority provided for the regulation of social workers at three levels: Registered Social Worker, Licensed Social Worker I and Licensed Social Worker II. The law also outlined extensive educational, work experience, and supervision requirements. The Social Work Board had the authority to discipline social workers who violated the statute.

In 1988, the General Assembly created the Board of Marriage and Family Therapist Examiners (MFT Board) and the Board of Licensed Professional Counselor Examiners (LPC Board) to license marriage and family therapists (MFTs) and professional counselors (LPCs), respectively. Importantly, these boards were not granted the authority to impose discipline on those to whom they issued licenses.

Simultaneous with the creation of these boards, the General Assembly determined that the mental health field was not regulated in a consistent, comprehensive manner. The Psychology and Social Work Boards pursuit, or apparent lack thereof, of disciplinary measures caused concern.

Therefore, the General Assembly severed the disciplinary function from the Psychology Board and the Social Work Board and vested it in a new, multi-disciplinary State Mental Health Grievance Board (SGB), which also had jurisdiction over MFTs and LPCs. Thus, Colorado became the first state to pass occupational legislation that separated the state's licensing and disciplinary functions.

The SGB was composed of members of the general public and licensed psychologists, social workers, LPCs and MFTs. In the 1987 sunset hearings, the General Assembly determined that a combined grievance board with members from the public and mixed interdisciplinary representatives could be more effective at policing the mental health professions involved. The SGB was intended to perform the disciplinary function of all of the mental health licensing boards with greater impartiality, fairness, and greater response to the public's need for enforcement, than independent boards.

Legislation in 1992 mandated that individuals who did not possess a license to practice psychology, social work, marriage and family therapy or professional counseling, but who did practice psychotherapy, could do so only if they listed with the Grievance Board Database (Database), which was to be administered by the Division. This legislation also extended the full range of disciplinary tools that were authorized for use against licensed mental health professionals to those listed in the Database, who became known as "unlicensed psychotherapists."

Other changes in 1992 included the implementation of a uniform fee schedule for all mental health professionals, and the licensing boards were authorized to delegate initial review of standard applications to staff.

In 1995, the statute was amended to specifically exempt persons regulated by the State Board of Nursing from the jurisdiction of the SGB. In 1997, the Medical Records Act was amended with language requiring all mental health professionals to provide their clients with a summary record of their therapy upon request.

In 1997, DORA conducted a sunset review of the SGB and the various mental health licensing boards. DORA concluded that the SGB-model of regulation served to protect the public health, safety and welfare and recommended that this model be continued. During the 1998 legislative session, however, the General Assembly instead enacted legislation that vested in the various licensing boards all licensing, disciplinary and policy-making authority. Under this scheme, the SGB was continued as the regulatory body for unlicensed psychotherapists.

In 2000, the General Assembly created the Domestic Violence Offender Management Board (DVOMB) within the Department of Public Safety, Division of Criminal Justice. In doing so, it vested in the DVOMB the authority to approve mental health professionals to provide treatment to convicted domestic violence offenders, as well as the authority to promulgate the standards by which such treatment is to be provided. However, the General Assembly vested in the various mental health boards at DORA, the authority to discipline such treatment providers for violation of the DVOMB-promulgated standards.

Finally, in 2000, the General Assembly transferred to the Division from the Department of Human Services, Alcohol and Drug Abuse Division (ADAD), the authority to certify, license and discipline addictions counselors. However, this program works in a manner similar to the way in which the Division enforces DVOMB-promulgated standards: ADAD promulgates the standards by which such individuals are certified, licensed and/or disciplined. The Division fulfills this function by means of a director-model of regulation, which means that the Director of the Division possesses the ultimate decision-making authority on disciplinary matters.

Legal Framework

Article 43 of Title 12 of the Colorado Revised Statutes (C.R.S.) (Statute), regulates those individuals who practice psychotherapy in Colorado. Section 12-43-201(9), C.R.S., defines "psychotherapy" as:

> the treatment, diagnosis, testing, assessment, or counseling in a professional relationship to assist individuals or groups to alleviate mental disorders, understand unconscious or conscious motivation, resolve emotional, relationship, or attitudinal conflicts, or modify behaviors which interfere with effective emotional, social, or intellectual functioning. Psychotherapy follows a planned procedure of intervention, which takes place on a regular basis, over a period of time, or in the cases of testing, assessment, and brief psychotherapy, it can be a single intervention. It is the intent of the general assembly that the definition of psychotherapy as used in this part 2 be interpreted in its narrowest sense to regulate only those persons who clearly fall within the definition set forth in this subsection.

The practice of psychotherapy is regulated by registering, certifying, and licensing those mental health professionals who practice psychotherapy. Toward this end, the Statute creates the following boards, which in turn regulate the relevant professionals: the Board of Psychology Examiners (Psychology Board); the Board of Social Work Examiners (Social Work Board); the Board of Marriage and Family Therapist Examiners (MFT Board); and, the Board of Licensed Professional Counselor Examiners (LPC Examiners). The State Grievance Board (SGB) regulates unlicensed psychotherapists. Hereinafter these various boards may be referred to collectively as the "boards."

Additionally, the Director of the Division of Registrations (Director) and the Department of Human Services, Alcohol and Drug Abuse Division (ADAD) jointly regulate addictions counselors, which may be certified or licensed. ADAD promulgates the requirements for certification and licensure, as well as standards of practice. To assist in the effort of holding these individuals accountable to both the ADAD standards and the requirements of the Statute, the Director has created the Addictions Counselors Advisory Committee (ACAC). This program may be referred to as the "Addictions Counselor Program" or "ACP."

Each board is composed of seven, Governor-appointed members: three are members of the regulated community and four are members of the general public. The ACAC is composed of four members of the regulated community, who are appointed by the Director.

Each board is authorized to: adopt and revise rules; adopt examinations; deny, withhold or approve license-applicants and to renew licenses; appoint advisory committees; and, hold hearings. In the case of the ACP, the Director possesses such authority.

To be licensed as a psychologist, an individual must be at least 21 years of age; hold a doctorate degree with a major in psychology from an approved school; have at least one year of post-doctoral, supervised experience; and, pass an examination that tests for knowledge in general psychology, clinical and counseling psychology, and knowledge of the appropriate statutes and ethical principals.

The Psychology Board has determined by rule that the examination process consist of three parts: the written Examination for Professional Practice in Psychology, which is a national examination; an oral examination, which was developed by and is administered by the Psychology Board; and, a written jurisprudence examination, which also was developed by and is administered by the Psychology Board.

Unique among the Boards is the Social Work Board. It both registers and licenses social workers: Registered Social Worker (RSW); Licensed Social Worker (LSW); Licensed Independent Social Worker (LISW); and, Licensed Clinical Social Worker (LCSW).

To become an RSW, an individual must be at least 21 years of age, hold a bachelor's degree in social work from an approved school and pass an examination. By rule, the Social Work Board has determined that candidates for registration must take and pass the Association of Social Work Boards' (ASWB's) Basic Examination.

To become an LSW, an individual must be at least 21 years of age, hold a master's degree from a graduate school of social work, and pass an examination. By rule, the Social Work Board has determined that LSW candidates must take and pass the ASWB's Intermediate, Advanced or Clinical Examination.

To become an LISW or an LCSW, an individual must be at least 21 years of age; hold a master's or doctorate degree from a graduate school of social work, practice social work for at least two years under the supervision of either an LISW or an LCSW, and pass an examination. By rule, the Social Work Board has determined that LISW and LCSW candidates must take and pass the ASWB's Advanced or Clinical Examination.

Additionally, the Social Work Board has the unique statutory authority to waive, upon request, the examination requirement for any level of regulation. Toward this end, the Social Work Board has developed a policy whereby it reviews each application for waiver on a case-by-case basis. Among the items considered are the date on which the applicant's degree was conferred, the number of years the applicant has practiced social work, and letters of recommendation.

Finally, the Social Work Board has determined, by rule, that all RSW, LSW, LISW and LCSW candidates must either take and pass a Social Work Board-developed and administered jurisprudence examination or complete a Social Work Board-approved jurisprudence workshop.

To become a licensed Marriage and Family Therapist (MFT), an individual must be at least 21 years of age; hold a master's or doctorate degree from an accredited school or college of marriage and family therapy; have at least two years of post-master's or one year of post-doctoral supervised experience, at least 1,000 of which must be face-to-face contact with couples and families; and, pass an examination.

The MFT Board has determined, by rule, that MFT candidates must take and pass the national examination developed and administered by the Association of Marital and Family Therapy Regulatory Boards. Additionally, candidates must attend an MFT Board-approved jurisprudence workshop.

To become a Licensed Professional Counselor (LPC), an individual must be at least 21 years of age; hold a master's or doctorate degree in professional counseling from an accredited school or college; have at least two years of post-master's or one year of post-doctoral supervised experience in applied psychotherapy; and, pass an examination.

By rule, the LPC Board has determined that LPC candidates must take and pass the National Board for Certified Counselors' Counselor Certification Examination. Additionally, candidates must attend a LPC Board-approved jurisprudence workshop.

ADAD has developed a set of rules that establish the requirements for certification as a Certified Addictions Counselor (CAC) I, II or III, as well as for Licensed Addictions Counselor (LAC).

To become a CAC I, an individual must have completed 1,000 hours of clinically supervised work consisting of at least three of the following: clinical evaluation; treatment planning; co-facilitation counseling; case management services; or, client and family education. Additionally, candidates must have completed an ADAD-approved addictions counseling course or passed the National Association of Alcoholism and Drug Addictions Counselors' (NAADAC's) National Certified Addictions Counselors II examination and ADAD-approved training in ethics, diversity in treatment populations and infectious diseases.

All candidates for certification as a CAC II must complete all of the training requirements for certification as a CAC I, plus an additional 105 hours of training in differential assessment and treatment planning, working with resistant clients, group counseling, and pharmacology.

The supervision requirements for certification as a CAC II are dependent upon whether the individual holds a clinical master's or clinical doctorate degree. Candidates who do not hold such degrees must complete at least 3,000 hours of clinically supervised work consisting of at least three of the following: clinical evaluation; treatment planning; co-facilitation counseling; case management services; or, client and family education. CAC II candidates who hold clinical masters or clinical doctorate degrees must complete at least 2,000 hours of such supervised work.

All candidates for certification as a CAC III must complete all of the training requirements for certification as a CAC I and CAC II, plus an additional 105 hours of training in clinical supervision and advanced counseling skills.

The supervision requirements for certification as a CAC III are dependent upon whether the individual holds a clinical master's or clinical doctorate degree. Candidates who do not hold such degrees must complete at least 5,000 hours of clinically supervised work consisting of at least three of the following: clinical evaluation; treatment planning; co-facilitation counseling; case management services; or, client and family education. CAC III candidates who hold clinical masters or clinical doctorate degrees must complete at least 4,000 hours of such supervised work.

To become a Licensed Addictions Counselor, an individual must be certified as a CAC III, hold a master's or doctorate degree and pass an examination given either by NAADAC or the International Certification Reciprocity Consortium (ICRC).

Individuals who desire to practice psychotherapy, but for whatever reason do not seek and/or obtain licensure or certification through any of the boards or programs discussed thus far, may do so, provided they are listed in the Grievance Board Database (Database). No unlicensed individuals may practice psychotherapy in Colorado without first being listed in the Database.

An individual seeking to be listed in the Database must provide to the Division the individual's name, current address, educational qualifications, copies of any statutorily required disclosure statements, therapeutic orientation or methodology, and number of years of experience in each specialty area. Additionally, such individuals must complete a SGB-approved jurisprudence workshop.

An individual may also obtain licensure as a psychologist, social worker, MFT or LPC through endorsement, if the individual already holds a valid license as such in another state and the individual possesses credentials and qualifications that are substantially similar to those required for licensure in Colorado.

An addictions counselor, too, may seek certification or licensure through endorsement, provided the individual holds a valid certificate from either NAADAC or ICRC.

Generally, only those persons who are registered, certified or licensed according to the provisions above may refer to themselves as such. That is, the titles associated with such registrations, certificates and licenses are protected and may not legally be used by any person who is not accordingly registered, certified or licensed. However, an individual who holds a doctorate in psychology, but conducts only research and does not provide psychotherapy services, may use the title, "psychologist."

Although each of the licensed professions (psychology, social work, professional counseling and marriage and family therapy) have a statutory scope of practice, no mental health professional may practice beyond his or her area of training, experience, or competence.

Table 1 summarizes the functions that are enumerated in the definitions of the various practices. This is a summary of enumerated functions only. Because the Statute is primarily a title protection statute, and not a practice protection statute, except for the practice of psychotherapy, it is possible, and indeed very likely, that some professionals perform functions outside of the functions enumerated for their given licenses.

Table 1
Scopes of Practice for Mental Health Professionals

	Psychotherapy (individual, group, families)	Testing & Assessment	Diagnosis	Alcohol & Drug Abuse	Evaluation	Rehabilitation Psychology	Heath Psychology	Forensic Psychology	Organizations	Communities	Sports Psychology	Research	Domestic Violence	Vocational Development	Treatment Planning	Crisis Intervention	Client Education	Case Management	Mediation	Advocacy	Care Planning	Consultation	Management & Administration	Social Policy Development	Supervision	Skills Building
Psychologists	X	X	X	X	X	X	X	X	X	X	X	X														
Social Workers	X	X	X	X					X	X		X	X		X	X	X	X	X	X	X	X	X	X	X	
MFTs	X	X	X	X	X								X		X		X					X			X	
LPCs	X	X		X									X	X												X
Unlicensed	X																									
CACs/LACs	X			X	X										X	X	X	X		X	X					

Any mental health professional may be disciplined by the appropriate board for engaging in any of the following activities:

- Being convicted of, or pleading guilty or *nolo contendere* to, a felony if the felony is related to the ability to practice;
- Violating or attempting to violate any provision in the Statute or any rules promulgated thereunder;
- Using false, deceptive or misleading advertising;
- Abusing health insurance;
- Being addicted to, or dependent upon, alcohol or any controlled substance;
- Having a mental or physical disability that makes such person unsafe to practice;
- Acting in a manner that falls below the generally accepted standards of practice;
- Performing services outside one's area of training, experience, or competence;
- Maintaining harmful dual relationships with clients;
- Exercising undue influence on a client to purchase property, goods, services, etc.;
- Failing to terminate a relationship with a client when it was clear that the client was not benefiting from the relationship;
- Failing to refer a client to an appropriate practitioner;
- Failing to obtain a consultation when necessary;
- Failing to render adequate professional supervision;
- Offering or accepting remuneration for referring clients;
- Failing to comply with any mandatory disclosure requirements;
- Engaging in sexual contact with a current client, or with a former client until six months have elapsed since the termination of the professional relationship;
- Committing fraud, deceit, or misrepresentation in applying for listing, registration, certification or licensure;

- Ordering or performing unnecessary tests and/or therapy; and,

- Using or recommending rebirthing therapy.

Additionally, ADAD has promulgated rules that expand the list of prohibited activities for CACs and LACs. These additions include:

- Refusal to consent to a chemical test or whenever the results of such tests indicate a blood or breath alcohol level of at least 0.10;

- Conviction of any felony or any substance abuse-related offense;

- Use of any substance in a manner that is dangerous to the practitioner or others; and,

- Practicing addictions counseling while the practitioner is in relapse.

Discipline may include suspension, probation or revocation of the individual's listing in the Database, registration, certification, or license, or it may include the issuance of letters of admonition or confidential letters of concern.

All mental health professionals must provide each client, during the initial contact with the client, a disclosure form that sets out:

- the practitioner's name, business address, and business phone number;

- any degrees, credentials and licenses held by the practitioner;

- a statement that the practice of psychotherapy is regulated by DORA, and DORA's address and phone number; and,

- a statement that informs the client that the client is entitled to receive information regarding the practitioner's methods of therapy, that the client may seek out a second opinion and that sexual intimacy is never appropriate and should be reported.

Disclosure forms are not required in cases of emergency, where the client is in the physical custody of the Colorado Department of Corrections or the Colorado Department of Human Services (DHS), where the client is incapable of understanding the disclosure, or by a Social Worker practicing in a licensed hospital.

Furthermore, a number of individuals who may practice psychotherapy are exempted from the general provisions of the Statute:

- Employment or rehabilitative counselors who do not provide psychotherapy services;
- Employees of DHS, employees of county departments of social services, or personnel under the direct supervision of such departments;
- School Psychologists licensed by the Colorado Department of Education, while such individuals are working in the public schools;
- Mediators resolving judicial disputes; and,
- Mental health professionals who perform custodial evaluations in domestic relations cases, or domestic and child abuse evaluations for the purposes of legal proceedings.

Finally, employees of community mental health centers or clinics that practice psychotherapy and are not licensed, are not required to be listed in the Database, although the SGB may impose discipline on them for any violation of the statute. If such individuals are licensed, the appropriate mental health board may discipline them.

Program Description and Administration

For the purpose of administering the following mental health regulatory programs, the Department of Regulatory Agencies (DORA), Division of Registrations (Division) has created the Mental Health Section (Section):

1. Board of Psychologist Examiners (Psychology Board);
2. Board of Social Work Examiners (Social Work Board);
3. Board of Marriage & Family Therapist Examiners (MFT Board);
4. Board of Licensed Professional Counselor Examiners (LPC Board);
5. State Grievance Board (SGB); and,
6. Addictions Counselors Program (ACP).

These boards and the ACP may collectively be referred to as the "boards" or as the "mental health boards."

Prior to July 1, 2003, the Section comprised 8.0 full-time equivalent employees (FTE). Table 2 illustrates the Section's staffing levels and expenditures for fiscal years 97-98 through 01-02.

Table 2
Agency Fiscal Information

Fiscal Year	Total Program Expenditure	FTE
97-98	$666,189	6.0
98-99	$703,149	8.0
99-00	$719,694	8.0
00-01	$776,387	8.0
01-02	$854,902	8.0

These 8.0 FTE consisted of the following classifications:

1.0 General Professional VI
2.0 Program Assistant II
5.0 Administrative Assistant III

Until July 1, 2003, the General Professional VI was the Program Administrator for all five boards and the ACP. The two Program Assistants staffed boards and performed other, generalized functions for all the boards. Four of the Administrative Assistants staffed the remaining boards, while the final Administrative Assistant provided general administrative support to the entire Section.

Effective July 1, 2003, however, the Division and the Section reorganized, and the staffing level of the Section was reduced to 5.0 FTE in the following classifications:

1.0 General Professional VI
2.0 Program Assistant II
2.0 Administrative Assistant III

The General Professional VI continues to serve as the Program Administrator for all boards and programs, but the boards no longer have staff members who are assigned exclusively to them. Rather, the program and administrative assistants divide their time between staffing boards and performing general, cross-board functions.

With the exception of the ACP's Addictions Counselors Advisory Committee (ACAC), all of the boards have four public members and three practitioner members, for a total of seven members each. Practitioner members must be licensed or registered, as the case may be, by the board on which they serve.

The ACAC, on the other hand, is composed of four practitioner members, all of whom are either certified or licensed addictions counselors. Under this regulatory scheme, the Director of the Division has the ultimate decision-making authority.

Except for the Psychology Board and the ACAC, all boards meet every two months. The Psychology Board meets monthly, and the ACAC meets quarterly.

Additionally, approximately twice per year, the Section organizes a joint or combined board/program meeting. This is supposed to afford the members of the various boards and the ACAC the opportunity to interact and address issues that are common to all boards and programs, such as jurisprudence workshops, and domestic violence and sex offender treatment providers. Attendance at these combined meetings is not mandatory for board members.

Licensing

The ACP and four of the mental health boards (Psychology Board, Social Work Board, MFT Board and LPC Board) issue licenses. In addition to licenses, the ACP also certifies addictions counselors and the Social Work Board registers individuals. The SGB regulates individuals listed in the Grievance Board Database (Database).

Table 3 below, offers summary information for the listing, registration, certification, and licensing activities for all boards. Note that the Division began administering the ACP in fiscal year 98-99, so numbers generally increase in that year, due to the acquisition of this program.

Table 3
Licensing Information

Fiscal Year	Exam/ Initial	Endorsement	Renewal	TOTAL
97-98	1,099	73	6,952	**8,124**
98-99	1,071	155	9,057	**10,283**
99-00	1,182	154	9,924	**11,260**
00-01	1,140	192	0	**1,332**
01-02	1,308	225	10,360	**11,893**

For detailed licensing information for each board, please see Appendices B through G, beginning on page 59.

The fee for initial licensure as a licensed addictions counselor (LAC) is $150, and it is $115 for initial certification as a Certified Addictions Counselor (CAC) I, II, or III. The initial license fee for all other mental health programs is $160, including initial listing in the Database and initial registration as a registered social worker.

Several of the figures in Table 3 merit additional discussion. First, it should be noted that licensure by endorsement is not available for unlicensed psychotherapists. This is logical: since licensure is not required, endorsement would be nonsensical.

Additionally, the records indicating numbers for licensure by endorsement for the Social Work Board for fiscal year 97-98 could not be located, thus the endorsement figures for that year appear abnormally low. The fee for licensure or certification by endorsement for LACs and CACs is $150, and it is $210 for all other mental health programs.

What Table 3 primarily highlights, however, is that the total number of regulated mental health professionals steadily increased during the five-year period under review, from approximately 8,000 in fiscal year 97-98, to almost 12,000 in fiscal year 01-02, representing an increase of approximately 25 percent.

Renewal numbers for fiscal year 00-01 are not available because, effective fiscal year 99-00, licenses for mental health professionals were renewable every two years and fiscal year 00-01 was not a renewal year. Similarly, information in Table 3 regarding total licenses issued for that fiscal year is abnormally low. The renewal fee for LACs and CACs is $165 every two years. The renewal fee for all other mental health professionals is $146 every two years.

Licensing has become a largely ministerial function, which is primarily handled by staff, rather than the boards. Two major exceptions to this generalization are pertinent.

First, most of the mental health programs require a period of documented, supervised practice before a candidate is permitted to sit for the relevant licensing examination. One of the licensing issues that frequently comes before the boards is candidates requesting permission to be supervised by a licensee of another mental health profession. For example, if an MFT candidate is unable to find a licensed MFT in the candidate's geographic or specialty area who is willing to supervise the candidate, but the candidate is able to find an LCSW who is willing, the MFT candidate may ask the MFT Board for permission to be supervised by the LCSW. These are decisions that the boards, not staff, make.

The second area of board involvement in licensing revolves around the schools or institutions of higher learning that award the candidates' degrees. The statutes of some of the boards, for example the Psychology Board, permit candidates from "regionally accredited" schools. There has been considerable debate surrounding the Psychology Board's previous practice of accepting graduates from California-approved schools, because these institutions frequently utilize distance learning that some claim use inadequate safeguards to ensure that the person taking examinations is truly the person to whom the degree is ultimately awarded. Therefore, some of the boards, but primarily the Psychology Board, occasionally deal with these types of issues.

Finally, the boards are somewhat unique in the fact that a single individual may hold more than one mental health credential (i.e., listing in the Database, a registration, a certificate or a license). For example, in fiscal year 01-02, 748 individuals held two credentials, 219 held three credentials and 24 held four credentials.

There are several possible explanations for this. First, since all of the licensing programs require a period of supervised practice prior to licensure, many of those being supervised must be listed with the Database in order to practice. In the year that person is licensed, that person may be reported as having two credentials: a listing in the Database and the new license.

Additionally, many licensees are also CACs or LACs. This allows them to provide ADAD-approved services in addition to their more traditional psychotherapeutic services.

Finally, some people simply qualify for and desire more than one type of license.

Examinations

The Section administers mental health programs that require some combination of three types of examinations: written professional licensing examinations; oral examinations; and, jurisprudence requirements. Table 4 illustrates summary information for all boards as to the number of candidates who have taken each over the five-year period indicated.

Table 4
Examination Information

Fiscal Year	Number of Written Examinations Given	Number of Oral Examinations Given	Number of Jurisprudence Examinations Given
97-98	625	80	95
98-99	660	95	115
99-00	692	97	124
00-01	665	88	147
01-02	584	83	151

For detailed examination information for each board, including pass rates, please see Appendices B through G, beginning on page 59.

The Psychology, Social Work, LPC and MFT Boards, and the ACP all require candidates to pass national, written examinations before issuing a registration, certificate or license, as the case may be.

The Psychology Board utilizes the Examination for Professional Practice in Psychology (EPPP), which is owned by the Association of State and Provincial Psychology Boards. The EPPP is a computerized examination consisting of 225 multiple-choice questions that must be answered within four hours and 15 minutes. It is administered six days per week by Professional Examination Service for a fee of $511.

The Social Work Board utilizes a series of examinations that are owned by the Association of Social Work Boards. The Basic Examination is used for registration as a Registered Social Worker. The Intermediate Examination is used for licensure as a Licensed Social Worker (LSW). The Advanced Examination may be used to obtain licensure as a LSW, Licensed Independent Social Worker (LISW) and Licensed Clinical Social Worker (LCSW). The Clinical Examination may be used to obtain licensure as a LCSW or LISW. Each examination consists of 170 multiple-choice questions that must be answered within four hours. The examinations are administered by American College Testing, Inc., for a fee of $175.

The LPC Board utilizes the National Counselor Examination (NCE), which is owned by the National Board for Certified Counselors (NBCC). The NCE consists of 200 multiple-choice questions that must be answered within four hours. The examination is administered four times per year by the NBCC for a fee of $120.

The MFT Board utilizes the Examination in Marital and Family Therapy (EMFT), which is owned by the Association of Marital and Family Therapy Regulatory Boards. The EMFT consists of 200 multiple-choice questions that must be answered within four hours. It is administered three times per year by Professional Examination Service for a fee of $220.

There is no examination required for initial certification or licensure as an addictions counselor. Rather, candidates must either complete ADAD-specified coursework or pass the National Certified Addictions Counselors II Examination, which consists of 250 multiple-choice questions that must be answered within four hours. Similarly, candidates for licensure must either complete the required coursework or take and pass the Masters Addiction Counselors Examination (MAC), which consists of 200 multiple-choice questions that must be completed within four hours. Both examinations have been approved by ADAD and are owned by the National Association of Alcohol and Drug Addictions Counselors. They are administered three times per year by Professional Testing Corporation. The certification examination fee is $250, and the fee for the MAC is $275.

Table 4 above also includes data regarding oral examinations. Only the Psychology Board requires candidates to pass an oral examination. Oral examinations are administered twice per year by the Psychology Board, which also develops and owns the examination.

Candidates are given approximately 30 minutes to prepare their answers to the questions that are administered, which typically number three. During any given administration of the examination, all candidates must answer the same three questions.

Candidates are given 35 minutes to answer all three questions before a panel of three licensed psychologists. Candidates may answer questions in any order and may use more time to answer one question than another, so long as the total time used does not exceed 35 minutes.

As Table B-2 in Appendix B on page 59 illustrates in greater detail, the pass rate for the oral examinations is generally in the 65 percent to 80 percent range.

On the same day as the oral examination, the Psychology Board also requires candidates to take a Psychology Board-developed, owned and administered jurisprudence examination. This jurisprudence examination consists of 30 multiple-choice questions and it is an open book examination. Questions pertain to the mental health statute.

All of the boards and the ACP require some type of jurisprudence component. By rule, the Social Work Board permits candidates to either attend a Social Work Board-approved jurisprudence workshop or to take a Social Work Board-developed, owned and administered jurisprudence examination. The social work jurisprudence examination consists of 25 multiple-choice questions and is an open-book type examination. There is no additional fee for taking this examination and it is offered once per week.

By rule, the ACP and the LPC and MFT Boards require candidates to attend board-approved jurisprudence workshops. Only the SGB has a statutory mandate to require participation in jurisprudence workshops for candidates for listing in the Database.

Workshops are provided by private individuals or organizations and typically cost between $80 and $100. Workshops must consist of at least seven clock hours of training and must address the following subject areas:

- Board Structure;
- Board Composition and Function;
- Grounds for Discipline;
- Mandatory Disclosure Statements;
- Psychotherapists' Duty to Report;
- Confidentiality and Privilege;
- Dual Relationships;
- Reporting Child/Elder Abuse and Neglect;
- Supervision and Consultation;
- General Practice Issues;
- Generally Accepted Standards of Practice; and,
- Minimum Standards for Testing.

Each jurisprudence workshop must be concluded with a provider-developed and scored examination.

Anyone seeking to provide jurisprudence workshops must submit, to the Jurisprudence Committee, an application, course curriculum, and the examination to be given at the conclusion of the workshop. The Jurisprudence Committee is composed of the chairs of the five boards and the ACAC. The Jurisprudence Committee has promulgated standards to which all jurisprudence workshop providers must adhere.

Complaints/Disciplinary Actions

The Division receives a wide variety of complaints regarding mental health practitioners. Table 5 illustrates the types and frequency of complaints during the five-year period under review.

Table 5
Complaint Information

Nature of Complaints	FY 97-98	FY 98-99	FY 99-00	FY 00-01	FY 01-02
Practicing w/o a License	25	6	9	13	22
Standard of Practice	57	62	103	109	169
Fee Dispute	0	1	1	0	6
Scope of Practice	19	14	13	17	6
Sexual Misconduct	8	2	13	4	13
Substance Abuse	4	9	3	6	3
Theft	0	0	0	0	0
Felony Conviction	1	0	3	3	1
Breach of Confidentiality	25	23	15	21	18
Biased Evaluation in Court	1	2	0	0	0
Failure to Provide Disclosure Statement	12	8	12	7	7
False/Incorrect Entries in Patient Records	8	10	4	12	1
Failure to Refer	6	2	8	3	2
Insurance Fraud	2	0	1	2	2
Inappropriate Relationship with Client	22	13	14	15	9
Inadequate Supervision	5	4	2	4	4
Inadequate Termination	2	0	4	1	3
Misrepresentation	9	4	5	5	2
Psychologically Impaired	3	3	0	1	0
Request for Records	1	0	0	2	0
Unnecessary Treatment/Tests	0	1	2	1	0
TOTAL	210	164	212	226	268

For detailed complaint information for each board, please see Appendices B through G, beginning on page 59.

Except for one case in fiscal year 00-01, and two cases in fiscal year 01-02, all complaints alleging practicing without a license involved unlicensed psychotherapists who had failed to list with the Database.

When the Section receives a complaint regarding a mental health professional, staff reviews the complaint. If it came from an individual in the custody of the Colorado Department of Corrections (DOC), staff mails the complainant a letter advising the complainant that prior to one of the boards asserting jurisdiction over the matter, the complainant must first exhaust the administrative remedies available through the DOC. These are frequently referred to as "DOC letters," and data regarding them can be found in Table 6 below.

If the complaint does not merit a DOC letter and if it is clear to staff that if proven true, the allegations in the complaint could reasonably constitute a violation of the mental health statute, staff will mail a "20-day letter" to the practitioner. This is a letter that simply advises the practitioner, also referred to as the "respondent," that a complaint has been filed, and affords the respondent 20 days in which to respond to the allegations. Once the response has been received, it is sent to the complainant, who is given 10 days in which to file a rebuttal. Once the rebuttal is received or the 10-day rebuttal period has expired, the file is forwarded to the appropriate board for further action.

Alternatively, if, when a complaint is first received, it does not merit a DOC letter and it appears to staff that the complained of activity does not constitute a violation, or that the complaint falls outside the jurisdiction of the boards, staff will place the complaint on the agenda for the appropriate board as a "case consideration." This allows the appropriate board to determine whether the case should be dismissed or whether a 20-day letter should be sent to the practitioner. Table 6 below provides information as to the number of cases that are dismissed via this process.

Once the complaint and the response are before the appropriate board, the board may refer the case to the Division's Investigations Unit for further investigation, it may dismiss the case due to lack of violation or lack of jurisdiction, or the board may take disciplinary action. If a case is referred to the Investigations Unit, the board will again review the case once the investigation is complete.

Table 6 illustrates, in summary form, the types of discipline imposed, as well as dismissals, during the five-year period indicated.

Table 6
Final Agency Actions

Type of Action	FY 97-98	FY 98-99	FY 99-00	FY 00-01	FY 01-02
Revocation	1	1	3	2	5
Surrender of License / Retirement	1	1	0	0	0
Suspension with Probation	0	0	0	4	0
Probation (no suspension) / Practice Limitation	19	12	20	13	9
Letter of Admonition	8	6	8	10	10
License Granted with Probation / Practice Limitations	0	0	0	0	0
License Denied after Hearing	0	0	0	0	1
Injunction	7	16	2	2	4
Stipulated Agreement	4	9	30	15	2
Suspension without Probation	0	0	0	0	0
TOTAL DISCIPLINARY ACTIONS	40	45	63	46	31
TOTAL DISMISSALS	165	131	178	250	242
Dismissals by Dept. of Corrections (DOC) Letter	0	0	0	0	19
Dismissals by Case Consideration (No 20-Day Letter)	0	0	26	32	42
Dismissals by Letter of Concern	N/A	19	11	25	30

For detailed information for each board, please see Appendices B through G, beginning on page 59.

For the five-year period under review, the boards received a total of 1,080 complaints and took disciplinary action on 225 (20.8 percent) of those cases. Probation with some type of practice monitoring, which very often includes continuing education as well, accounted for 34 percent of all discipline. Stipulations, which may include any number of sanctions, including cessation of practice, accounted for 26.6 percent of all disciplinary actions. Letters of admonition, which are the least severe form of discipline, accounted for 18.6 percent of all disciplinary actions.

Of the twelve revocations reported above, half were imposed by the LPC Board. Additionally, all but two of the injunctions reported were initiated by the SGB. Of these, approximately half were taken against individuals who were not listed in the Database and who had committed some other violation. For example, seven of the 14 injunctions imposed on unlisted individuals involved some sort of sexual activity with a client. Furthermore, two involved the death of a client in the now infamous rebirthing case. Of the total number of injunctions imposed during the five-year period under review, 14 involved some sort of sexual activity with clients, and only two involved alcohol and/or drug abuse.

If a board determines that a violation has occurred and that disciplinary action is warranted, the case may be referred to the Attorney General's Office (AGO) for prosecution, or it may first be referred the Section's staff for early settlement. The early settlement process (ESP) involves staff attempting to reach a settlement with the respondent within the parameters established by the relevant board. If successful, ESP typically results in a stipulation in which the respondent agrees to practice monitoring for a period of years and to take a certain amount and type of continuing education units, all in an attempt to rehabilitate the practitioner and return the practitioner to competent practice.

If ESP fails or if the appropriate board so directs, cases are referred to the AGO for the filing of charges and the institution of formal disciplinary proceedings.

It should also be noted that when a mental health practitioner is publicly disciplined, which includes letters of admonition but excludes letters of concern, such discipline must be reported to the national Healthcare Integrity and Protection Databank (HIPDB), which is maintained and operated by the U.S. Department of Health and Human Services. This can adversely affect that practitioner's ability to secure future employment and/or participation in insurance provider panels. It will very likely also cause an increase in the practitioner's malpractice insurance premiums.

All of the boards meet every two months, except the Psychology Board, which meets monthly, and the ACAC, which meets quarterly. As a result, it can take quite a while for a complaint to be resolved, as Table 7 illustrates.

Table 7
Average Time to Complaint Closure

Fiscal Year	Average Number of Days to Closure
97-98	156
98-99	309
99-00	206
00-01	221
01-02	176

For detailed information for each board, please see Appendices B through G, beginning on page 59.

Based on this information for all boards for the five-year period indicated, an average of 214 days (approximately seven months) passed between the time a complaint is received and the time final agency action is taken.

However, over the course of the five-year period under review, the average time to closure for the Psychology Board, which meets monthly, is 177 days (approximately 6 months). Thus, this differential can at least partially be attributed to the fact that the ACAC meets quarterly, and the Social Work, MFT, LPC and SGB Boards meet every other month. This essentially means that up to two months could conceivably pass before a particular board is even aware that a complaint exists.

Additionally, the boards are charged with enforcing the standards promulgated by the Division of Criminal Justice, Domestic Violence Offender Management Board (DVOMB). The DVOMB has the statutory authority to approve domestic violence offender treatment providers, who must be registered with, or certified or licensed by, one of the mental health boards, but it lacks the authority to discipline such providers. The DVOMB has also promulgated standards for the treatment of convicted domestic violence offenders, which must be followed by approved domestic violence offender treatment providers. However, the General Assembly determined that the various mental health boards were better able to take enforcement action against such practitioners. As a result, the mental health boards enforce the DVOMB-promulgated standards.

Analysis and Recommendations

During the course of this sunset review, the Department of Regulatory Agencies (DORA) solicited input from a variety of sources. A number of significant issues were presented and considered including:

- Continuation of the regulation of psychotherapy;
- Continuation of the multiple board model of regulation or replacing it with an omnibus, multidisciplinary board;
- Continuation of the director model of regulation for the Addictions Counselors Program, or replacing it with a Type I board;
- Continuation of the practice of unlicensed psychotherapy;
- The definition of "psychotherapy;"
- The definition of "social work;"
- Creation of a specific exemption from the definition of "psychotherapy," and thus from regulation, for life coaches and/or mediators;
- Continuation of the exemption from regulation, for court appointed custody evaluators, parenting coordinators, and special advocates;
- Continuation of the current composition of the mental health boards, in terms of public versus professional member ratios;
- Imposition of a mandatory continuing education requirement;
- Disciplinary discussions in open session versus closed session;
- Regulatory coordination between the Division of Registrations and the Domestic Violence Offender Management Board;
- Regulatory coordination between the Division of Registrations and the Alcohol and Drug Abuse Division;
- Continuation of the requirement that candidates attend jurisprudence workshops;
- Creation of special psychology license designations for psychologists that desire to be considered "inactive" and/or for those individuals who have earned doctorate degrees in psychology and who are actively pursuing licensure, but have not yet fulfilled the requirements for licensure;
- Creation of license portability for psychologists;
- Continuation of the Psychology Board's oral examination;
- Continuation of the regulation of school psychologists who practice outside of public schools by the State Grievance Board, rather than the Psychology Board;
- Continuation of four levels of regulation for social workers; and,
- Granting to addictions counselors, the ability to place clients on 72-hour mental health holds.

Some of these issues are discussed in the recommendations that follow. Those that are not discussed were found to have fallen outside the scope of the statutory criteria of sunset reviews.

Recommendation 1 – Continue the Boards of Psychologist Examiners, Social Work Examiners, Marriage and Family Therapist Examiners and Licensed Professional Counselor Examiners, the State Grievance Board and the Department of Regulatory Agencies' licensing and disciplinary functions relating to the Addictions Counselors Program until 2013.

The driving question in any sunset review is whether regulation is necessary to protect the health, safety or welfare of the public. Arguably, Article 43 of Title 12 of the Colorado Revised Statutes (C.R.S.), (Statute) does two things: 1) it is a title protection act for psychologists, social workers, marriage and family therapists (MFTs) and licensed professional counselors (LPCs); and, 2) it regulates the practice of psychotherapy.

Title protection, in and of itself, does not directly enhance public protection. Rather, title protection typically reserves the use of a title to those who have met certain requirements. This then aids the consumer in making a choice between a practitioner who holds a particular title and another individual who may perform the same functions, but cannot use the title. It also aids the practitioner by limiting competition from others who might otherwise advertise services using the same name.

In the case of mental health professionals, only those who have satisfied the educational, experiential, and examination requirements of the relevant boards may use the relevant titles. This aids the consumer in deciding from which type of mental health professional to seek services.

Among the mental health professionals, there is considerable overlap in terms of education, training and scope of practice. However, each profession employs relatively unique theoretical approaches. Thus, a psychologist can provide couples counseling, just as can a marriage and family therapist, but the manner in which these two mental health professionals approach clients' problems will be, in part, dictated by the theoretical maxims of the given profession.

Second, psychotherapy itself is a very intimate process. It very often entails a client sharing that client's innermost fears and vulnerabilities with the mental health professional, often at a time when the client is most vulnerable. This tends to create a relationship of unequal power, with the mental health professional in a position to exert a great deal of influence over the client. This is accomplished by virtue of the fact that a client can very easily develop an affinity for any person that is willing to listen, to validate, and to simply "be there."

As a result, the potential for harm due to exploitation of the client by the mental health professional is high. Such exploitation could take the form of a simple economic arrangement all the way up to emotional or sexual exploitation.

Importantly, the risks of harm are not merely limited to the financial and emotional realms. In April 2000, the adoptive mother of nine-year old Candace Newmaker sought the help of some therapists in Colorado. The subsequent rebirthing therapy resulted in Candace's death and the imprisonment of the therapists involved.

Finally, with respect to addictions counselors, according to the Colorado Department of Human Service, Alcohol and Drug Abuse Division (ADAD), Harvard Medical School recently completed a study that ranked Colorado as second in the nation in terms of substance abuse.

Thus, because title protection indirectly protects the public by enabling the public to more easily choose one mental health professional over another, and because the function of psychotherapy poses risks of financial, emotional and physical harm, DORA concludes that the regulation of the mental health professionals subject to the Statute serves to protect the health, safety and welfare of the public.

A second sunset criterion, however, asks whether the agency under review performs its statutory duties efficiently and effectively. Currently, the various mental health professions are regulated by five Type 1, policy autonomous boards and the Addictions Counselors Program (ACP). Prior to July 1, 1998, however, psychologists, social workers, MFTs, and LPCs each had their own licensing boards, but disciplinary functions were delegated, by statute, to the State Mental Health Grievance Board (old Grievance Board), which was composed of representatives from each of the mental health professions and the general public. During this time, addictions counselors were licensed and certified by ADAD.

In its 1997 sunset review of the old Grievance Board and the various licensing boards, DORA concluded that the old Grievance Board adequately protected the health safety and welfare of the public and recommended its continuation. However, the General Assembly instead vested in the various licensing boards the power to discipline as well.

Colorado has thus had recent experience with two different regulatory program structures. This sunset review will examine which model best protects the public and is more efficient: the old omnibus, multidisciplinary model of the old Grievance Board, or the current model of five independent boards plus the ACP.

Quantitatively, there is considerable disparity between the mental health boards. A comparison of the complaint and disciplinary data of the various boards reveals that the Board of Licensed Professional Counselor Examiners (LPC Board) imposes discipline in 12.4 percent of the complaints it receives; the Board of Psychologist Examiners (Psychology Board) 14.1 percent; the Board of Social Work Examiners (Social Work Board) 16.3 percent; the Board of Marriage and Family Therapist Examiners (MFT Board) 18.4 percent; the State Grievance Board (SGB) 25 percent; and, the ACP 41 percent. Collectively, these boards and the ACP may be referred to as the “boards” or the “mental health boards.”

However, these statistics do not paint an entirely accurate picture. Anyone can file a complaint against a mental health professional and many complaints lack merit. Thus, the quantitative analysis above needs to be supplemented with a qualitative analysis.

During the course of this sunset review, a representative from DORA attended nearly every meeting of the boards held between November 2002 and June 2003. DORA was able to observe the boards discuss the merits of every case that came before them, and deliberate as to whether a violation had occurred and, if so, what type of discipline should be imposed.

With minor exceptions, the DORA representative agreed with the decisions of the various boards. That is, there were no cases in which the DORA representative found probable cause to believe a violation occurred and the relevant mental health board dismissed a case, and vice versa.

Additionally, the difference in the frequency of the sanctions imposed between the old Grievance Board and the current boards is not significant. According to a 1997 study, the old Grievance Board imposed sanctions resulting in loss of practice in approximately 24 percent of all cases resulting in discipline. For the current boards, this figure is approximately 30 percent.

Further, the old Grievance Board imposed some type of probation in approximately 42 percent of such cases, whereas the current boards have done so in approximately 34 percent of such cases.

Finally, the most significant difference relates to the issuance of letters of admonition. The old Grievance Board issued letters of admonition in 34 percent of its discipline cases, but the current boards have done so in only 19 percent. However, this is at least partially attributable to the fact that the boards are conscious of the fact that even a letter of admonition must be reported to the U.S. Department of Human Services-administered Healthcare Integrity and Protection Databank, so they are more inclined to issue a letter of concern, which need not be reported, rather than a letter of admonition in matters involving minor violations. Additionally, the old Grievance Board did not have the authority to issue letters of concern.

As a result of these observations, DORA concludes that the mental health boards seriously debate every case that is brought before them with a keen sense of responsibility toward protecting the public. DORA further concludes that the current regulatory model of five independent boards, plus the ACP, adequately protects the public – and does so at least as well as, if not better than, the omnibus, multidisciplinary model represented by the old Grievance Board.

The question remains, however: is the current model of regulation efficient?

Under the current model, the staff of the Division of Registrations (Division), Mental Health Section (Section) must prepare for, attend and conduct follow-up duties for approximately 39 board meetings each year. Depending on the board and the number of cases to review, board meetings typically last anywhere from two to six hours. Thus a single board meeting has the potential to last all day.

The Section estimates that the Program Administrator spends approximately 30 hours each week preparing for board meetings and that Section staff spends approximately 60 percent of its time on disciplinary matters, which may include processing complaints and mailing 20-day letters, dismissal letters, letters of concern and letters of admonition, etc. With the Division's recent reorganization and hence the Section's staff reductions, from 8.0 full-time equivalent (FTE) employees to 5.0 FTE, these ratios can be expected to change.

While reverting back to an omnibus, multi-disciplinary board may help to maximize staff time because staff would then only have to prepare for 12 board meetings per year instead of 39, the number of complaints could not reasonably be expected to decrease as a result of the change in regulatory structure, so staff would continue to spend the same amount of time on complaint processing.

Additionally, an omnibus, multi-disciplinary board could result in lower expenditures, and thus, lower fees. The total budget for the old Grievance Board in fiscal year 95-96, was $632,452. In fiscal year 01-02, there were approximately 25 percent more people regulated by the mental health boards, including the ACP, than there were in fiscal year 95-96. Assuming that the agency's budget would have increased in proportion to the number of people being regulated, adding 25 percent to the fiscal year 95-96 budget would result in a budget, all other things being equal, of approximately $790,565 today. This figure is approximately $65,000 less than the fiscal year 01-02 budget for the Section.

With this tentative budget figure in mind, license fees could be expected to drop from $146 every two years to $130 every two years, representing a reduction of $16 every two years, or $8 annually.

It must be emphasized, however, that these figures represent estimates. They have not been prepared under the same rigors as would a fiscal note analysis.

From a purely monetary standpoint, an omnibus, multi-disciplinary board could arguably be more efficient than the current model. However, there are other measures of efficiency. According to the 1997 sunset review of the old Grievance Board, the average time to closure for a complaint, that is the amount of time that passed from the time a complaint was received until final disposition of that complaint, was 388 days. The average time to closure for all boards under the current model of regulation, for the period beginning fiscal year 97-98 and ending fiscal year 01-02, was 214 days. This represents an improvement of 174 days, or 55 percent.

It should be noted that the usage of averaged numbers has its limitations. For example, unusually high or low numbers can disproportionately influence the calculation of the average. The use of averaged figures in the present context is justified, however, due to the fact that the 1997 study utilized such figures.

Regardless, the improvement is surprising given that the old Grievance Board met monthly. It would not be unreasonable to presume that case files would have had a shorter time to wait to be acted upon than under the current system where most boards meet every other month.

Additionally, this fact cannot be understated. Average time to closure is an important statistic for two important reasons. First, it represents the amount of time a potentially innocent respondent must work with the specter of disciplinary action lingering about. This can have an adverse impact on that practitioner's ability to retain malpractice insurance and to participate on insurance provider panels.

Second, and more importantly, it represents the amount of time a potentially dangerous respondent may continue to practice, thus inflicting even more harm on the public.

This issue can be reduced to a single question: are 174 days (six months) per case, worth $65,000? For the reasons just articulated, DORA concludes that they are and that the current model of regulation is, surprisingly, more efficient from a public protection standpoint than the old Grievance Board.

An additional issue with the mental health boards is that of board composition. The five mental health boards are composed of three professional members and four public members. They all have public member majorities. While many mental health practitioners and professional associations argue that professional member majorities would better serve the public, DORA disagrees.

Prior to the creation of the old Grievance Board, DORA found that its predecessors, the old Psychology and Social Work Boards, which both had professional member majorities, had become protectionist, taking disciplinary action on only a handful of occasions over a 10-year period. Thus, the old Grievance Board was created.

There is also a general fear that public members become co-opted by the professional members on a board. That is, the public members cease representing the public and begin voting along with the professionals, thus defeating the purpose of public members.

However, this has not been the case with the mental health boards. To be sure, there are plenty of occasions on which the public members of the boards ask questions of the professional members. This is exactly how the system was intended to operate.

The professional members on a board are the subject-matter experts. Public members should ask them questions and should press them on their positions on various cases. On the mental health boards, this occurs on a routine basis.

Additionally, rarely are cases that come before the mental health boards so technical in nature that a layperson of average intelligence cannot understand the issues involved. In those rare cases where there is such complexity, the mental health boards have the ability to retain consultants and/or to convene advisory committees.

The public member majority on the mental health boards adequately serves to protect the public and should be continued.

Furthermore, the way in which board meetings are held has come under scrutiny. During the 2000 legislative session, the General Assembly passed Senate Bill 00-101, which effectively closed to the public the disciplinary process of the boards unless and until a notice of formal charges is served on the licensee. Prior to the passage of this bill, all board discussions and deliberations were open to the public.

DORA finds that the current process, implemented in 2000 adequately protects the public and need not be changed. In conducting this review, DORA found no instances where the closed nature of deliberations was abused by any mental health board.

Additionally, the current process is consistent with the practice of most other healthcare-related professional regulatory boards in DORA, where the intimately personal information that is revealed during the complaint process necessitates a higher degree of confidentiality in order to protect complainants.

A final issue regarding continuation of the current model of regulation merits discussion, and that is the proposal that school psychologists be licensed by and placed under the jurisdiction of the Psychology Board, or, alternatively, a new board. In either instance, the proponents of such a change have expressed their desire to continue the school psychologist-licensing program at the Colorado Department of Education (CDE).

Currently, school psychologists working as such in the state's public schools must be licensed by the CDE. School psychologists may work outside of the public schools, but need not be licensed by the CDE. If such school psychologists practice psychotherapy in the course of practicing school psychology, they must either be licensed by one of the mental health licensing boards, or they must be listed in the Grievance Board Database (Database).

The issue of whether to create a new board exclusively for school psychologists is beyond the scope of this sunset review and would be more appropriately addressed in a sunrise review. Expanding the scope of the Psychology Board to include school psychologists, however, is within the scope of this sunset review.

Under the current regulatory scheme, in order to work as a school psychologist in a public school in Colorado, an individual must be licensed as such by the CDE. An individual may work outside of the public schools as a school psychologist without a CDE-issued license. Many of these people are already licensed by the various mental health boards or are listed in the Database.

According to CDE statistics, as of August 2003, there were 971 school psychologists licensed to work in Colorado's public schools. Of these, 2 were licensed by the Social Work Board, 6 by the MFT Board, 14 by the LPC Board, 89 by the Psychology Board and 92 were listed in the Database and fell within the jurisdiction of the SGB. It is unknown how many school psychologists practice as such outside of the public schools, but are licensed by a mental health board and not by CDE.

These figures demonstrate that at least 203, or 21 percent, of CDE-licensed school psychologists desiring a mental health credential, for whatever reason, have already obtained such a credential. Since there is no requirement that CDE-licensed school psychologists inform DORA of such status upon application, this figure could be much higher.

Additionally, there is nothing to prevent a CDE-licensed school psychologist that wishes to practice outside of the public schools from doing so. Such individuals may seek additional licensure, as many have done, or they may list with the Database. Such individuals may also continue to refer to themselves as "school psychologists." Thus, there is no legal barrier preventing them from practicing.

Proponents of this issue argue, however, that the public would be better protected if the Psychology Board regulated school psychologists and that such regulation would be more prestigious.

However, the scope of practice for psychology is substantially different than that of school psychology. For one board to regulate both professions would necessitate expanding the Psychology Board to include school psychologists.

Additionally, school psychologists have admitted that they would not be qualified to sit in judgment of a psychologist and vice versa.

Because school psychologists can currently practice their profession under the current regulatory scheme, because many of them currently do so, and because no compelling argument can be made to expand the jurisdiction of the Psychology Board to specifically include school psychologists, DORA recommends maintaining the *status quo* with respect to this issue.

Because the mental health boards are doing an adequate job of protecting the public and because the current regulatory model is adequately efficient, the current model of regulation should be continued.

Since DORA is not recommending any major changes to the Statute or to the composition of the various boards, 2013 is an appropriate repeal date.

The General Assembly should continue the Boards of Psychologist Examiners, Social Work Examiners, Marriage and Family Therapist Examiners and Licensed Professional Counselor Examiners, the State Grievance Board and the Addictions Counselors Program for nine years, until 2013.

Recommendation 2 – Require each mental health board to fund itself by repealing the uniform fee requirement.

Section 12-43-204(3.5), C.R.S., requires that all initial and renewal license and Database listing fees, except for addictions counselors, be uniform. Under an omnibus, multi-disciplinary board approach to regulation, this uniform fee structure was logical.

However, since 1998, the boards have been independent of one another. They each have different numbers of individuals listed, registered, certified and licensed. They each take different numbers of disciplinary actions, thus incurring different levels of legal services expenditures. The Psychology Board meets monthly; the others meet every other month.

In almost every respect, the mental health boards are independent of one another and have their own sources of revenue (licensees) and their own, unique levels of expenditures. Yet the uniform fee structure continues.

This has unintended consequences. For example, large licensee groups, such as social workers, subsidize the regulation of smaller licensee groups, such as MFTs.

Under this example, assume that the costs associated with operating the MFT program and the social worker program are equal. Due to the uniform fee structure, an MFT pays the same license fee as a social worker. However, if each program were required to adjust its license fees to cover its own program costs, the license fees for MFTs would likely increase because a relatively low number of licensees would be paying license fees to cover the costs associated with the program. Similarly, the license fees for social workers would decrease because program costs would be spread out among a larger pool of licensees.

However, the costs associated with administering each of the mental health programs are not equal. For example, each of the mental health boards receives an annual legal services budget.

If one mental health board exhausts its legal services budget prior to the end of the fiscal year, it can "borrow" money from another mental health board's legal services budget. If the mental health boards were each self-funded and did not have a uniform fee structure, it is reasonable to conclude that in the year following the "loan" from one board to the other, the license fees for the borrower would increase in order to repay the loan. Similarly, the license fees for the lender could decrease due to the additional revenue resulting from the payback of the loan.

Under the uniform fee structure, however, this is not the case. The license fees for the borrower do not increase and the fees for the lender do not decrease. The end result is that the lender subsidizes the borrower, which is inherently unfair.

For these reasons, the General Assembly should amend section 12-43-204(3.5), C.R.S., as follows:

> The director of the division of registrations shall coordinate fee setting pursuant to this section so that all licensees, registrants, and unlicensed psychotherapists pay fees as required by this section and section 12-43-702.5(1). ~~The fees for renewal licenses or registrations for psychologists, social workers, marriage and family therapists, and professional counselors and for listing in the data base for unlicensed psychotherapists pursuant to this section shall be uniform.~~

Recommendation 3 – Amend section 12-43-702.5(4), C.R.S., and ADAD rules to eliminate the requirements for all candidates for listing in the Database and certified addictions counselors candidates to attend a jurisprudence workshop and replace such requirement with a new requirement that such candidates take and pass an open book, mail-in/take home type jurisprudence examination. Repeal the jurisprudence requirements found in Psychology Board Rule 18(d)(2)(E), Social Work Board Rule 17(c)(1), MFT Board Rule 18(d)(1), and LPC Board Rule 18(c)(1).

Section 12-43-702.5(4), C.R.S., requires, in part, all individuals listed in the Database as unlicensed psychotherapists to successfully complete "a jurisprudence workshop and corresponding examination." The jurisprudence requirements for all other mental health professionals are based on rule, rather than statute.

By rule, the Social Work Board requires candidates for registration and licensure to either take a Social Work Board-approved jurisprudence workshop or to take and pass a Social Work Board-developed jurisprudence examination. The Psychology Board requires candidates for licensure to take and pass a Psychology Board-developed jurisprudence examination on the same day as the candidates take the Board's oral examination. All other mental health boards, including the ACP, require, by rule, candidates to successfully complete a jurisprudence workshop and corresponding examination.

Section 25-1-207(1)(d), C.R.S., grants to ADAD the authority to promulgate the standards governing addictions counselors. ADAD Rule 14.310(E)(3) requires 14 clock hours of ADAD-approved ethics training. The jurisprudence workshops have been approved as satisfying a portion of this requirement. Thus, the ADAD rule represents an exercise of the authority specifically granted by statute. Thus, and for reasons that will become clear by the end of this discussion, the first part of this Recommendation 3, rather than the second part, applies to the ACP's jurisprudence requirement.

The purpose behind a jurisprudence requirement, whether it be a workshop or an examination, is to ensure that the practitioner has read the relevant practice act and is reasonably familiar with it. However, there is no evidence to suggest that such an exercise serves to enhance public protection.

Even if such evidence could be found, the system that has evolved with respect to the mental health boards does not fulfill this goal. The chairs of the various mental health boards comprise the Jurisprudence Committee. The Jurisprudence Committee has promulgated criteria to which every jurisprudence workshop must adhere before it is approved. These criteria specify the subjects to be covered in the workshop and specify that the workshop provider, not the state, develop an examination, which must also be approved by the Jurisprudence Committee. Once approved, the jurisprudence workshop provider may offer workshops to candidates for listing, registration, certification and licensing.

The problems with this system are many. First, there is the issue of consistency. Because the workshop and the examination are provider-specific, what a candidate learns and is tested on is entirely dependent upon the workshop attended.

Compounding this problem is the fact that workshops are now offered over the Internet. At least one Internet workshop consists of nothing more than reading a document prepared by the workshop provider that briefly addresses the subjects mandated by the Jurisprudence Committee. The examination for this workshop consists of emailing back to the provider answers to a series of questions.

Additionally, the purpose of the examination is an issue. In general, most examinations are intended to objectively measure an examinee's knowledge of the particular subject matter. At least one jurisprudence workshop provider, however, provides workshop participants with the examination at the beginning of the workshop so that the participants can complete the examination during the course of the workshop. While this results in less test anxiety, it does not test for actual knowledge gained.

Furthermore, because the provider designs the workshop and the examination, the examination becomes superfluous. The examination in such settings does not test what the state wants participants to know; it merely reinforces the apparent credibility of the workshop provider. In other words, the examination can be developed in conjunction with the workshop itself, thus making it nearly impossible for someone to fail the examination. This makes the provider look better to prospective students and the Jurisprudence Committee.

More importantly, however, the process tends to place greater emphasis on approving what is taught in the workshops, rather than on ensuring that candidates have learned what the state deems important for them to know. In other words, the workshop providers are held to a higher level of accountability than the candidates themselves. This is poor public policy because the state should be less concerned with how something is taught and how candidates acquire this knowledge than it is with the candidate's ability to demonstrate that the candidate has learned what the state deems to be important.

Admittedly, the live workshops provide an excellent forum for candidates to interact and debate the nuances and more subjective provisions of the Statute. However, during the course of this sunset review, a representative of DORA attended a jurisprudence workshop and found that the provider often provided bright line answers to questions that could be answered in a number of ways, depending on the particular facts of a case. The idea of interactivity also loses credibility given that "workshops" can be attended over the Internet, where there is no interaction with others.

A viable alternative to the jurisprudence workshops is to require candidates for listing in the Database and certified addictions counselor (CAC) candidates to take and pass a standardized, state-developed, jurisprudence examination. The appeal of such examinations is vast. First, consistency would no longer be an issue because every such candidate would be required to take and pass the same examination.

Second, the state would be assured that candidates who pass the examination have demonstrated knowledge in the areas the state has determined are important, not the areas the jurisprudence workshop provider has determined are important.

Third, it could save the candidates a considerable sum of money. Most jurisprudence workshops cost approximately $100. A simple examination should cost considerably less.

The cost of administering the jurisprudence examinations should also be minimal. The open-book, mail-in format envisioned by this Recommendation 3 would eliminate the need for the Section to provide a physical venue in which candidates would take the new jurisprudence examination. Additionally, discussions with the Division of Registrations, Office of Examination Services indicate that software is currently available to enable candidates to take the examinations over the Internet, thus eliminating, or at least reducing, any costs associated with the printing and/or scoring of these examinations.

For all of these reasons, section 12-43-702.5(4), C.R.S., and the appropriate ADAD rules should be amended so as to require an open-book, mail-in/take-home type jurisprudence examination, rather than participation in a jurisprudence workshop.

The second part of this Recommendation 3 relates to the various other mental health boards and their requirements for participation in jurisprudence workshops. Psychology Board Rule 18(d)(2)(E) requires the passage of a jurisprudence examination as a precondition to licensure. However, section 12-43-304(1), C.R.S., directs the Board to issue a license provided the enumerated conditions have been satisfied. Paragraph (e) of that subsection reads, "Has demonstrated professional competence by passing an examination in psychology prescribed by the board." This language requires an examination – a single examination.

The Psychology Board currently requires candidates for licensure to take and pass the national Examination for the Professional Practice of Psychology, a Psychology Board-developed and administered oral examination and a Psychology Board-developed and administered jurisprudence examination. Whereas section 12-43-304(1)(e), C.R.S., authorizes the Psychology Board to prescribe a single examination, the Psychology Board requires the passage of three examinations. This issue has been skirted by use of semantics – the Psychology Board claims that it does not require passage of three examinations, but rather requires the passage of three parts of single examination.

Social Work Board Rule 17(c)(1) requires candidates to take and pass a Social Work Board-developed jurisprudence examination, or, alternatively, to participate in a jurisprudence workshop. Section 12-43-404(1)(c), C.R.S., however, requires candidates for licensure as social workers to demonstrate "professional competence by satisfactorily passing an examination." Again, the statute requires a single examination.

Similarly, ADAD Rule 14.310(E)(3) requires 14 clock hours of ADAD-approved training on ethical issues for addictions counselors. ADAD has approved the six-hour jurisprudence workshops as satisfying a portion of this requirement.

The LPC and MFT Boards simply require, by rule, candidates to participate in board-approved jurisprudence workshops.

Thus, aside from the SGB, all of the mental health boards have imposed some type of jurisprudence requirement on candidates by rule. This is despite the fact that only the SGB is statutorily authorized to impose such a requirement. According to at least one theory of statutory construction, the fact that the General Assembly passed legislation regarding unlicensed psychotherapists and not for other mental health professionals is evidence of the General Assembly's intent that only unlicensed psychotherapists be required to attend workshops. Thus, the rule-mandated jurisprudence workshops and examinations are contrary to legislative intent.

A credible argument can also be made that, with the exception of the SGB, the boards have exceeded their statutory authority in this respect. There is nothing in the Statute, aside from the provisions relating to the SGB, upon which a credible argument can be made that the General Assembly has authorized the boards to impose a jurisprudence requirement. Indeed, the provisions regarding licensure specifically outline the conditions for licensure and go so far as to articulate the minimum age. Since there are no provisions addressing a jurisprudence requirement, the boards have clearly exceeded their statutory authority in this area.

Finally, in mandating the jurisprudence workshops, the boards, without General Assembly sanction, have created a new industry – jurisprudence workshops. It should not be the role of the state's regulatory bureaucracy to create and then maintain industries where the need for such industries is of dubious public protection value.

The ACP's jurisprudence requirement, however, stands on somewhat more stable legal ground. Section 25-1-207(1)(d), C.R.S., grants to ADAD the authority to promulgate the standards governing addictions counselors. Thus, ADAD Rule 14.310(E)(3) does not exceed statutory authority and, arguably, is not contrary to legislative intent because in passing section 25-1-207(1)(d), C.R.S., the General Assembly gave very little direction to ADAD and granted a considerable degree of discretion. Thus, the second part of this Recommendation 3 does not apply to the ACP's jurisprudence requirement. Rather, the first part of this Recommendation 3, regarding jurisprudence examinations, applies to the ACP.

Because the Psychology, Social Work, LPC and MFT Boards' rules discussed herein are inconsistent with legislative intent and because they exceed the statutory authority granted to the relevant boards, the General Assembly should, by appropriate legislative means, repeal these board rules and eliminate the need for candidates to participate in jurisprudence workshops.

At first glance, the two parts of this Recommendation 3 may appear contradictory – on the one hand, DORA recommends that candidates for listing in the Database and CAC candidates take and pass jurisprudence examinations, and on the other hand, DORA recommends that the jurisprudence requirements for the other mental health professionals be repealed entirely.

Recall, however, that candidates for licensure by examination, that is non-endorsement candidates, generally must list with the Database during their period of supervised work experience, which occurs prior to licensure. This is the period during which individuals practice psychotherapy under supervision while in pursuit of licensure. In order to comply with state law, they must list with the Database during this period because any person who practices psychotherapy and is not licensed, must list with the Database.

As a result of this recommendation, individuals seeking licensure who must list with the Database in order to practice psychotherapy under supervision will be required to take a single jurisprudence examination prior to listing in the Database. Additionally, since licensed addictions counselors typically begin their careers as CACs, they too will, at some point, be required to take a jurisprudence examination. Thus any public protection value such an examination holds will be preserved because most licensees will continue to have a jurisprudence requirement, albeit an indirect requirement.

Additionally, this recommendation is in keeping with the second sunset criteria, which asks whether existing rules represent the least restrictive form of regulation consistent with the public interest. Under the current system, a candidate for licensure as a MFT, for example, would participate in a jurisprudence workshop in order to be listed in the Database, thus enabling the candidate to begin the required supervised practice period. If more than five years pass between participation in that jurisprudence workshop and ultimate licensure, the MFT Board would require the candidate to participate in a second jurisprudence workshop. In other words, the MFT Board would accept the original jurisprudence workshop as satisfying its workshop requirement for five years. It is reasonable to conclude that a single examination is less restrictive than two, $100, six-hour workshops. Furthermore, the public protection value is arguably greater for the examination than for the workshops, for the reasons articulated in the first part of this Recommendation 3.

Finally, imposing a jurisprudence requirement on healthcare workers is not unusual. Currently, the state imposes similar requirements on 7 out of the other 15 healthcare-related professions.

For the foregoing reasons, the General Assembly should amend section 12-43-702.5(4), C.R.S., and the appropriate ADAD rules to require candidates for listing in the Database and CAC candidates to take and pass a jurisprudence examination, and the General Assembly should repeal the rules of the Psychology, Social Work, LPC and MFT Boards that require passage of a jurisprudence examination or participation in a jurisprudence workshop for the mental health professionals regulated by such boards.

Recommendation 4 – Clarify that the exemption from the Statute afforded to court-appointed mental health professionals for the purpose of custody and domestic evaluations is limited to acts and omissions made within the scope of that appointment only, and that such exemption does not exempt from the jurisdiciton of the mental health boards evaluations conducted by approved domestic violence offender treatment providers conducting court-ordered domestic violence offender treatment evaluations pursuant to section 16-11.8-101, et seq., C.R.S.

Section 12-43-215(7), C.R.S., states:

> The provisions of this article shall not apply to custodial evaluations undertaken in domestic relations cases in the courts of this state or domestic and child abuse evaluations undertaken for purposes of legal proceedings in the courts of this state.

This statutory exemption has caused a variety of problems for a number of reasons. First, the mental health boards have interpreted this exemption to cover virtually any mental health professional that is appointed by a court to conduct a parental responsibility evaluation (custody evaluation), to serve as a special advocate, or to serve as a parenting coordinator.

Section 14-10-127(1)(a)(I), C.R.S., restricts a court's ability to appoint a parental responsibility evaluator by requiring such an evaluator to be an employee of the court's probation department, an employee of any county or district social services department, or a licensed mental health professional that meets certain statutory experience criteria. Thus, mental health professionals may be appointed as parental responsibility evaluators by virtue of their license, but once appointed, they are not held accountable to that license.

Perhaps even more troubling is the issue of special advocates. Section 14-10-116(2)(b), C.R.S., defines the scope of what a special advocate's role is, but provides little, if any, guidance as to the qualifications for a special advocate. In fact, the statutory provision states that, "the special advocate may be, but need not be, an attorney." Anyone can serve as a special advocate.

Because special advocates investigate, report and make recommendations to the courts, they arguably engage in evaluations, and are thus exempt from the Statute. Compared to the parental responsibility evaluators, the argument for the special advocate exemption is a bit stronger because they are not appointed by virtue of their licenses.

However, in conducting this sunset review, DORA contacted the Colorado Supreme Court, Office of Attorney Regulation and discovered that an attorney who serves as a special advocate could be disciplined for violating the Code of Professional Conduct. Thus, an attorney who serves as a special advocate could be disciplined for misconduct, but a mental health professional that committed the very same act would not be disciplined. A double standard exists.

On the other hand, the justification for the exemption is valid. Mental health professionals who accept these appointments are thrust into situations in which one of the parties is likely to be unhappy with the outcome. In the case of special advocates, which are typically appointed post-divorce because the parties cannot work together and one or both of them petitioned the court to intervene, they are working with parties who have already demonstrated their propensity to litigate and to seek the intervention of the legal system. These can, therefore, be considered appointments that carry with them a high risk of someone complaining to a mental health board.

The roles that parental responsibility evaluators and special advocates play in the legal system are invaluable. Judges rely extensively on the recommendations made by these appointees. This is also a reason to instill greater accountability.

Problems arise when the appointee begins to engage in questionable behavior. For example, a mental health professional that served as a therapist to a family pre-divorce is subsequently appointed to serve as parental responsibility evaluator. This situation often ends in disaster as one parent alleges the mental health professional violated the confidentiality of the original therapeutic relationship in reaching conclusions as to which parent should have custody of the minor children. A parent may also allege bias on the part of the evaluator.

Another example is the mental health professional that is appointed as parental responsibility evaluator or special advocate and subsequently develops a personal relationship with one of the parties, thus losing objectivity and credibility.

The entire system was originally created based on the premise that the courts would handle misconduct on the part of appointees. However, this is not always the case, as is demonstrated by the receipt by the mental health boards of complaints against parental responsibility evaluators and special advocates filed by the courts. This makes it clear that not even the courts understand whose responsibility it is to deal with misconduct by appointees.

In the meantime, complainants, many of whom have lost custody of their children, have nowhere to turn. The judge has already ruled and the mental health boards dismiss these cases for lack of jurisdiction.

Repealing the exemption would seem a logical alternative. However, repeal is inadvisable for at least two reasons. First, these are high-risk appointments and many mental health professionals accept these appointments because they know they cannot be grieved. This has the effect of allowing them to make difficult recommendations that are in the best interests of the child even though they understand one or both of the parties will be dissatisfied. Repealing the exemption would very likely result in a diminishing pool of individuals willing to accept these crucial appointments.

Second, are the mental health boards or the appointing courts the appropriate forum for airing these grievances? The Judicial Department has appointed a task force to look at the very issues discussed in this Recommendation 4, and it is DORA's conclusion that the courts, not the mental health boards, should hear these complaints and sanction the appointees as appropriate.

However, the statutory exemption should be clarified to apply only to court-appointed evaluations and, even then, only to the mental health professional while acting within the specific confines of the appointment. This will more clearly enable the mental health boards to assert jurisdiction over a mental health professional who violates the Statute while engaging in conduct that is not specifically covered by the appointment. Thus, the exemption would not be a blanket exemption, as it is currently interpreted to be.

The second part of this recommendation is more technical in nature. Section 12-43-215(7), C.R.S., also seems to exempt mental health professionals who perform domestic violence offender treatment evaluations. This provision is in direct conflict with the statutory provisions enacting the Domestic Violence Offender Management Board (DVOMB), which is administered by the Division of Criminal Justice (DCJ). The DVOMB has promulgated a series of standards that must be complied with while approved domestic violence offender treatment providers perform post-conviction domestic violence evaluations.

This is a problem for the boards because section 16-11.8-103(4)(c), C.R.S., reads, in pertinent part,

> Notwithstanding any other law or administrative rule, the resolution of any complaint or grievance referred by the [DVOMB] pursuant to this paragraph (c) shall be based on such standards. All complaints and grievances shall be reviewed by the appropriate board pursuant to part 2 of article 43 of title 12, C.R.S., whose decision shall be based on accepted community standards as described in subparagraphs (I) and (II) of paragraph (b) of this subsection (4) and the prohibited activities as defined in section 12-43-222(1), C.R.S. The department of regulatory agencies shall provide notice of the disciplinary action to the board.

Since these two statutory provisions seem to conflict, notwithstanding the "notwithstanding" language, section 12-43-215(7), C.R.S., should be amended to clarify that the exemption provided therein does not apply to domestic violence offender treatment evaluations conducted pursuant to section 16-11.8-101, *et seq.*, C.R.S.

The General Assembly should amend section 12-43-215(7), C.R.S., to clarify that in the case of custodial evaluations, the exemption is confined to mental health professionals acting within the scope of said appointments and that such exemption does not apply to mental health professionals acting pursuant to section 16-11.8-101, *et seq.*, C.R.S.

Recommendation 5 – Amend the list of prohibited activities to include as grounds for discipline having sexual contact with a former client for two years following the conclusion of the professional relationship.

Among the list of prohibited acts for mental health professionals, as enumerated in section 12-43-222(1)(r), C.R.S., is engaging:

> in sexual contact, sexual intrusion or sexual penetration, as defined in section 18-3-401, C.R.S., with a client during the period of time in which a therapeutic relationship exists *or for up to six months after the period in which such a relationship exists;* (emphasis added)

The questionable provision of this prohibition is the requirement that a mental health professional wait only six months before engaging in a sexual relationship with a former client. In its discussions with members of the regulated community, DORA encountered a nearly unanimous belief that six months was too short of a waiting period.

Recall that one of the justifications for regulation of mental health professionals is to reduce the risk of the therapist exploiting the client due, in part, to the power differential in a therapist-client relationship.

There is a fear that after only six months, this power differential can still be very much alive and that, in most cases, the issues of transference and counter-transference that could lead to a therapist having sexual relations with a client are also still very much alive.

Furthermore, without exception, the mental health professional associations have addressed this issue in their codes of ethics. The American Psychological Association, American Counseling Association and the American Association of Marriage and Family Therapy all require their members to wait for two years after termination of the professional relationship before having sexual relations with a former client.

The National Association of Social Workers and the National Association for Alcoholism and Drug Addictions Counselors have gone even further by stating that having sexual relations with a former client, regardless of the amount of time that has passed, is never appropriate. Surprisingly, many mental health professionals believe this should be the standard for all. However, there would be adverse Constitutional implications for the state to legislate such a restriction on a practitioner's freedom of association.

Due to these conflicting statutory and ethical obligations, mental health professionals may become confused as to which standard they are expected to adhere.

On the other hand, the boards do not receive many complaints regarding this issue. Most complaints involving sexual relations occur during the professional relationship. This recommendation can, therefore, be viewed as pre-emptive. That is, the standard should be changed before there is a problem and to give mental health professionals greater consistency between state standards and the ethical responsibilities of their respective professional associations.

In order to simplify the issue and to enhance public protection, the General Assembly should require mental health professionals to wait for two years before engaging in sexual contact with a former client.

Recommendation 6 – Amend the list of prohibited activities to include as grounds for discipline the excessive or habitual use or abuse of alcohol or controlled substances.

Pursuant to section 12-43-222(1)(e), C.R.S., a mental health professional may be disciplined for being:

> Addicted to or dependent on alcohol or any habit-forming drug, as defined in section 12-22-102(13), or is habitual user of any controlled substance, as defined in section 12-22-303(7), or any alcoholic beverage;

This provision should be amended to simply prohibit the habitual or excessive use or abuse of alcohol or controlled substances, and the reference to addiction and dependency should be repealed.

In *Robinson v. California*, 370 U.S. 660 (1962), the U.S. Supreme Court held that narcotic addiction is an illness and that any state law that seeks to punish a person because of an illness violates the Eighth and Fourteenth Amendments. This holding nullifies the prohibition against addiction, so it should be repealed.

The General Assembly should repeal the prohibition against addiction and dependency to alcohol or controlled substances, and instead prohibit the excessive or habitual use of such substances.

Recommendation 7 – Enable the mental health boards to achieve a quorum and to conduct business via electronic means.

Section 12-43-203(2)(a), C.R.S., concludes by stating, "A majority of each board shall constitute a quorum at any meeting or hearing." This provision could reasonably be interpreted as requiring the physical presence of members. Another reasonable interpretation could be that members need only participate by any means, including by teleconference.

Although the boards have occasionally permitted members to participate in meetings via telephone, it is not common practice. This is understandable given the vagueness of the statutory provision. A board that achieved quorum by virtue of one member participating via telephone could have its actions challenged.

The benefits of permitting the attainment of quorum via electronic means are many. First, it could save the state money on travel-related expenses for members who do not live in the Denver Metropolitan Area, which is where most board meetings are held. For example, board members who live on the Western Slope often must fly into Denver on the day of a board meeting. The ability to attain quorum and to conduct business electronically could help to reduce these expenses.

Second, because some board members must fly in from the Western Slope, they occasionally are late to board meetings, due to flight delays, or they miss meetings altogether because flights are cancelled. The ability to attain quorum and to conduct business electronically could help to prevent this situation.

Third, it would likely enlarge the pool of people willing to serve on the mental health boards if they had the ability to participate in meetings electronically. For example, there are some parts of the state that would require a drive of several hours and then flight-time to arrive in Denver. Individuals in such rural areas have an understandable disincentive to serving on regulatory boards. However, if such individuals were permitted to attend electronically, they could be more willing to serve.

On the other hand, it can be difficult to participate in a teleconference for hours at a time. The board member on the telephone could be more easily distracted from the board's deliberations. Additionally, the board members who are physically present might forget about the member on the telephone and fail to solicit input from that member.

However, this recommendation would not mandate that boards utilize electronic conferencing. This recommendation simply advocates for the mental health boards to have the ability to do so.

Additionally, the statute should be amended so as to be broad enough to encompass all forms of electronic conferencing, such as teleconferencing, video conferencing, web conferencing, and whatever other form of technology that comes along but which is, as of yet, unimaginable.

The General Assembly should grant to the mental health boards, the permissive authority to attain quorum and to conduct business via electronic means.

Recommendation 8 – Change the timelines for appealing a letter of admonition to 30 days from the date of mailing, rather than 20 days from the date of proven receipt.

Section 12-43-224(3)(d), C.R.S., provides that letters of admonition may be appealed within 20 days of proven receipt. In practice, this requires a letter of admonition to be mailed via certified mail, return receipt requested. This is the only verifiable way to prove the date on which such letter is received.

However, letters of admonition in other regulatory programs have been returned as undeliverable or unclaimed. One possible explanation for this is that the respondent may have moved and not notified the relevant board of the new address. An additional consideration here is that state mail is not forwarded, it is returned to the relevant board as undeliverable.

A more pessimistic explanation is that the respondent simply refuses to sign for the letter, thus preventing the tolling period from beginning.

The Colorado Court of Appeals recently addressed this issue in *Colorado State Board of Medical Examiners v. Roberts*, 42 P.3d 70 (Colo. App. 2001). In *Roberts*, the court reviewed a provision in the Medical Practice Act that is substantially similar to the statute discussed here. The Board of Medical Examiners issued a letter of admonition to Dr. Roberts and mailed it to him at his place of business via certified mail, return receipt requested. However, Dr. Roberts and his staff refused to sign for the letter on two separate occasions. Three months later, Dr. Roberts requested that the Board of Medical Examiners vacate the letter of admonition and institute formal disciplinary proceedings against him. The Board of Medical Examiners refused, stating that two notices of attempted delivery by the U.S. Postal Service was sufficient to constitute receipt and begin the 20-day tolling period for requesting formal disciplinary proceedings.

Dr. Roberts and the Court of Appeals disagreed. In focusing on the plain language of the statute, the court held that "receipt" in the statute requires actual receipt.

Since the Statute contains language that is substantially similar to the statutory provision reviewed in *Roberts*, it is not unreasonable to conclude that at some point, the mental health boards may encounter a similar problem.

This Recommendation 8 attempts to expedite the disciplinary process while protecting the rights of the mental health professional. By requiring the letter of admonition to be mailed by certified mail, the relevant board will be able to establish the date on which it is mailed. To allow for delivery time, and to be consistent with other appeals timelines, the time in which a mental health professional may request formal disciplinary proceedings is extended from 20 days to 30 days.

This recommendation neither restricts nor expands the powers of the boards or the rights of mental health professionals. Rather, it attempts to correct a procedural problem that may be exacerbated by the *Roberts* decision.

The General Assembly should change the timelines for appealing a letter of admonition to 30 days from the date of mailing, rather than 20 days from the date of proven receipt.

Recommendation 9 – Repeal the requirement that the various mental health boards meet jointly, on a periodic basis.

Section 12-43-203(2)(a), C.R.S., requires the various mental health boards to hold periodic meetings in joint session "for the discussion of policies related to the regulation of psychotherapy."

Until 1998, the old Grievance Board afforded the opportunity for the various professional disciplines to come together to meet and share common issues. Following the break-up of the old Grievance Board, that forum was eliminated, so the General Assembly mandated that the individual boards periodically hold joint meetings so as to facilitate the sharing of information and ideas.

However, attendance at such meetings is not mandatory for board members. Between fiscal years 97-98 and 01-02, attendance at these meetings has fluctuated from a high of 25 to a low of 7, for an average of 15 board members per joint board meeting. Recall that with five boards of seven members each, plus four members of the ACAC, there are 39 potential attendees. Fewer than half of the board members deem joint meetings to be worth their time.

Additionally, the joint meetings have evolved to accommodate more of a presentation format, rather than the discussion of common issues. Therefore, the original goal behind mandating such meetings has not been met.

It is important to note that by repealing the requirement to meet periodically, the General Assembly would not be prohibiting the boards from meeting jointly should the need arise. They simply would not be required to do so.

Because the joint meetings are poorly attended and serve no discernable public protection function, the General Assembly should repeal the requirement that the mental health boards periodically meet in joint session.

Recommendation 10 – Repeal the requirement that the members of the various mental health boards take an oath.

Sections 12-43-302(6), -402(6), -502(6) and -602(6), C.R.S., require the members of the Psychology Board, Social Work Board, MFT Board and LPC Board to swear oaths prior to officially joining their respective boards. Evidence of these oaths must then be recorded with the Secretary of State.

Because such oaths do not provide any public protection value whatsoever and actually add slight administrative costs to the Section's staff and the staff of the Secretary of State, the General Assembly should repeal this requirement. Few, if any, other boards in DORA require an oath.

Recommendation 11 – Repeal obsolete language regarding initial board appointments and the transfer of cases from the old Grievance Board to the current boards.

Several provisions throughout the Statute should be repealed as obsolete. Specifically, certain provisions in sections 12-43-302(4), -402(3), -502(2)(c), -602(2)(c), and –702(2), (3) and (4), C.R.S., refer to initial board appointments and terms of office relating to the creation of the multiple, independent board model in 1998. These provisions are no longer necessary and should be repealed.

Additionally, section 12-43-710, C.R.S., provides for the transfer of then-pending cases from the old Grievance Board, to the various independent boards. This provision, too, is no longer needed and should be repealed.

The General Assembly should repeal all obsolete language contained in the Statute.

Recommendation 12 – Repeal Psychology Board Rule 18(d)(2)(D), which mandates the passage of an oral examination as a condition of licensure.

Section 24-34-104(9)(b)(II), C.R.S., requires DORA, in the course of conducting a sunset review, to determine, whether the current regulatory system is the least restrictive form of regulation consistent with the public interest and whether agency rules are within the scope of legislative intent.

Section 12-43-304(1), C.R.S., directs the Psychology Board to issue a license as a psychologist to each applicant who files an application; pays the required fee and furnishes evidence that he or she is at least 21 years old; is not in violation of any of the provisions of the Statute; holds a doctorate degree in psychology; has had at least one year of supervised, postdoctoral work experience; and, "has demonstrated professional competence by passing an examination in psychology prescribed by the board." This final requirement, which can be found at section 12-43-304(1)(e), C.R.S., is written in the singular – the Psychology Board may require "an examination" – a single examination.

However, by rule, the Psychology Board requires license applicants to pass the Association of State and Provincial Psychology Boards' (ASPPB's) Examination for the Professional Practice of Psychology (EPPP), a Board-developed, owned and administered oral examination, and a Board-developed, owned and administered jurisprudence examination. Applicants must have taken and passed the EPPP before sitting for the oral and jurisprudence examinations, and the oral and jurisprudence examinations are offered on the same day. This series of examinations is three distinct examinations.

The Psychology Board maintains, however, that the EPPP, the oral examination, and the jurisprudence examination are not three separate examinations, but are rather three parts of a single examination.

The Psychology Board's position is simply an argument based on semantics, rather than logic. The EPPP is a written examination owned by the ASPPB. It consists of 225 multiple-choice questions. It is administered by Professional Examination Service (PES) six days per week at PES' test sites. Examination fees are paid directly to PES.

The jurisprudence examination, on the other hand, is owned by the Psychology Board and consists of 30 multiple-choice questions. It is administered by the Psychology Board two times per year and in conjunction with the oral examination.

The oral examination is also owned and administered by the Psychology Board. It generally consists of three questions. Examinees are given a fact pattern and then asked to address specific practice area aspects relevant to the fact pattern. Examinees verbalize their responses to panels composed of three licensed psychologists, and accumulate points for touching upon various issues in their responses.

Examination fees for both the jurisprudence and oral examinations are paid directly to the Psychology Board.

Thus, the various "parts" of the Psychology Board examination are owned and administered by different entities and are administered at different times.

It is therefore reasonable to conclude that the Psychology Board examination is, in reality, three distinct examinations. This means that in mandating passage of such examinations, the Psychology Board has exceeded its statutory authority to prescribe a single examination.

Additionally, the public protection value of the oral examination is dubious. In conducting this sunset review, DORA met with the Director of the Division's Office of Examination Services (OES). OES has been conducting statistical analyses of the Psychology Board's examination for several years, and based on these analyses, OES has concluded that there is no statistically significant association between how well someone does on the EPPP and how well that same person does on the oral examination. While the lack of a significant correlation (positive or negative) typically indicates that different constructs may be assessed by the two instruments, the identification and interpretation of the differing dimensions and their relationship to public safety is much less clear. Thus, it is impossible to conclude whether the oral examination adds to the public protection value of the examination process.

The questionable effectiveness of the oral examination in the Psychology Board's mission to protect the public also raises the question of whether the examination process is the least restrictive form of regulation consistent with the public interest. Since the public protection value of the oral examination is questionable, requiring candidates to pass such an examination is unduly restrictive. The public can be protected in a less restrictive manner without the Psychology Board's oral examination.

Finally, during the course of this review, DORA representatives were able to observe the orientation session of the oral examination that was presented to the examination panels in June 2003. Examination panels consist of three psychologists who grade the examinees on the responses of the examinees.

The Psychology Board has made every effort to make the oral examination process as objective and as defensible as possible. And for this, the Board deserves a tremendous amount of credit.

However, at the orientation session that DORA observed, instructions to panel members made it clear that it is the responsibility of panel members to infer a considerable amount of information from examinees. For example, examinees are not necessarily required to say specific words to receive credit for a correct response to a question. Rather, if a panel member determines that what the examinee said is reasonably close to the required response, the examinee receives credit. However, if another panel member concludes differently, the examinee may not receive credit. Thus, the grading is necessarily infused with a degree of subjectivity.

Additionally, this particular orientation session was wrought with confusion when one of the examination questions was discussed. Specifically, some panel members persuaded the two Board members that led the orientation session, that two required responses on one examination question were so similar, that one of them should be dropped. A few minutes later, the Board members reversed themselves and it was not at all clear whether all of the panel members in the room were aware of the reversal.

Despite the Board's best efforts to develop and administer an objective and defensible examination to better enhance public protection, DORA concludes that the Psychology Board's oral examination is seriously flawed and its administration should be ceased.

Because the oral examination exceeds the Board's statutory authority, because the oral examination is of questionable public protection value, because the oral examination is overly restrictive, and because the oral examination process is flawed by its inherent subjectivity, the Psychology Board should immediately cease requiring passage of it as a condition for licensure and the General Assembly should repeal, by use of the appropriate legislative mechanisms, Psychology Board Rule 18(d)(2)(D).

Recommendation 13 – Repeal the direct regulation of Registered Social Workers, Licensed Social Workers and Licensed Independent Social Workers by the Board of Social Work Examiners and attach title protection for "social worker" to the attainment of a Master's of Social Work or higher degree.

One of the primary questions in any sunset review is whether current regulation establishes the least restrictive form of regulation consistent with the public interest. This question is particularly relevant when discussing the regulation of social workers.

Section 12-43-404, C.R.S., mandates four levels of regulated social work practice: Registered Social Worker (RSW); Licensed Social Worker (LSW); Licensed Clinical Social Worker (LCSW) and Licensed Independent Social Worker (LISW). The primary differences between these various levels of regulation are educational background and the authority to practice independently. For example, an RSW must hold at least a bachelor's degree in social work and may practice social work only under the supervision of a LCSW or LISW. Similarly, an LSW must hold at least a master's degree in social work and may practice social work only under the supervision of a LCSW or LISW.

The distinction between LCSW and LISW is less clear, however. Both levels require the licensee to hold at least a master's degree in social work, and candidates for either license must take the Association of Social Work Boards' Advanced or Clinical Examination. Both levels of licensure authorize the licensee to practice independently, that is, without supervision, and authorize the licensee to supervise RSWs and LSWs.

The primary difference between the LISW and LCSW is practice. LCSWs practice direct social work, which can most easily be described as psychotherapy. An LISW, on the other hand, does not practice psychotherapy, but rather engages in indirect practice, which can be characterized as advocacy, administration, community services, public policy, etc. Thus, there is no public protection argument to be made in favor of retaining the LISW level of licensure, because they do not directly engage clients.

Importantly, only individuals who hold a RSW, LSW, LCSW or LISW may refer to themselves as "social worker." Thus, title protection has been tied to regulation.

This does not necessarily have to be the case, however. An individual that holds a Psy.D. or a Ph.D. in psychology may use the title "psychologist" so long as that individual is not engaged in the clinical practice of psychology, but rather is involved in teaching, administration, etc. If a psychologist is practicing clinically, that psychologist must be licensed as a psychologist in order to use the title, "psychologist." Thus, title protection for psychologists is tied to the degree and not directly to the license.

Additionally, Missouri recently passed legislation affecting the title protection aspects of its regulation of social workers. Missouri has two primary levels of licensure for social workers: LCSW and Licensed Baccalaureate Social Worker (LBSW). Only individuals duly licensed as either may use such titles. The Missouri practice act, however, is silent as to the use of the title, "social worker."

This Recommendation 13 has two parts that work together. First, the General Assembly should sever protection of the title "social worker" from licensure and attach it to the degree of master's degree in social work or higher. This will enhance public protection by allowing only those individuals who have earned graduate degrees to use the title, regardless of whether they are licensed. Although it is impossible to estimate their numbers, there are a great many individuals who have earned the master's degree in social work and work for departments of human services around the state, but because they work for state agencies, they are not required to be licensed. Anecdotally, many of these individuals use the title "social worker" in violation of the Statute. This part of the recommendation would permit these individuals to legally use the title and would alert the public to the fact that anyone calling himself/herself a social worker has attained either a master's or a doctoral degree in social work.

Second, the General Assembly should repeal all of the levels of regulation for social workers except for the LCSW, but the licensure requirements for the LCSW should not be changed. Individuals pursuing licensure as an LCSW should continue to be required to obtain supervised work experience and that supervision should be provided by a LCSW.

The number of regulated individuals impacted by such a change would be minimal and, importantly, their ability to practice would not be inhibited. According to Social Work Board statistics, in fiscal year 01-02, there were 242 LSWs and only 22 RSWs.

Due to the title protection change recommended in the first part of this Recommendation 13, an LSW could continue to use the title "social worker" and could continue to engage in clinical practice. If that individual seeks licensure as a LCSW, that individual would need to be supervised by an LCSW, just as is the case now. The change is that prior to licensure, that individual would be required to be listed in the Database and would come under the jurisdiction of the SGB, just as candidates for licensure as psychologists, LPCs and MFTs currently do. If the individual did not seek licensure as a LCSW, that individual would simply continue to fall under the jurisdiction of the SGB.

The situation for the RSW, however, is slightly different. An individual holding an RSW is only required to have earned a bachelor's degree in social work, so, according to the new title protection provisions recommended herein, such an individual may not be entitled to use the title, "social worker." However, such individuals could continue to engage in clinical practice by listing with the Database. Additionally, there is nothing to prevent such an individual from retaining a LCSW supervisor. Although such supervision would not necessarily lead to licensure, it may add to the prestige and quality of the individual's practice.

The LISW level of licensure would also be repealed under this recommendation. However, since the requirements for licensure for LISW are virtually identical to those for the LCSW, those LISWs that wish to transition to the LCSW designation should have little or no difficulty in doing so. Additionally, according to Social Work Board statistics, in fiscal year 01-02, there were only 44 LISWs.

The purpose behind all of this is relatively simple. The current regulatory scheme of four levels of licensure, two requiring supervision, two not requiring supervision, is confusing, both to the public and to practitioners. During the course of this review, DORA spoke with many social workers of all levels, and most of them indicated that they themselves did not truly understand all of the distinctions between the various levels.

It is also an inefficient use of state resources to maintain the RSW and LISW levels of regulation when the numbers for each level are so low. This is particularly true in light of the fact that between fiscal years 97-98 and 01-02, all but two of the complaints received by the Social Work Board were lodged against LCSWs. In other words, few to no complaints have been lodged against RSWs, LSWs or LISWs -- further bolstering the proposition that direct regulation of such individuals is an inefficient use of state resources.

Additionally, no other mental health profession, except for addictions counselors, has multiple levels of regulation. An individual with a master's degree in professional counseling or marriage and family therapy that has not yet satisfied the supervised work experience requirement must list with the Database. This is also true for an individual holding a Psy.D. or a Ph.D. in psychology. Only the Social Work Board is authorized to regulate various levels of individuals engaging in social work and there is no compelling reason as to why this is necessary to protect the public.

Indeed, it has been argued that the current regulatory scheme is detrimental to the public because it is so confusing. This Recommendation 13 would help to eliminate this confusion by creating, *de facto*, two levels of social worker, licensed and non-licensed. Licensed social workers, the LCSWs, would be regulated by the Social Work Board. Non-licensed social workers would be regulated by the SGB if they choose to practice psychotherapy, just like all other unlicensed psychotherapists. Thus, the proposed regulatory scheme would be less restrictive than the current model of regulation.

In order to regulate social workers in a less restrictive manner while at the same time reducing confusion among the public and enhancing public protection, the General Assembly should detach protection of the title, "social worker" from licensure and attach it to the attainment of a master's degree in social work or higher degree, and repeal all levels of social work regulation except for the LCSW.

Recommendation 14 – Require social workers that work in licensed hospitals and that practice psychotherapy to provide their clients with the disclosures mandated by section 12-43-214(1), C.R.S.

Section 12-43-214(1), C.R.S., mandates that, unless otherwise exempted, all mental health professionals must provide clients with a mandatory disclosure statement that sets forth the practitioner's name, business address, and business phone number; all degrees, credentials and licenses; a statement that the mental health professional is regulated by DORA and DORA's address and phone number; a statement indicating that the client is entitled to receive information regarding the therapeutic techniques employed by the practitioner; a statement that the client is entitled to seek a second opinion; and, a statement that sexual intimacy is never appropriate in a therapeutic relationship and that such conduct should be reported.

Section 12-43-214(4)(f), C.R.S., exempts from this disclosure requirement social workers practicing in Colorado Department of Health and Environment-licensed or certified hospitals. No similar exemption exists for other mental health professionals that practice in such hospitals.

This exemption was originally based on the idea that most social workers practicing social work in hospitals were: 1) employees of the hospital, and thus covered by the confidentiality and other provisions of the hospital; and, 2) not providing psychotherapeutic services, but were rather engaged in non-psychotherapeutic activities, such as post-discharge care planning. This is no longer necessarily the case.

Many social workers, like psychologists, LPCs, etc., practice psychotherapy in hospitals and are not employees of those hospitals. Rather, like many physicians, they bill clients for their services directly because they are "on staff" at the hospital, meaning, essentially, that they are independent contractors at the hospital.

Additionally, many social workers, but certainly not all, practice psychotherapy in hospitals and are employees of those hospitals. In general, mental health professionals are required to provide mandatory disclosure forms to clients in order to inform the clients of the clients' rights. These reasons are just as valid for a social worker practicing psychotherapy in a hospital as they are for an MFT practicing psychotherapy in a hospital, regardless of the entity for which the psychotherapist works.

This recommendation addresses the social worker that practices psychotherapy in a licensed hospital. The exemption for social workers engaged in non-psychotherapeutic activities should be retained.

The General Assembly should amend section 12-43-214(4)(f), C.R.S., as follows:

> (f) By a social worker ~~practicing~~ NOT ENGAGED IN PSYCHOTHERAPEUTIC ACTIVITIES in a hospital that is licensed or certified under section 25-1-107(1)(l)(I) or (1)(l)(II), C.R.S.

Recommendation 15 – Amend statutory provisions regarding the listing of unlicensed psychotherapists in the Database to provide for a traditional registration program and permit such practitioners to refer to themselves as "Registered Psychotherapists."

In principal, there are three basic forms of professional regulation: registration, certification and licensure. In the case of the mental health boards, all three forms of regulation are represented: psychologists, social workers, LPCs, MFTs and licensed addictions counselors are licensed; CACs are certified; and social workers are registered. Notably, and from a purely legal perspective, unlicensed psychotherapists are not licensed, certified or registered; they are listed. However, the status of unlicensed psychotherapists is one of mere semantics.

At one end of this regulatory spectrum are licensing programs. Candidates for licensure typically are required to have attained a certain level of education, demonstrate a certain amount of experience and/or pass an examination. All of this is intended to demonstrate that the licensee is minimally competent.

At the other end of the regulatory spectrum are registration programs. Typically, the goal of a registration program is simply to enable the state to know who is engaging in a particular activity/occupation. This often takes the form of the registrant providing his/her name and contact information to the state. In some cases, registrants may also be required to satisfy other, relatively minimal requirements, but these requirements rarely involve any showing of competency.

In order to be listed in the Database, an unlicensed psychotherapist must submit his/her name, current address, educational qualifications, disclosure statements, therapeutic orientation or methodology, and years of experience. Additionally, candidates for listing must complete a SGB-approved jurisprudence workshop.

The jurisprudence workshops simply seek to familiarize candidates with the Statute. Furthermore, the required submissions are for informational purposes only; there are no minimal education requirements for listing in the Database and unlicensed psychotherapists may subscribe to any therapeutic orientation or methodology they choose. Provided a candidate satisfies all of these requirements, the SGB lacks the authority to deny listing such candidate in the Database. Thus, the entire Database listing scheme possesses all of the hallmark elements of a registration program.

However, section 12-43-702.5(3), C.R.S., specifically prohibits unlicensed psychotherapists from referring to themselves as "registered." Originally, this prohibition was enacted out of a fear that use of the term "registered" would somehow convey the idea that the state recommended such therapists. However, use of the term "licensed psychologist" does not convey the idea that the state recommends the services of a particular psychologist, it simply acknowledges the legal reality that such an individual is a licensed psychologist. It is unreasonable to conclude that use of the term "registered psychotherapist" would somehow convey more than the fact that the practitioner is registered. Thus, the fear behind the prohibition of using the term "registered psychotherapist" is unfounded.

Additionally, one of the sunset criteria directs DORA to explore whether statutory changes are necessary to improve agency operations. Due to the uniqueness of the current Database listing scheme and its prohibition on using the term "registered," the Division is effectively barred from using many of its standardized forms and processes. For example, most professionals that are regulated by the Division's various boards and programs, whether they be licensed or registered, receive standardized cards that state their name and the period for which such licenses or registrations are valid.

However, because of the prohibition against using the term "registered," the Division must send practitioners who are listed in the Database a letter that states that their listings are current. The Division cannot use its standard certificate of registration.

The General Assembly should repeal the prohibition against unlicensed psychotherapists referring to themselves as "registered psychotherapists" because the Database listing program is, in fact, a registration program and because it will allow the Division to operate more efficiently.

Administrative Recommendation 1 – The boards and the Domestic Violence Offender Management Board in the Division of Criminal Justice should work towards developing a memorandum of understanding regarding the processing of all complaints involving domestic violence offender treatment providers that are approved pursuant to section 16-11.8-101, et seq., C.R.S.

The Domestic Violence Offender Management Board (DVOMB), created in section 16-11.8-103(1), C.R.S., is authorized to promulgate standards for the treatment and management of convicted domestic violence offenders and to approve mental health professionals to provide such treatment and management when appropriately ordered by the courts of this state. Importantly, DVOMB-approved treatment providers must be mental health professionals that are regulated by one of the mental health boards. However, the DVOMB is not authorized to discipline approved providers when they violate the DVOMB-promulgated standards.

Rather, these responsibilities have been delegated to the mental health boards. Section 16-11.8-103(4)(c), C.R.S., reads, in pertinent part,

> Notwithstanding any other law or administrative rule, the resolution of any complaint or grievance referred by the [DVOMB] pursuant to this paragraph (c) shall be based on such standards. All complaints and grievances shall be reviewed by the appropriate board pursuant to part 2 of article 43 of title 12, C.R.S., whose decision shall be based on accepted community standards as described in subparagraphs (I) and (II) of paragraph (b) of this subsection (4) and the prohibited activities as defined in section 12-43-222(1), C.R.S. The department of regulatory agencies shall provide notice of the disciplinary action to the board.

Since the DVOMB was created in 2000, approximately 27 complaints involving approved domestic violence offender treatment providers have been filed with the mental health boards. Letters of admonition were issued in two of these cases for violation of the DVOMB standards. Letters of concern were issued in five cases, but not for anything having to do with the DVOMB standards. Finally, there were two revocations, which were based on grounds other than violation of the DVOMB standards.

Since October 2001, the mental health boards and the DVOMB have had an arrangement whereby the staff of the mental health boards would solicit input from the staff of the DVOMB on cases involving approved domestic violence offender treatment providers. The staff of the DVOMB alleges that it has not been kept informed as to the status of many of these cases and, in some situations, it has not been informed of the final dispositions of the cases. The staff of the mental health boards has alleged that it has lived up to the terms of the agreement with the DVOMB and that those cases in which the DVOMB was not kept informed did not involve violation of the DVOMB standards.

As part of this review, DORA reviewed all 27 case files involving approved domestic violence offender treatment providers and finds that arguments put forth by the DVOMB and the mental health boards have merit. Additional evidence of this is the fact that the two agencies provided conflicting data to DORA as to the number of complaints involved and the discipline involved.

Several files contained documentation evidencing the fact that DVOMB-input was solicited but not provided. Still other files contained no evidence that the DVOMB was ever contacted, let alone solicited for input.

Some cases involved the DVOMB standards, while other cases clearly did not, thus obviating the apparent need or propriety for soliciting input from the DVOMB.

Primarily, however, the review of these case files and DORA's discussions with staff from the DVOMB and the mental health boards reveals that the agencies simply have a communications problem. The DVOMB has expressed a great deal of frustration at not being kept informed of the status of complaints involving its approved providers. The mental health boards have also expressed frustration over the fact that not every case involving an approved provider necessarily involves the DVOMB standards, in which case the DVOMB should not be notified of a complaint, let alone apprised of its disposition, unless such disposition results in a cessation of practice.

Additionally, the concluding sentence of section 16-11.8-103(4)(c), C.R.S., states, "The department of regulatory agencies shall provide notice of the disciplinary action to the board." Any reasonable interpretation of this provision would lead to the conclusion that the mental health boards are statutorily required to inform the DVOMB of dispositions only. The mental health boards are not statutorily required to solicit or receive input from the DVOMB regarding complaints.

However, since the DVOMB has an understandable interest in the outcome of complaints involving its approved providers and because the staff of the DVOMB has a greater technical knowledge of the DVOMB standards, the DVOMB and the mental health boards should negotiate a mutually agreeable memorandum of understanding to formalize when information should be exchanged and the manner in which such exchanges should take place.

Appendix A – Sunset Statutory Evaluation Criteria

(I) Whether regulation by the agency is necessary to protect the public health, safety and welfare; whether the conditions which led to the initial regulation have changed; and whether other conditions have arisen which would warrant more, less or the same degree of regulation;

(II) If regulation is necessary, whether the existing statutes and regulations establish the least restrictive form of regulation consistent with the public interest, considering other available regulatory mechanisms and whether agency rules enhance the public interest and are within the scope of legislative intent;

(III) Whether the agency operates in the public interest and whether its operation is impeded or enhanced by existing statutes, rules, procedures and practices and any other circumstances, including budgetary, resource and personnel matters;

(IV) Whether an analysis of agency operations indicates that the agency performs its statutory duties efficiently and effectively;

(V) Whether the composition of the agency's board or commission adequately represents the public interest and whether the agency encourages public participation in its decisions rather than participation only by the people it regulates;

(VI) The economic impact of regulation and, if national economic information is not available, whether the agency stimulates or restricts competition;

(VII) Whether complaint, investigation and disciplinary procedures adequately protect the public and whether final dispositions of complaints are in the public interest or self-serving to the profession;

(VIII) Whether the scope of practice of the regulated occupation contributes to the optimum utilization of personnel and whether entry requirements encourage affirmative action;

(IX) Whether administrative and statutory changes are necessary to improve agency operations to enhance the public interest.

Appendix B – Program Information Tables for the Board of Psychologist Examiners

Table B-1
Licensing Information

	Number of Licenses			
Fiscal Year	**Exam**	**Endorsement**	**Renewal/ Reinstatement**	**TOTAL**
97-98	67	23	1,655	**1,745**
98-99	66	25	1,764	**1,855**
99-00	73	21	1,877	**1,971**
00-01	56	19	4*	**2,046**
01-02	62	34	1,909	**2,005**

* Effective fiscal year 99-00, the mental health boards began renewing licenses every two years, rather than annually. The licenses indicated here represent reinstatements.

Table B-2
Examination Information

FISCAL YEAR	NUMBER OF WRITTEN EXAMS GIVEN EPPP & JURISPRUDENCE	PASS RATE (%)	NUMBER OF ORAL/PRACTICAL EXAMS GIVEN	PASS RATE (%)
97-98	EPPP - October 1997 = 23 EPPP - April 1998 = 46 Jurisprudence = 95	73% 82% 93%	Dec. 1997= 42 June 1998 = 38	81% 79%
98-99	EPPP - October 1998 = 29 EPPP - April 1999 = 68 Jurisprudence = 115	62% 63% 98%	Dec. 1998 = 52 June 1999 = 43	75% 65%
99-00	EPPP - October 1999 = 39 EPPP - April 2000 = 64 Jurisprudence = 90	72% 84% 91%	Dec. 1999 = 47 June 2000 = 50	70% 74%
00-01	EPPP - October 2000 = 31 EPPP - April 2001 = 45 Jurisprudence = 104	61% 73% 95%	Dec. 2000 = 41 June 2001 = 47	59% 66%
01-02	EPPP - October 2001 = 23 EPPP - Computer-based = 12 Jurisprudence = 115	87% 83% 96%	Dec. 2001 = 47 June 2002 = 36	66% 78%

Table B-3
Complaint Information

Nature of Complaints	FY 97-98	FY 98-99	FY 99-00	FY 00-01	FY 01-02
Practicing w/o a License	0	0	0	1	0
Standard of Practice	20	22	33	21	24
Fee Dispute	0	0	1	0	2
Scope of Practice	2	3	3	4	4
Sexual Misconduct	0	0	1	1	3
Substance Abuse	0	2	0	0	0
Felony Conviction	0	0	0	0	0
Breached Confidence	8	5	2	10	10
Biased Evaluation in Court	1	1	0	0	0
Failed to Provide Disclosure	2	4	2	3	2
False/Incorrect Entries in Pt. Records	3	5	2	8	1
Failure to Perform Referral	2	2	3	2	0
Insurance Fraud	1	0	1	1	1
Inadequate Psychotherapy Services	1	0	0	0	0
Inappr. Relationship w/Client	5	3	0	3	1
Inadequate Supervision	2	0	1	2	1
Inadequate Termination	0	0	1	1	1
Medicaid Fraud	0	0	0	1	0
Misrepresentation	1	1	0	1	0
Psychologically Impaired	2	1	0	0	0
Request for Records	1	0	0	1	0
Unnecessary Treatment/Tests	0	1	1	1	0
TOTAL	**51**	**50**	**51**	**61**	**50**

Table B-4
Final Agency Actions

Type of Action	FY97-98	FY98-99	FY99-00	FY00-01	FY01-02
Revocation	0	0	0	1	1
Surrender of License/Retirement	0	0	0	0	0
Suspension with Probation	0	0	0	1	0
Probation (no suspension)/Practice Limitation	2	4	0	0	2
Letter of Admonition	1	1	0	5	2
License Granted with Probation/Practice Limitations	0	0	0	0	0
License Denied after Hearing	0	0	0	0	0
Injunctions/Cease & Desist Orders	0	0	0	0	0
Stipulated Agreements	2	4	5	5	1
Suspension without Probation	0	0	0	0	0
TOTAL DISCIPLINARY ACTIONS	**5**	**9**	**5**	**12**	**6**
TOTAL DISMISSALS	***44***	***36***	***44***	***64***	***43***
Dismissals by Dept. of Corrections Letter	0	0	0	0	1
Dismissals by Case Consideration (No 20-Day Letter)	0	0	9	6	15
Dismissals by Letter of Concern	N/A	3	1	10	7

Table B-5
Average Time to Closure

Fiscal Year	Number of Days
97-98	99
98-99	177
99-00	179
00-01	204
01-02	225
Average for Period	**177**

Appendix C – Program Information Tables for the Board of Social Work Examiners

Table C-1
Licensing Information

	Number of Licenses			
Fiscal Year	**Exam**	**Endorsement**	**Renewal/ Reinstatement**	**TOTAL**
97-98	CSW 167	NOT AVAILABLE	**2426**	**2593**
98-99	RSW 0 LSW 15 LISW 1 LCSW 146	RSW 1 LSW 13 LISW 1 LCSW 69	RSW 0 LSW 2 LISW 0 LCSW 2426	RSW 1 LSW 30 ISW 2 LCSW 2641 **2674**
99-00	RSW 3 LSW 61 LISW 3 LCSW 134	RSW 1 LSW 17 LISW 7 LCSW 43	RSW 0 LSW 4 LISW 0 LCSW 2578	RSW 4 LSW 82 LISW 10 LCSW 2755 **2851**
00-01	RSW 4 LSW 53 LISW 0 LCSW 137	RSW 1 LSW 21 LISW 15 LCSW 70	RSW 10 LSW 109 LISW 22 LCSW 2618	RSW 15 LSW 183 LISW 37 LCSW 2825 **3060**
01-02	RSW 3 LSW 33 LISW 0 LCSW 159	RSW 4 LSW 25 LISW 7 LCSW 81	RSW 15 LSW 184 LISW 37 LCSW 2684	RSW 22 LSW 242 LISW 44 LCSW 2924 **3232**

Table C-2
Examination Information

Fiscal Year	Number of Written Examinations Given		Pass Rate (%)	Number of Jurisprudence Examinations Given	Pass Rate (%)
97-98	Advanced CSW	15 169	53% 81%	NOT AVAILABLE	
98-99	BASIC INTERMEDIATE ADVANCED CLINICAL	4 6 14 165	66% 100% 42% 67%	NOT AVAILABLE	
99-00	BASIC INTERMEDIATE ADVANCED CLINICAL	1 45 1 192	100% 94% 50% 67%	34	94%
00-01	BASIC INTERMEDIATE ADVANCED CLINICAL	1 35 1 172	100% 77% 100% 84%	43	93%
01-02	BASIC INTERMEDIATE ADVANCED CLINICAL	1 15 0 189	100% 73% 0 71%	36	96%

Table C-3
Complaint Information

Nature of Complaints	FY 97-98	FY 98-99	FY 99-00	FY 00-01	FY 01-02
Practicing w/o a License	0	0	0	0	0
Standard of Practice	12	10	22	24	17
Fee Dispute	0	1	0	0	4
Scope of Practice	5	4	1	1	1
Sexual Misconduct	2	0	0	0	0
Substance Abuse	0	1	1	1	1
Felony Conviction	0	0	0	0	0
Breached Confidence	9	6	1	2	6
Biased Evaluation in Court	0	1	0	0	0
Failed to Provide Disclosure	2	0	3	0	2
False/Incorrect Entries in Pt. Records	0	2	1	0	0
Failed to list in Database	4	0	0	0	0
Failure to Perform Referral	1	0	3	1	2
Insurance Fraud	1	0	0	0	0
Inadequate Psychotherapy Services	0	0	2	0	0
Inappr. Relationship w/Client	5	4	3	3	1
Inadequate Supervision	0	2	1	2	3
Inadequate Termination	0	0	1	0	2
Misrepresentation	0	0	0	0	0
TOTAL	**41**	**31**	**39**	**34**	**39**

Table C-4
Final Agency Actions

Type of Action	FY 97-98	FY 98-99	FY 99-00	FY 00-01	FY 01-02
Revocation	1	0	0	1	0
Surrender of License / Retirement	0	1	0	0	0
Suspension with Probation	0	0	0	1	0
Probation (no suspension) / Practice Limitation	2	1	4	3	1
Letter of Admonition	0	5	1	2	1
License Granted with Probation / Practice Limitations	0	0	0	0	0
License Denied after Hearing	0	0	0	0	0
Injunction	1	1			
Stipulated Agreement	0	0	2	2	0
Suspension without Probation	0	0	0	0	0
TOTAL DISCIPLINARY ACTIONS	**4**	**8**	**7**	**9**	**2**
TOTAL DISMISSALS	***35***	***30***	***26***	***30***	***24***
Dismissal by Dept. of Corrections Letter	0	0	0	0	2
Dismissal by Case Consideration (No 20-Day Letter)	0	0	9	6	6
Dismissal by Letter of Concern	N/A	5	7	0	2

Table C-5
Average Time to Closure

Fiscal Year	Number of Days
97-98	167
98-99	219
99-00	289
00-01	299
01-02	181
Average for Period	**231**

Appendix D – Program Information Tables for the Board of Marriage & Family Therapist Examiners

Table D-1
Licensing Information

	Number of Licenses			
Fiscal Year	**Exam**	**Endorsement**	**Renewal/ Reinstatement**	**Total Active Licenses**
97-98	27	18	326	**371**
98-99	24	17	377	**418**
99-00	32	14	411	**457**
00-01	26	18	7*	**462**
01-02	22	12	458	**492**

* Effective fiscal year 99-00, the mental health boards began renewing licenses every two years, rather than annually. The licenses indicated here represent reinstatements.

Table D-2
Examination Information

FISCAL YEAR	NUMBER OF WRITTEN EXAMS	PASS RATE (%)
97-98	21 10	71 70
98-99	14 21	64 76
99-00	25 24	76 75
00-01	19 8	79 63
01-02	12 5	92 80

Table D-3
Complaint Information

Nature of Complaints	FY97-98	FY98-99	FY99-00	FY00-01	FY01-02
Practicing w/o a license	0	0	0	0	0
Standard of Practice	0	0	6	7	13
Fee Dispute	0	0	0	0	0
Scope of Practice	0	0	0	0	0
Sexual Misconduct	0	0	0	0	0
Substance Abuse	0	0	0	0	0
Felony Conviction	0	0	0	1	0
Practicing Beyond Scope of Training/Experience	1	0	0	0	0
Failure to Provide Disclosure	1	0	0	0	0
Failure to Refer Client	1	0	0	0	0
Breach of Confidentiality	0	1	0	2	0
Inappropriate Relationship	0	1	1	0	1
Inadequate Supervision	0	1	0	0	0
Physical Abuse	0	0	1	0	0
TOTAL	**3**	**3**	**8**	**10**	**14**

Table D-4
Final Agency Actions

Type of Action	FY97-98	FY98-99	FY99-00	FY00-01	FY01-02
Revocation	0	0	0	0	0
Surrender of License/Retirement	0	0	0	0	0
Suspension with Probation	0	0	0	0	0
Probation (no suspension) Practice Limitation	0	0	0	0	0
Letter of Admonition	1	0	0	1	0
License Granted with Probation/Practice Limitations	0	0	0	0	0
License Denied after Hearing	0	0	0	0	0
Injunctions/Cease & Desist Orders	0	0	0	0	0
Stipulated Agreements	0	2	0	1	1
Suspension without Probation	0	0	0	0	0
Other	0	0	0	1	0
TOTAL DISCIPLINARY ACTIONS	**1**	**2**	**0**	**3**	**1**
TOTAL DISMISSALS	***4***	***4***	***7***	***4***	***13***
Dismissals by Dept. of Corrections Letter	0	0	0	0	0
Dismissals by Case Consideration (No 20-Day Letter)	0	0	0	0	0
Dismissals by Letter of Concern	N/A	0	1	1	2

Table D-5
Average Time to Closure

Fiscal Year	Number of Days
97-98	156
98-99	406
99-00	40
00-01	229
01-02	110
Average for Period	**188**

Appendix E – Program Information Tables for the Board of Licensed Professional Counselor Examiners

Table E-1
Licensing Information

	Number of Licenses			
Fiscal Year	**Exam**	**Endorsement**	**Renewal/ Reinstatement**	**TOTAL**
97-98	242	32	1,496	**1,770**
98-99	230	26	1,795	**2,051**
99-00	264	48	2,242	**2,554**
00-01	235	46	15*	**2,835**
01-02	288	59	2,305	**2,652**

* Effective fiscal year 99-00, the mental health boards began renewing licenses every two years, rather than annually. The licenses indicated here represent reinstatements.

Table E-2
Examination Information

FISCAL YEAR	NUMBER OF WRITTEN EXAMS	PASS RATE (%)
97-98	45 /July 1997 75 /October 1997 42/January 1998 67/April 1998	84 76 92 89
98-99	64 /July 1998 75 /October 1998 26/January 1999 65/April 1999	82 89 92 76
99-00	37 /July 1999 70 /October 1999 39/January 2000 69/April 2000	31 94 94 82
00-01	42 /July 2000 58 /October 2000 34/January 2001 42/April 2001	80 93 100 80
01-02	43 /July 2001 50 /October 2001 42/January 2002 54/April 2002	76 88 80 83

Table E-3
Complaint Information

Nature of Complaints	FY97-98	FY98-99	FY99-00	FY00-01	FY01-02
Practicing w/o a License	0	0	0	0	0
Standard of Practice	9	12	16	15	34
Fee Dispute	0	0	0	0	0
Scope of Practice	0	0	0	0	0
Sexual Misconduct	2	0	0	0	2
Substance Abuse	0	1	1	0	1
Felony Conviction	0	0	0	0	0
Breach of Confidentiality	6	5	5	4	0
Beyond Scope of Training	5	0	2	1	0
Failed to list in Database	3	0	0	0	0
Failure to Provide Disclosure	2	3	4	0	0
False/Incorrect Entries	1	1	0	1	0
Failure to Perform Referral	2	0	1	0	0
Inappropriate Relationship	7	2	5	2	2
Inadequate Supervision	2	0	0	0	0
Lapsed License	0	0	0	0	2
Misrepresentation	2	0	2	0	0
Psychologically Impaired	0	1	0	1	0
Request for Records	0	0	0	1	0
Unprofessional Conduct	0	0	0	0	7
Unnecessary Tests/Treatment	0	0	1	0	0
Violation of Stipulation	1	0	0	0	0
TOTAL	**42**	**25**	**37**	**25**	**48**

Table E-4
Final Agency Actions

Type of Action	FY97-98	FY98-99	FY99-00	FY00-01	FY01-02
Revocation	0	1	3	0	2
Surrender of License / Retirement	1	0	0	0	0
Suspension with Probation	0	0	0	0	0
Probation (no suspension) / Practice Limitation	0	0	0	0	0
Letter of Admonition	2	0	1	1	2
License Granted with Probation / Practice Limitations	0	0	0	0	0
License Denied after Hearing	0	0	0	0	0
Injunction	0	0	0	0	0
Stipulated Agreement	1	1	4	3	0
Suspension without Probation	0	0	0	0	0
TOTAL DISCIPLINARY ACTIONS	**4**	**2**	**8**	**4**	**4**
TOTAL DISMISSALS	***20***	***26***	***30***	***26***	***31***
Dismissals by Dept. of Corrections Letter	0	0	0	0	1
Dismissals by Case Consideration (No 20-Day Letter)	0	0	3	7	4
Dismissals by Letter of Concern	N/A	4	1	5	11

Table E-5
Average Time to Closure

Fiscal Year	Number of Days
97-98	148
98-99	187
99-00	206
00-01	169
01-02	141
Average for Period	**170**

Appendix F – Program Information Tables for the State Grievance Board

Table F-1
Licensing Information

	Number of Licenses			
Fiscal Year	**Initial**	**Endorsement**	**Renewal/ Reinstatement**	**TOTAL**
97-98	596	N/A	1,026	**1,622**
98-99	366	N/A	1,081	**1,447**
99-00	485	N/A	1,053	**1,538**
00-01	442	N/A	0	**1,980**
01-02	484	N/A	1,171	**1,655**

* Effective fiscal year 99-00, the State Grievance Board began renewing Database listings every two years, rather than annually.

Table F-2
Complaint Information

Nature of Complaints	FY 97-98	FY 98-99	FY 99-00	FY 00-01	FY 01-02
Practicing w/o a License	18	6	9	12	20
Standard of Practice	15	7	16	17	32
Fee Dispute	0	0	0	0	0
Scope of Practice	11	7	10	11	1
Sexual Misconduct	4	1	5	2	4
Substance Abuse	4	0	0	2	1
Theft	0	0	0	0	0
Felony Conviction	1	0	2	2	1
Breach of Confidentiality	2	6	7	3	2
Failure to Provide MD	5	1	3	4	3
False/Incorrect Entries	4	2	1	3	0
Failure to Perform Referral	0	0	1	0	0
Insurance Fraud	0	0	0	0	1
Inappropriate Relationship	5	3	5	7	4
Inadequate Supervision	1	1	0	0	0
Inadequate Termination	2	0	2	0	0
Misrepresentation	6	3	3	4	2
Psychologically Impaired	1	1	0	0	0
TOTAL	**79**	**38**	**64**	**67**	**71**

Table F-3
Final Agency Actions

Type of Action	FY 97-98	FY 98-99	FY 99-00	FY 00-01	FY 01-02
Revocation	0	0	0	0	0
Surrender of License / Retirement	0	0	0	0	0
Suspension with Probation	0	0	0	1	0
Probation (no suspension) / Practice Limitation	15	3	7	2	2
Letter of Admonition	4	0	4	2	4
License Granted with Probation / Practice Limitations	0	0	0	0	0
License Denied after Hearing	0	0	0	0	0
Injunction	6	15	2	2	4
Fine	0	0	0	0	0
Stipulated Agreement	1	2	1	2	0
Suspension without Probation	0	0	0	0	0
TOTAL DISCIPLINARY ACTIONS	**26**	**20**	**14**	**9**	**10**
TOTAL DISMISSALS	***62***	***25***	***38***	***52***	***47***
Dismissal by Dept. of Corrections Letter	0	0	0	0	11
Dismissal by Case Consideration (No 20-Day Letter)	0	0	4	11	13
Dismissal by Letter of Concern	N/A	6	1	9	8

Table F-4
Average Time to Closure

Fiscal Year	Number of Days
97-98	212
98-99	776
99-00	269
00-01	185
01-02	193
Average for Period	**327**

Appendix G – Program Information Tables for the Addictions Counselors Program

Table G-1
Licensing Information

	Number of Licenses			
Fiscal Year	**Exam**	**Endorsement**	**Renewal/ Reinstatement**	**TOTAL**
97-98	N/A	N/A	N/A	**N/A**
98-99	CAC I - 95 CAC II - 88 CAC III - 40 Total - 223	CAC III – 3 Total - 3	1,614	**1,850**
99-00	CAC I – 66 CAC II – 45 CAC III – 16 Total - 127	CAC III – 3 Total - 3	1,763	**1,893**
00-01	CAC I – 79 CAC II – 79 CAC III – 29 Total - 187	CAC III – 2 Total - 2	0*	**2,082**
01-02	CAC I – 97 CAC II – 63 CAC III – 35 LAC – 62 Total - 257	CAC III – 3 Total - 3	1,833	**2,093**

* Effective fiscal year 99-00, the mental health boards began renewing licenses every two years, rather than annually.

Table G-2
Complaint Information

Nature of Complaints	FY 97-98	FY 98-99	FY 99-00	FY 00-01	FY 01-02
Practicing w/o a License	N/A	N/A	N/A	N/A	N/A
Standard of Practice	N/A	11	15	25	42
Fee Dispute	N/A	0	0	0	0
Scope of Practice	N/A	0	1	1	0
Sexual Misconduct	N/A	1	7	1	4
Substance Abuse	N/A	5	1	3	0
Theft	N/A	N/A	N/A	N/A	N/A
Felony Conviction	N/A	0	1	0	0
TOTAL	**N/A**	**17**	**25**	**30**	**46**

Table G-3
Final Agency Actions

Type of Action	FY 97-98	FY 98-99	FY 99-00	FY 00-01	FY 01-02
Revocation	N/A	0	0	1	2
Surrender of License / Retirement	N/A	0	0	0	0
Suspension with Probation	N/A	0	0	2	0
Probation (no suspension) / Practice Limitation	N/A	4	9	8	4
Letter of Admonition (LOA)	N/A	0	2	3	1
License Granted with Probation / Practice Limitations	N/A	0	0	0	0
License Denied after Hearing	N/A	0	0	0	1
Injunction/Cease & Desist Orders	N/A	0	0	0	0
Stipulated Agreement	N/A	0	11	2	0
Suspension without Probation	N/A	0	0	0	0
TOTAL DISCIPLINARY ACTIONS	**N/A**	**4**	**22**	**16**	**8**
TOTAL DISMISSALS	***N/A***	***10***	***7***	***42***	***23***
Dismissal by Dept. of Corrections Letter	N/A	0	0	0	4
Dismissal by Case Consideration (No 20-Day Letter)	N/A	0	1	1	4
Dismissal by Letter of Concern	N/A	1	0	0	3

Table G-4
Average Time to Closure

Fiscal Year	Number of Days
97-98	N/A
98-99	89
99-00	255
00-01	241
01-02	209
Average for Period	**199**

Appendix H – Mandatory Continuing Education

Section 24-34-901, C.R.S., states:

> (1) Before any bill is introduced in the general assembly that contains, or any bill is amended to contain, a mandatory continuing education requirement for any occupation or profession, the practice of which requires a state of Colorado license, certificate, or registration, the group or association proposing such mandatory continuing education requirement shall first submit information concerning the need for such a requirement to the office of the executive director of the department of regulatory agencies. The executive director shall impartially review such evidence, analyze and evaluate the proposal, and report in writing to the general assembly whether mandatory continuing education would likely protect the public served by the practitioners. Proposals may include, but need not be limited to: Information that shows that the knowledge base for the profession or occupation is changing; that mandatory continuing education of this profession or occupation is required in other states; if applicable, that any independent studies have shown that mandatory continuing education is effective in assuring the competency of practitioners. The proposal may also include any assessment tool that shows the effectiveness of mandatory continuing education and recommendations about sanctions that should be included for noncompliance with the requirement of mandatory continuing education. The provisions of this section shall not be applicable to:
>
> (a) Any profession or occupation that, as of July 1, 1991, has mandatory continuing education requirements in place;
>
> (b) Any bill that is introduced as a result of a legislative interim committee and that as introduced in the general assembly includes a mandatory continuing education requirement.
>
> (2) This section is exempt from the provisions of section 24-1-136(11), and the periodic reporting requirement of this section shall remain in effect until changed by the general assembly acting by bill.

Pursuant to this statutory requirement, the following professional associations, representing the indicated mental health professionals, submitted to DORA's Executive Director, on April 30, 2003, the required filing in support of their request that continuing education (CE) be mandated as a condition of continued licensure as a mental health professional in Colorado:

- Colorado Chapter of the National Association of Social Workers (NASW) – social workers
- Colorado Society for Clinical Social Work (CSCSW) – social workers
- University of Denver Graduate School of Social Work (DU-GSSW) – social workers

- Colorado Psychological Association (CPA) – psychologists
- Society of Addiction Counselors of Colorado (SACC) – addictions counselors
- Colorado Counseling Association (CCA) – LPCs
- Colorado Mental Health Counselor Association (CMHCA) – LPCs
- Colorado Society of School Psychologists (CSSP) – school psychologists

These professional associations may hereinafter be referred to collectively as the "Applicants."

This Appendix H shall constitute the Executive Director's written report to the General Assembly, as mandated by section 24-34-901(1), C.R.S.

The Applicants contend that mandatory continuing education (MCE) is necessary for the following reasons:

> (1) Because the knowledge base of the profession is changing, competent practice requires mental health professionals to remain knowledgeable about current laws, diagnoses, treatments, and professional ethical behavior;
>
> (2) Because the vast majority of legislatures in the United States have mandated CE for mental health professionals;
>
> (3) Because considerable empirical evidence exists showing the link between MCE and professional competency and thus public protection; and,
>
> (4) Because effective assessment tools and procedures exist today with which to monitor the quality of MCE programs.

As evidence of the changing practice of mental health professionals, the Applicants point to advances in treating child abuse and neglect and patients with HIV/AIDS; computerized client assessment; and, pharmacological advances that have revolutionized the treatment of mental illnesses.

Additionally, the Applicants posit that a practitioner that obtained a mental health education prior to 1990 would not understand the dimensions of sexual abuse and the dynamics of sexual perpetration; be able to use electronic library catalogues and electronic reference materials; understand effective responses to trauma; or, know the current drugs of choice for substance abusing teens and adults.

While some of these arguments have merit, others, such as the ability to use computerized library catalogues and being familiar with the drugs of choice among drug abusers, have none. Such things can be, and often are, learned during the course of everyday life, not in a formal or continuing education environment.

Also, it is not unreasonable to expect that mental health professionals will remain current on new theories and practices involving their specific areas of practice. Thus, a therapist who works with abused children, for example, is likely to be aware of new approaches due to professional interest. State intervention is not necessary.

This proposition is supported by the results of a survey conducted by DORA as part of this sunset review. Surveys were mailed to a random 10 percent sampling of mental health professionals. With an overall response rate of 47.6 percent, the data gathered from this survey deserves acknowledgement.

The first finding worth noting from this survey is that 84.5 percent of mental health professionals already obtain CE voluntarily.

One question posed on this survey asked respondents to rank, in order of importance, why they take CE. The number one response, with 79.2 percent of those taking CE ranking it as the most important reason, was "to learn about trends and new techniques and therapeutic approaches that are pertinent to my area of practice." If the total number of responses to this item are added together, which would include those ranking this as the first, second or third most important reasons, 93.8 percent of those taking CE take it to learn about new trends, techniques and therapeutic approaches.

Thus, the Applicants' assertion that MCE is necessary because the practice of mental health therapy is changing and practitioners are not staying current with such changes, is not very convincing. DORA's survey found that 93.8 percent of practitioners who take CE, take CE for this very reason.

Presumably, the examples offered by the Applicants serve as justification for why MCE is necessary to protect the public. However, the applicants have not presented any evidence or arguments to establish that the number of complaints received or violations found by the mental health boards are abnormally high or that MCE would reduce such numbers.

An examination of complaint statistics in Table 5 on page 21, as well as the board-specific tables in Appendices B through G, beginning on page 59, reveals that most complaints received by the boards entail some type of allegation regarding standards of practice, the very area one would expect MCE to impact the most. However, the "standard of practice" characterization in all of these tables is somewhat misleading because this designation is often used as a "catch all" for allegations that do not specifically fall within the confines of another, enumerated prohibited act. Additionally, for a period of years, the boards, acting on the advice of the Attorney General's Office, included the "standard of practice" violation in all complaint documents under the theory that even a breach of confidentiality, for example, which is an enumerated violation, is also a violation of the generally accepted standards of practice.

The Applicants have not presented any evidence to suggest, and DORA's own research was unable to establish, that MCE would cause a decrease in such numbers, particularly in light of the fact that approximately 85 percent of mental health professionals already take CE voluntarily.

Next, the Applicants assert that most states require MCE for continued licensure. While this is technically correct, it is not entirely accurate. While 47 states have MCE requirements for social workers and 46 states have such a requirement for LPCs, only 34 have such requirements for psychologists, 24 for addictions counselors, and only 9 for school psychologists.

Furthermore, not all state legislatures may be as conscious of the "public protection vs. overly burdensome regulation" balance as is the Colorado General Assembly. The possible reasons behind why a state has MCE requirements are many. A prime example would be making the assumption that MCE enhances competency without adequately exploring the research that suggests this is not the case. Such laws are not necessarily passed due to an interest in enhancing public protection with the least restrictive form of regulation or on the insistence that public protection claims be substantiated.

The Applicants also posit that there is considerable empirical evidence to suggest that MCE enhances continued competency. The evidence presented does not support this conclusion.

For example, the NASW's application focuses on empirical evidence to support the proposition that continuing education, as opposed to *mandatory* continuing education, enhances competency. The CPA application, on the other hand, concedes that there is a "lack of consistent research findings,"[1] regarding MCE.

The research indicates that CE and MCE are two entirely different propositions.

> Continuing education is not the same as mandatory continuing education. More continuing education is better; more mandatory continuing education is worse. It is compulsory, obligatory, and pre-determines what constitutes education. Both the knowledge to be learned and the educational methods, practices, and objectives of the learning process have to be pre-approved.[2]

Thus, any discussion that focuses exclusively on CE, rather than MCE, is superfluous.

Both the NASW and the CPA also present as empirical evidence of the effectiveness of MCE, the fact that many other states mandate CE. However, this is not empirical evidence of the effectiveness of MCE. Rather, it is empirical evidence of the fact that other states have MCE requirements. A logical argument cannot be made to support the proposition that the mere popularity of MCE means that MCE is effective at enhancing minimal competency.

[1] "Information Concerning the Need for Continuing Education for the Psychology Profession," submitted by the Colorado Psychological Association to the Department of Regulatory Agencies, April 30, 2003, p. 4.
[2] "Mandatory Continuing Education (MCE): Industrializing and Deprofessionalizing Psychology" by Patrick B. Kavanaugh, Ph.D. by the Academy for the Study of Psychoanalytic Arts, as downloaded from www.academyanalyticarts.org/kava15.html on 4/3/03 at p. 3

In researching this issue, DORA discovered an abundance of research to indicate that MCE does not reasonably ensure continued competency. Indeed,

> . . . mandated continuing education, on the basis of some standard number of units or hours in a given time period, can range in quality. It might mean nothing more than sitting on a chair a sufficient number of times to qualify. Only if effective means of evaluation can be applied is it possible to determine the educational results of the number of hours.[3]

Some have even opined that MCE actually represents the de-professionalization of the subject profession by removing the ability of the professional to judge for himself/herself what might be the most relevant subject matter to study and the most effective manner in which to study it. Thus, professional judgment is replaced with the need to verify the satisfaction of pre-approved bureaucratic requirements.[4]

MCE represents, "[a] bureaucratic solution . . . proposed for an unspecified problem to achieve ambiguous results."[5]

In conclusion, the Applicants assert that effective assessment tools and procedures exist with which to monitor the quality of MCE offerings. There are essentially two options by which to achieve this goal: 1) each mental health board would be required to approve each MCE course offering; or, 2) approvals for MCE offerings could be delegated to a national professional association. Neither option is appealing.

First, the mental health boards would incur significant costs if they were required to review and approve each MCE offering. Such an effort would necessitate a review of the instructor(s) credentials as well as course curricula and materials. This would consume a considerable amount of both staff and board time and would be quite inefficient.

Second, delegating approval authority to a national association would be counter to public policy. Colorado would not control which courses are approved and which are not. Thus the state would have no assurance as to whether a particular MCE offering promoted competency or simply offered practitioners with tips on how to operate a more profitable practice. Such delegation could also violate the "police powers" authority upon which the regulation of mental health professionals is premised.

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[3] "Mandatory Continuing Education: Time for Reevaluation," by Richard L. Edwards and Ronald K. Green, *National Association of Social Workers*, January-February 1983, pp. 43-48 at 45, quoting Phillip E. Frandson, "Continuing Education for the Professions,'" in Edgar J. Boone, Ronald W. Shearon, Estelle E. White and Associates, eds., *Serving Personal and Community Needs Through Adult Education* (San Francisco: Jossey-Bass, 1980), pp. 67-68.

[4] Kavanaugh at p. 3.

[5] Id.

There is also the matter of determining whether the professional learns what a particular MCE offering purports to teach. In order to achieve some semblance of continued competency, each course would have to include an objective instrument, such as an examination, at its conclusion to ensure that the mental health professional had learned what was taught. It would also require a showing by each mental health professional for each course taken, that the course is somehow relevant to the practice of that particular mental health professional. This would be necessary to ensure that mental health professionals obtain MCE credits that enhance their competency, rather than for courses that are designed to help them build their practices.

Such measures would be expensive. MCE units would cost even more because providers would have to develop, administer and possibly report on end-of-course examinations. The mental health boards would also incur administrative costs (which would likely result in higher fees) due to the need to not only track MCE units to ensure that mental health professionals were complying with the law, but also to ensure that the courses taken by each mental health professional were somehow related to that mental health professional's practice.

The Applicants contend that it would not be necessary for the mental health boards to track MCE units, however. They propose that the mental health boards simply require mental health professionals to retain evidence of MCE units obtained. The mental health boards would then have the authority to request, at any time of any mental health professional, production of such evidence. If such evidence could not be produced, disciplinary action could be taken.

While this approach would likely reduce some of the administrative costs associated with MCE, it would not necessarily enhance public protection. Mental health professionals who are opposed to an MCE requirement could play the odds that they would not be audited and not obtain the required number of MCE units. Additionally, it would be more difficult to ensure that mental health professionals took courses relevant to their practices because any such audit would come after the fact. If a mental health board determined that a particular course did not pertain to a mental health professional's practice, then that mental health professional could be disciplined for not taking enough MCE when the mental health professional believed in good faith that the requirement had been satisfied.

There are plenty of other arguments to be made against MCE. First, the market theory of economics suggests that if CE were mandated the cost of MCE units would increase due to increased, forced demand. MCE providers would know that their market needed X credits per renewal cycle, so providers would charge as much as they possibly could, knowing that their market, licensees, were compelled by force of law to take their courses. Additional costs to the mental health professional could include travel-related costs and time away from clients.

DORA's survey also asked respondents to rank, in order of importance, why they do not take CE. The number one response to this question, with 30.8 percent of respondents ranking it as the most important reason, was the cost of the CE. If all responses to this item are considered, which would include those indicating that this was the first, second or third most important reason why CE is not taken, the proportion of respondents jumps to 53.8 percent. Another 10.3 percent ranked as most important, the expense associated with being away from the mental health professional's practice, or 29.5 percent when the second and third most important reasons are included. Finally, 14.1 percent indicated that the most important reason was that CE courses are not offered in the geographic areas in which such mental health professionals live, thus necessitating travel and additional expenditures. This number climbs to 23 percent if first, second and third rankings are considered.

It is clear that cost is a primary obstacle to mental health professionals obtaining CE under the current, voluntary system. Since MCE can reasonably be expected to drive up the cost of CE units, MCE will impose an even greater financial burden on practitioners. This is particularly troublesome given that the efficacy of MCE is so dubious.

Second, the state should not create new industries simply for the sake of creating new industries. While an MCE requirement would not necessarily create an entirely new industry, because the CE industry currently exists in this state, it would significantly increase the size and economics of that industry. It is not the role of the state to interfere in the marketplace where the justification for such interference has been discredited, as with MCE.

Third, how much MCE is enough to enhance public protection? If the state is to impose an MCE requirement, it must do so responsibly by ensuring that the number of MCE units required is sufficient, if possible, to enhance public protection.

Fourth, even assuming MCE would enhance continuing competency, there is no need to mandate it. Many insurance companies, as the CPA application confirms,[6] provide significant discounts to mental health professionals who obtain CE. Thus, there is a financial incentive for practitioners to take CE; the state need not mandate it.

Additionally, and more convincingly, a high proportion of mental health professionals in Colorado are already obtaining CE units. Again, DORA's survey found that 84.5 percent of mental health professionals currently obtain CE units without any statutory mandate to do so.

Finally, it would be misleading for the state to mandate CE when there are no assurances that such a mandate will lead to enhanced public protection. Every condition placed on licensure should be reasonably related to enhancing public protection (i.e., educational requirements, passage of examinations, etc.) because when the state issues a license, it represents to the public that such person is minimally competent. MCE, without assurances that it enhances public protection, would create a false sense of security and would mislead the public into believing that if a person obtains MCE units, that person must be competent.

[6] CPA application at p. 4.

For all the reasons cited above, but particularly because there is no clear evidence to suggest that MCE would enhance continuing competency, and thus public protection, and because the vast majority of mental health professionals in this state already obtain CE units voluntarily, DORA cannot endorse the application submitted by the Applicants.

The General Assembly should not impose a MCE requirement as a condition for continued registration, certification or licensure for mental health professionals that are represented by the Applicants.

Appendix I – Sunset Survey of Mental Health Professionals

On June 25, 2003, DORA mailed a survey to 1,311 individuals who are either listed in the Database, or that are registered, certified or licensed by one of the mental health boards or the Addictions Counselors Program (ACP). The 1,311 recipients represent a 10 percent random sampling of each of the classifications of mental health professional regulated by the mental health boards, including the ACP. The following number of surveys were mailed to the indicated regulated classification:

Psychologists – 210
LCSW – 314
LISW – 3
LSW – 19
RSW – 1
LPC – 293
MFT – 53
CAC I – 21
CAC II – 63
CAC III – 149
LAC – 7
Unlicensed – 178

Of the 1,311 surveys mailed, 195 (14.9 percent) were returned by the U.S. Postal Service as undeliverable.

Of the 1,311 surveys mailed, 531 were completed and returned to DORA, representing an overall response rate of 40.5 percent. If the non-deliverable surveys are subtracted from the total, however, the response rate was an astounding 47.6 percent.

The following figures represent the response rate by regulated classification:

Psychologists – 50.5 %
LCSW – 43.3%
LISW – 33.3%
LSW – 31.6%
RSW – 0%
LPC – 54.9%
School Psychologists – 3
MFT – 54.7%
CAC I – 9.5%
CAC II – 49.2%
CAC III – 57.0%
LAC – 114.2%
Unlicensed – 25.8%

Survey respondents were asked to check a box for each type of listing, registration, certification or license held, which explains why the response rate for LACs exceeds 100 percent. Only 10 percent of LACs were intentionally sent a survey. However, if a LPC, for example, received the survey as a LPC, but is also a LAC, both boxes were checked, thus raising the overall total. This also explains why there were three responses indicating licensure as a school psychologist when school psychologists were not targeted for receipt of this survey.

The following represent the actual survey questions posed. The number of responses received for each response item follows that response item. The numbers in front of response items represent the ranking of that response item.

For question 2, the top three responses for each degree are provided.

For those items asking survey participants to rank in order of preference (questions 5, 6, 7 and 9), actual responses are illustrated in tabular form, so as to facilitate the expression of the numerical rankings for each item.

Survey of Registrants, Certificate Holders and Licensees of the Colorado Mental Health Boards

1. Please indicate all registrations, certificates or licenses you currently hold that were issued by the State of Colorado:

106	(a) Psychologist	161	(f) LPC	8	(k) LAC
136	(b) LCSW	29	(g) LMFT	46	(l) Unlicensed
1	(c) LISW	2	(h) CAC I	3	(m) School Psychologist
6	(d) LSW	31	(i) CAC II		
0	(e) RSW	85	(j) CAC III		

2. Please indicate the highest level of education you have completed:

140 (a) Doctorate in (44 Clinical Psychology, 40 Psychology, 17 Counseling Psychology)
356 (b) Master's in (139 Social Work, 54 Counseling, 41 Counseling Psychology)
22 (c) Bachelor's in (8 Psychology, 4 Social Work, 3 Sociology)
5 (d) Associate's in (1 Criminal Justice, 1 D/A, 1 General Studies, 1 Nursing, 1 Psychology)
0 (e) Certificate in _____
4 (f) High School/GED
3 (g) Other (please specify) _____

3. Please indicate all of the professional associations to which you belong:

7 (a) American Association for Marriage and Family Therapists - *35*
16 (b) American Board of Professional Psychology - *2*
4 (c) American Counseling Association - *83*
15 (d) American Mental Health Counselors Association - *5*
3 (e) American Psychological Association - *94*
9 (f) Colorado Association for Marriage and Family Therapists - *19*
12 (g) Colorado Association of Psychotherapists - *13*
11 (h) Colorado Counseling Association - *15*
14 (i) Colorado Mental Health Counselor Association - *8*
6 (j) Colorado Psychological Association - *37*
13 (k) Colorado Society for Clinical Social Work - *11*
17 (l) Colorado Society of School Psychologists - *1*
2 (m) National Association of Social Workers - *98*
8 (n) National Association of Drug and Alcoholism Addictions Counselors - *32*
5 (o) National Board of Certified Counselors - *47*
10 (p) Society of Addiction Counselors of Colorado - *16*
___ (q) Other (please specify) _____
1 *(r)* *I do not belong to any professional associations* - 112

4. How many hours/units of continuing education (CE) do you obtain in an average year?

4 (a) I do not regularly obtain CE units - *78*
2 (b) 1 – 10 - *141*
1 *(c) 10 – 20* - 144
3 (d) 20 – 30 - *102*
5 (e) More than 30 - *62*

5. If you regularly obtain continuing education (CE) units, please rank, in order of importance (with "1" being the most important), the top three (3) reasons why you obtain CE units:

Response Item	Number "1" Rankings	Number "2" Rankings	Number "3" Rankings
(a) I do not regularly obtain CE units.	52	1	2
(b) To learn about trends and new techniques and therapeutic approaches that are pertinent to my area of practice.	**356**	48	17
(c) To learn about new areas of practice that are of interest to me, but which I have no plans to enter into.	8	28	38
(d) To learn about new areas of practice that I may enter into.	25	**110**	54
(e) To learn new business practices.	6	5	33
(f) My liability insurance carrier gives me a discount for obtaining CE units.	2	6	3
(g) The professional association to which I belong requires CE.	11	0	0
(h) The organization that issued a specialty certificate or other credential that I hold requires CE for continued certification/credentialing.	28	36	22
(i) To take a trip that I can deduct from my taxes.	1	3	9
(j) It provides me an opportunity to interact with my colleagues.	15	65	**103**
(k) My employer requires me to take CE.	12	12	11
(l) The insurance panels in which I participate require it.	2	6	10
(m) Other (please specify)	20	16	22

6. If you DO NOT regularly obtain continuing education (CE) units, please rank, in order of importance (with "1" being the most important), the top three (3) reasons why you DO NOT obtain CE units:

Response Item	Number "1" Rankings	Number "2" Rankings	Number "3" Rankings
(a) I regularly obtain CE units.	13	0	1
(b) The cost of CE units is unreasonably expensive.	**24**	12	6
(c) I cannot afford to spend that much time away from my practice.	8	12	3
(d) CE classes do not teach me anything that I don't already know.	7	3	5
(e) CE classes are taught in a format that is not conducive to learning.	5	1	0
(f) I live in an area in which CE classes are not routinely offered.	11	4	3
(g) CE classes that are offered do not apply to my area of practice.	8	2	2
(h) I am generally bored in classes.	2	1	3
(i) I can read an article and learn just as much as I would in a class.	14	9	7
(j) Obtaining CE units is not a priority for me.	8	**14**	**9**
(k) Other (please specify)	19	6	4

7. Please rank, in order of importance, (with "1" being the most important), the top three (3) reasons why it is important to you to hold a State of Colorado-issued registration, certificate or license:

Response Item	Number "1" Rankings	Number "2" Rankings	Number "3" Rankings
(a) It provides information to my clients as to the type of education I have completed.	76	83	35
(b) It informs my clients that I have satisfied the state's requirements to practice.	**206**	**111**	59
(c) It provides information to my clients as to the scope of my practice.	20	31	53
(d) It is a matter of professional pride.	53	56	**76**
e) It distinguishes me from other psychotherapists.	21	53	53
(f) If a complaint is ever filed against me, I will be judged by a panel of individuals who hold the same type of license that I hold.	17	23	52
(g) It is required for inclusion on managed care or health insurance panels.	48	41	57
(h) It is a practical necessity to remain competitive, both in private practice and in institutional settings.	97	70	66
(i) Other (please specify)	7	2	2

8. When it comes to the practice of psychotherapy, how would you characterize the difference between your profession and the other mental health professions?

4 (a) There is no practical difference. - *66*
3 (b) There is a small difference. - *98*
1 *(c) There is a medium-sized difference.* - 197
2 (d) There is a large difference. - *148*

9. If you are an unlicensed psychotherapist, please indicate the top three (3) reasons why you are not licensed by one of the mental health licensing boards.

Response Item	Number "1" Rankings	Number "2" Rankings	Number "3" Rankings
(a) I am currently seeking licensure, but must register with the database so that I may practice under supervision until I am licensed.	**21**	2	0
(b) I currently hold a license, but I registered with the database prior to licensure and have not yet canceled my registration.	4	0	0
(c) I have not attained the education level required for licensure.	12	1	0
(d) I attempted to obtain a license, but I was denied because the school from which I graduated was not accredited by an organization that is recognized by Colorado's licensing boards.	2	0	0
(e) I have attained the education level required for licensure, but I have not satisfied the post-degree supervision requirements and do not intend to do so.	6	2	0
(f) I practice in an area that is outside of mainstream/traditional areas of practice, and is therefore not recognized by the various licensing boards and professional standards.	4	7	1
(g) I choose not to seek licensure.	15	**8**	2
(h) I attempted to obtain a license but I did not pass the licensing examination.	3	1	0
(i) I am afraid to take the licensing examination.	4	1	3
(j) The licensing process is too much hassle since I can practice without a license.	5	2	**6**
(k) I was licensed, but lost my license due to disciplinary action.	0	0	0
(l) I allowed my license to lapse, but wish to continue practicing.	0	0	0