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February 4, 2015

Hon. Andrew M. Cuomo
Governor of the State of New York
The Executive Chamber
State Capitol
Albany, NY 12224

Hon. Carl Heastie
New York State Assembly
Legislative Office Building, Room 522
Albany, NY 12248

Hon. Dean G. Skelos
New York State Senate
Legislative Office Building, Room 909
Albany, NY 12247

Hon. Kenneth LaValle
New York State Senate
Legislative Office Building, Room 806
Albany, NY 12247

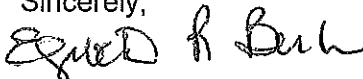
Hon. Deborah Glick
New York State Assembly
Legislative Office Building, Room 717
Albany, NY 12248

Dear Governor Cuomo, Majority Leader Skelos, Speaker Heastie, Senator LaValle and Assemblymember Glick:

It is my pleasure to submit to you the New York State Education Department's report Pursuant to Chapters 57 of the Laws of 2013 in regard to the exemption from professional licensure for certain entities and individuals providing services within the scopes of practice of social work, psychology, and mental health practitioners.

The enclosed report was prepared with the assistance of the eight agencies that are exempt from the licensing laws until July 1, 2016. While the final report accurately reflects the information received by the Department, the law also allows the commissioners of the exempt agencies to submit statements or alternative recommendations. We have received statements from the exempt agencies that are attached to this report. We will post the final report with attachments and appendices on the OP website (www.op.nysed.gov).

My colleagues in the Department look forward to working with you in the coming months to consider the need for changes to the law. If you have any questions about the report or wish to schedule follow-up meetings, please contact Deputy Commissioner Douglas E. Lentivech in the Office of the Professions at (518) 486-1765.

Sincerely,


Elizabeth R. Berlin
Acting Commissioner

Enclosure

c: Douglas E. Lentivech, Deputy Commissioner
David Hamilton, Executive Secretary
Kathleen Doyle, Executive Secretary

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Report to the Legislature and Governor

The Board of Regents oversees the licensure, practice and conduct of more than 50 professions established under Title VIII of the Education Law. In 2002, New York State enacted laws to restrict the practice of psychotherapy to individuals licensed by the Education Department. Previously, any individual could provide psychotherapy services. While the Education Law had previously authorized the licensure of psychologists and certified social workers and protected those titles, the 2002 legislation:

1. provided a protected scope of practice for psychologists;
2. replaced the single certified social worker license with two new title and scope protected licenses – licensed master social worker and licensed clinical social worker – and established licensure requirements for each;
3. created four new title and scope-protected professions – licensed creative arts therapist, licensed marriage and family therapist, licensed mental health counselor and licensed psychoanalyst – and established licensure requirements for each.

The statutes provided that, beginning with the profession of psychology on September 1, 2003 and concluding on January 1, 2006 for the Mental Health Practitioner professions, the practices of the seven professions became restricted to those licensed, otherwise authorized, or exempt. Exemptions, which are established in statute, include students under supervision, other licensed professions and occupations, and individuals in certain settings. In addition, the 2002 statutes enacted an exemption from licensure until January 1, 2010 for individuals in the employ of programs and services that are regulated, operated, funded or approved by the Office of Mental Health (OMH), the Office of Mental Retardation and Developmental Disabilities (OMRDD), the Office of Alcohol and Substance Abuse Services (OASAS), or a local government unit as defined in the Mental Hygiene Law¹.

The original exemptions in the 2002 bills had been expanded in 2003 to include individuals in programs that are operated, regulated, funded or approved by the Office of Children and Family Services (OCFS) or a local social services district². The exemption was then extended to July 1, 2013 by chapters 130 and 132 of the Laws of 2010. With regard to the professions of social work and mental health practitioners, Chapters 130 and 132 also expanded the exemptions to include the Department of Health (DOH), State Office for the Aging (SOFA), and the Department of Corrections and Community Supervision (DOCCS).³ The expansion of the exemptions to these agencies did not apply to the profession of psychology since, in part, this profession

¹ The exemption applied to individuals in programs but restricted the use of the titles established in Articles 153, 154, and 163 (Chapters 420 and 676 of Laws of 2002).

² The exemption was authorized by Chapter 433 of Laws of 2003.

³ The exemption was extended from January 1, 2010 to July 2010 in budget extenders and then extended until July 1, 2013 (Chapters 130 and 132 of Laws of 2010).

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contains permanent exemptions for persons employed in salaried positions in governmental entities, and further expansion of the exemption was opposed by the professional associations.

Chapter 57 of the Laws of 2013 extended until July 1, 2016 the exemption from licensure under Article 153 (psychology) for individuals in programs that are operated, regulated, approved or funded by certain state or local government agencies. Chapter 57 extended and expanded the exemption from licensure under Articles 154 (social work) and 163 (mental health practitioners) to include individuals in programs that are operated, regulated, funded or approved by the Office of Temporary and Disability Assistance (OTDA) until July 1, 2016. The law also clarified activities that may be performed by an unlicensed individual, including a member of an interdisciplinary team that is directed by a licensed professional.

Since 2008, the Office of the Professions convened numerous meetings with the stakeholders, including the Executive and Legislative staff, State agencies, professional associations, provider associations and consumers. The goal of Chapters 130 and 132 of the Laws of 2010 was to ensure the continuation of services to at-risk consumers while providing oversight and accountability for professional practice, consistent with the Board of Regents authority, while reaching a resolution of the licensure concerns.

The 2010 laws mandated a report from the State Education Department to the Legislature and the Governor by July 1, 2012 that recommended any changes in law, rules or regulations that are necessary to fully implement the licensing laws by July 1, 2013. The law set forth a process and timelines by which the Education Department, in consultation with the seven exempt agencies and other stakeholders, would complete the report. The report was delivered to the Governor and Legislative leaders by June 30, 2012; the major findings of the report are summarized in this document. The original report with attachments is posted on the Office of the Professions website: <http://www.op.nysed.gov/surveys/mhpsw/exempt-finalreport.htm>.

As noted above, Chapter 57 of the Laws of 2013 extended the exemption from licensure for individuals in certain programs and agencies; it also clarified activities that do not require licensure to reduce the impact of licensing laws on the agencies/programs that are regulated, operated, funded or approved by the specified state or local government entities. Chapter 57 also requires the Department, in consultation with the affected agencies, professional associations, providers and consumers, to issue a report to the Legislature by January 1, 2015. The Department collected information from programs and agencies regarding:

- a. whether the number of unlicensed individuals increased or decreased between July 1, 2013 and July 1, 2014;
- b. what requirements have not been met by individuals employed in titles that approximate the licensed professions; and
- c. what requirements could not be met by individuals employed in other occupational titles.

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The Department developed and posted online surveys in 2013 and 2014 to collect information necessary to comply with the statutory mandate. The exempt agencies selected and notified programs when the surveys were posted on SurveyMonkey. Those agencies encouraged the programs/agencies that are regulated, operated, funded or approved by one or more of the exempt state and local government agencies, to complete the surveys. The survey and a summary of the responses are attached to this summary.

Data Collection

The 2010 law required the exempt agencies to submit to the Commissioner of Education, data concerning the functions performed by their workforce and the workforces of the local governmental units and social services districts, as defined in law, over which the agency has regulatory authority. It also required the Department to convene a workgroup of the exempt agencies to review the data and to make recommendations regarding amendments to law, rule or regulation necessary to clarify which tasks and activities must be performed only by licensed or otherwise authorized personnel. Working collectively, a survey was developed to collect relevant data.

In developing the surveys that were administered in 2014, the Department drew extensively upon the language of the 2011 surveys. This approach yields consistency in the examples of activities that, if not for the exemption, could only be provided by individuals licensed or authorized under the law (e.g., diagnosis and psychotherapy), and for the activities that, even without an exemption, would not require licensure (e.g., case management and determination of client eligibility for a social service program).

The Education Department does not have direct access to agencies or programs that are regulated, operated, funded or approved by any of the exempt state and local government agencies. Data collected for all the surveys was submitted by programs and agencies that were notified of the survey by the exempt agencies. In addition, a link was posted on the Office of the Professions website to allow other interested parties to access and complete the survey. Self-selected respondents may not be representative of the entire population of agencies that provide services within the scope of psychology, social work and mental health practice, as defined in the Education Law. These restrictions prevent the public from knowing the number of individuals who would be affected by any changes in the law, including the ability to make a reasonable estimate of cost-benefits and improved treatment outcomes that may result from professional staff in the exempted programs.

Status of the 2012 Recommendations

The Department's 2012 report included 22 recommendations related to the professions of psychology, social work and mental health practitioners, summarized in the table below.

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Ref.	Proposed solutions in July 1, 2012 report	Status
SW1.	Clarification of practice	Amended Education Law 7706
SW2	Delegation of professional services	No change
SW3	Occupational exemptions	No change
SW4	Alternative pathways	No change
SW5	Extension of broad-based exemptions from licensure	July 1, 2016
SW6	Civil Service titles	No change
MHP1	Clarification of practice	Amended Education Law 8410
MHP2	Delegation of professional services	No change
MHP3	Occupational exemptions	No change
MHP4	Alternative pathways	No change
MHP5	Extension of broad-based exemptions from licensure	July 1, 2016
MHP6	Civil Service titles	No change
P1	Clarification of practice	Amended Education Law 7605
P2	Delegation of professional services	No change
P3	Occupational exemptions	No change
P4	Alternative pathways	None
P5	Extension of broad-based exemptions from licensure	July 1, 2016
P6	Civil Service titles	No action
P7	New Profession	New ABA professions established in 2014.

Summary of changes proposed in the 2012 report and the status of those recommendations.

The Governor's proposed State budget for fiscal year 2013-14 included provisions to make the exemption from licensure permanent. After extensive discussion by all interested parties, including exempt State and local government, not-for-profit providers, professional associations and with the technical assistance from the Office of the Professions, a different result was reached. Chapter 57 of the laws of 2013 extended the exemption for three years, mandated this report, and, most importantly, clarified professional practice by amending the exempt activities that could be performed by an unlicensed person. These amendments addressed concerns of the exempt agencies and the programs/agencies that they regulate, approve, operate or fund, in regard to activities that do not require licensure under Title VIII. This may have reduced the need to provide a permanent broad-based exemption in certain settings and for certain job titles and services.

Chapter 554 of 2013, as amended by Chapter 8 of 2014, defines the new professions of Licensed Applied Behavior Analyst and Certified Applied Behavior Analyst Assistant, effective July 1, 2014. The law restricts the practice of the professions to individuals who are licensed by the Department or otherwise authorized. This statute resolves a long-standing conflict between the restricted scope of practice for psychology and the activities performed by previously unlicensed applied behavior analysts. The State Board for Applied Behavior Analysis has been appointed by the Board of Regents to assist the Department in the license, practice and discipline of the professions.

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Since the majority of the recommendations from the 2012 report have not been acted upon, they have been updated and are repeated here, for discussion and consideration by policy makers.

Proposed Solutions based on 2012 recommendations and actions

Introduction. The Department's 2014 surveys found that most agencies do not use unlicensed staff to provide one or more of the five activities that are restricted under law:

- the diagnosis of mental, emotional, behavioral, addictive and developmental disorders and disabilities;
- patient assessment and evaluation;
- the provision of psychotherapeutic treatment;
- the provision of treatment other than psychotherapeutic treatment and/or
- the development and implementation of assessment-based treatment plans, as defined in section 7701 of the education law or as authorized in articles 153, 154 and 163 of the education law.

The survey indicated that there are some agencies that utilize unlicensed staff to provide these services. Therefore, the Department would recommend that policymakers review the areas of concern identified for each profession, as set forth below. These areas reflect changes that have already been made in the laws and regulations related to the profession. However, it appears that additional work needs to be completed in order to meet the stated, statutory goal of appropriate licensure or other authorization of individuals providing services that are within the restricted practice of professions licensed or otherwise authorized under article 153, 154 or 163 of the Education Law.

Topics for Discussion -- Social Work

The proposals in the 2012 report have been updated and are presented for the licensure and practice of Social Work (SW) in the areas of:

1. clarification of practice
2. delegation of professional services
3. occupational exemptions
4. alternative pathways
5. extension of broad-based exemptions from licensure
6. Civil Service titles

SW1. Clarification of practice. Chapter 57 of the Laws of 2012 added a new paragraph 7 to section 7706 of the Education Law to clarify additional activities that do not require licensure. The terminology and examples used in the Department's surveys may form the basis of practice guidelines to assist programs in assigning duties to staff, in order to comply with the licensing laws.

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There continues to be confusion about certain tasks and activities that not clearly defined in law. For instance, section 7702 defines “psychotherapy” and “diagnosis” within the context of practice as an LCSW. It does not define the term “counseling” when performed by an LMSW, although it can be interpreted to suggest that this is an activity that is different from “psychotherapy” as an LMSW does not require supervision to provide counseling, but may only provide psychotherapy under supervision. Any changes in laws, regulations or guidance from the Education Department must be based on discussions with the State Board, providers and others, in order to avoid further confusion about the restricted practice of the professions.

Section 7702 of the Education Law defines activities that are within the scope of LMSW and LCSW, but which may be provided by an unlicensed person. This has resulted in confusion among employers, licensees, and consumers whether an individual with an MSW degree is practicing the profession as a licensee or not. The law restricts the use of the title to those licensed and registered and the licensee is responsible for practicing within the authorized scope. The Department is committed to working with stakeholders to provide clarification about professional practice and those activities that are performed by unlicensed persons.

Conclusion. The Board of Regents and the Education Department, with the assistance of the State Board for Social Work, will continue to provide further clarification of terms and functions within the law. In some circumstances, it may be appropriate for the Department to seek amendments to the Education Law to ensure the practice of the professions is consistent with education and examination requirements to protect the public.

SW2. Delegation of professional services. Throughout this process, several of the State oversight agencies have raised concerns about the effect of licensure on an inter-disciplinary model of assessment, diagnosis, and treatment. In this type of model a licensed individual may head the team and delegate activities to licensed and unlicensed individuals. It was suggested that by allowing unlicensed personnel to work with and assist in the delivery of services and, where appropriate and recommend treatment options to the extent that these did not require professional judgment, subject to the direct supervision by licensed practitioners, the multi-disciplinary team offers a proven, cost effective and viable alternative to the traditional private practice model.

The Education Law and the Regents Rules define as unprofessional conduct by a licensed professional the delegation of activities that are restricted to an individual who is not authorized, such as, an aide or an unlicensed assistant; in other words a licensee may not delegate restricted activities to an unlicensed person. However, this does not prevent the unlicensed person from engaging in activities that do not require licensure, including the collection of data from and observations of certain behaviors of consumers and clients, as long as these activities do not result in professional decision making.

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Conclusion. Multi-disciplinary teams of licensed professionals and unlicensed persons are an appropriate way to provide certain services to consumers. However, it is important that the activities assigned to members of the team are consistent with the scope of practice for each team member licensed or authorized under Title VIII, and those who are not so authorized may not engage in restricted activities, even under supervision. The Department and the exempt agencies may collaborate in defining appropriate roles for unlicensed individuals, such as peer counselors, mental health therapy aides, and others who function as part of a multi-disciplinary team, but who do not make professional determinations requiring the use of professional judgment.

SW3. Occupational exemptions. Article 154 provides a permanent exemption from licensure for individuals who are licensed in other Title VIII professions (e.g., psychology, nursing, occupational therapy) as well as individuals who are credentialed under any law. The latter includes attorneys, rape crisis counselors, and credentialed alcoholism and substance abuse counselors (CASAC) whose scope of practice includes the practices defined in the Education Law and who are performing or claiming to perform work authorized by the mental hygiene law (section 7706(5)(a)).

Respondents to the Department surveys have identified a number of titles for unlicensed individuals who engage in activities that fall within the restricted scope of social work and, if not for the exemption, could only be performed by a licensed individual. Some of these occupational titles, such as the individual with certification as a CASAC, are exempt under the statute. On the other hand, individuals employed in occupational titles such as the Mental Health Therapy Aide (MHATA) and Residential or Program Counselor/Aide do not meet certification requirements and are not identified as exempt in statute.

Conclusion. There should be further discussion about the certified or credentialed individuals who may engage in activities that overlap with the restricted practice of the profession. It may be appropriate to clarify whether the statutory exemption should apply to individuals in specific occupational titles, or those who perform functions that are not currently defined as exempt under Article 154.

The Office of Mental Health (OMH) and Office of Alcoholism and Substance Abuse Services (OASAS) continue to suggest that providers approved by those agencies under Article 31 or 19 of the Mental Hygiene Law, respectively, are sufficiently regulated, and negate the need for licensing laws. However, a public hospital licensed by the Department of Health under Article 28 of the Public Health law is similarly regulated. There have been no suggestions that unlicensed individuals could substitute for physicians, registered professional nurses, physical or occupational therapists or pharmacists in a hospital. The programs and agencies that serve New Yorkers with mental illness, substance abuse disorder or other conditions must use licensed or authorized staff to provide behavioral health services to the public.

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Conclusion. The overarching concern of professional licensing relates to the protection of the public. Accordingly, many have expressed concerns about any exemption to allow unlicensed persons to provide services that the law restricts to individuals licensed or authorized (e.g., students, permit holders and interns under supervision). The statutory restriction on the practice of the professions seeks to ensure that defined services are provided by qualified individuals, licensed under the Education Law and accountable for their practice without regard to the setting in which the services are provided.

Sections 7706 (5)(e) and (f) provide an exemption, effective September 1, 2004, for individuals who were performing clinical social work services as an employee of a federal, state, county or municipal government or in any other legal settings, so long as the individual maintains employment in the qualifying position. The exemption is limited to the services provided by the individual on September 1, 2004 and does not authorize the use of the title “clinical social worker.” Some of the individuals identified in the survey of agency staff may qualify for the exemption, although it would be limited to those who maintained continuous employment in the same title with the same functions since September 1, 2004. It may be appropriate to consider an extension of this exemption, if policymakers choose to offer alternative pathways to licensure and a full implementation of the licensing law.

SW4. Alternative pathways. Chapter 420 of the Laws 2002 provided for a one-year period of licensure as an LMSW or LCSW without examination, for individuals who met the requirements in law and applied by September 1, 2005. An individual with an MSW degree and 5 years of post-degree practice, acceptable to the Department, who applied to the Department, paid the application and registration fee, and was of good moral character, as determined by the Department, was licensed as an LMSW without examination. A Certified Social Worker, who met the requirement for either the three-year (“P”) or six-year (“R”) psychotherapy privilege, and who filed the application for licensure, application and registration fee, and was of good moral character, as determined by the Department, was licensed as an LCSW without examination.

Since September 1, 2005, there have been inquiries from individuals and employers of these individuals, who did not qualify for licensure without examination and who have not passed the Masters or Clinical examination required for licensure as an LMSW or an LCSW, respectively. The law does not provide such an option which resulted in a number of individuals and organizations advocating for licensure without examination or an alternative examination. Although legislation has been introduced to allow certain individuals to become licensed as an LMSW without examination, the bills have not been acted on by the Senate or Assembly.

Conclusion. Although it would be extremely rare for a profession to be granted a statutorily enacted, second period of licensing without examination (“grandparenting”), it may be an issue for consideration by the Legislature. If policymakers choose such an option, it may be appropriate to limit this to

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individuals who are/were employed in an exempt program after September 1, 2004. An individual who practiced the profession without licensure in any other setting may have engaged in the illegal practice of a profession, which is a felony. Generally, the Department would not accept illegal experience to meet the requirements for licensure under Title VIII.

Chapter 420 of the Laws of 2002 took effect on September 1, 2004, after which time individuals should have been appropriately licensed or authorized under the law. The law provided an exemption until January 1, 2010 so that individuals who did not hold appropriate licensure could meet the requirements for education, experience and/or examination. The surveys fail to show that the oversight agencies have aggressively pursued appropriate licensure of staff providing social work services, as defined under Article 154. Although providers who responded to the Department's surveys identified the title and number of unlicensed individuals, they were not asked to provide the name or identifying information to allow the Department to determine who had applied for licensure or the outstanding requirements to be met by such applicant. However, the Fall 2014 respondents indicated that more than two-thirds (153) of the 383 unlicensed MSWs had not applied for licensure.

Conclusion. Policymakers may want to consider incentives to encourage the programs and agencies to work with unlicensed staff to apply for licensure and meet all requirements by a date certain. It may be appropriate to provide a temporary license for such applicants, to allow them to continue to practice in the setting, while submitting the application and documentation to become licensed as an LMSW or LCSW. An on-going commitment to licensure within public programs and employer support for applicants could achieve the goal of licensure for individuals who seek to provide services that are restricted under law.

As noted above, there are some individuals who have not passed the social work examination, in spite of repeated attempts. The examination vendor (ASWB) has demonstrated that the items used on the exam are free of racial or other bias and reflect the practice of the social work profession across North America. In addition, the examination is written at a 10th grade level, other than the use of professional terms, which is appropriate for a profession licensed at the master's degree level.

However, concerned individuals continue to assert that some persons of color are more likely to fail the exam, based on the educational privilege enjoyed by white social workers. The purpose of the licensing examination is to demonstrate minimum competence for the entry-level practice of the profession; a candidate who fails the examination has not met the standards. Opponents to the examination argue that failing candidates are often bi-lingual and bi-cultural, so that such populations cannot be served by using only licensed individuals. These groups and individuals have suggested that policymakers consider changing the laws to allow an applicant to meet the examination requirement for LMSW by (1) completing a period of supervised experience and portfolio, for review by the State Board (similar to a program in Texas); (2) providing

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an oral examination; (3) authorizing special arrangements for self-identified Limited-English-Proficient (LEP) candidates, such as the use of a translating dictionary when taking the exam (as allowed in about one-half of U.S. jurisdictions), paper-and-pencil versus computer-based examination, and/or extra time to complete the examination.

New York and every other jurisdiction in North America utilize ASWB examinations for social work licensure, except California which has developed and administered their own examination for decades. This allows a candidate to pass the test for licensure in one jurisdiction, knowing that the same test will be accepted in another jurisdiction. An amendment of Education Law to allow the Department to offer an oral examination, a New York State-specific written and/or computer-administered examination, or the submission of a portfolio based on post-MSW supervised experience, would affect the timeliness and cost of the licensing process. An applicant who is licensed under a state-specific examination or process would have to pass the ASWB examination for licensure in any other jurisdiction. The costs of developing a New York-specific oral or written examination will be borne by each candidate who takes the examination; with a smaller pool than national examinations, this will result in a higher examination cost for applicants. An examination must be based on well-written items that reflect the practice of the profession and it will take any vendor time to develop such an examination.

The use of an oral examination introduces rater subjectivity as well as the potential for discrimination into the process, as has been determined by several jurisdictions. In Texas, which offers the portfolio option, a candidate must first fail the ASWB examination twice, with a score that is close to the passing point, in order to qualify for that option and then pay a fee that is equal to the ASWB examination cost. Finally, the use of an oral examination or a portfolio as an alternative to the existing examination raises a concern that the alternative examination will not measure comparable knowledge, skills and abilities that are required to engage in social work practice. These options would all increase the time required to meet or, in the case of NY-specific or oral examination, the time to score the examination.

Conclusion. Policymakers may consider alternative examinations, as a permanent form of licensure without examination, for candidates who meet criteria that are identified in statute. However, such alternatives may have unintended negative impacts.

SW5. Extension of broad-based exemptions from licensure. The licensing law for social work was enacted in 2002, with an effective date of September 1, 2004, to allow time for the Department to promulgate regulations to implement the law. In order to provide additional time for programs under the authority of specific state agencies to comply, the law provided an exemption until January 1, 2010. The agencies that are defined as exempt and the deadline were subsequently amended, so that the current date for compliance is July 1, 2016.

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Although the licensing laws have been in place for a decade, it would appear that programs under the exempt agencies are not ready to require licensure by the July 1, 2016 deadline. In addition, the implementation of alternative pathways to licensure and further clarification of activities that do or do not require licensure will require time and it is important to avoid disruption in services to vulnerable individuals. Therefore, the Legislature may want to consider ways to ensure a smooth transition for the exempt agencies and the individuals in programs that they regulate, fund or approve to provide services.

Conclusion. It is important to ensure that fragile members of the public uniformly receive adequate preferred services, regardless of where they receive those services. The Department is ready to collaborate with the Legislature, Executive and other stakeholders, to discuss the timeline for implementing changes in the licensing laws to minimize any disruptions in services and displacement of individuals or programs.

SW6. Civil Service titles. The Department of Civil Service is responsible for establishing titles, defining the requirements for entry to such title, and setting out the functions that may be performed by an individual in such title, including the need for supervision where appropriate. At this time, the Civil Service has a tentative title for social workers but those do not require appropriate licensure under the Education Law. In our discussions with the exempt agencies, we learned of situations in which a licensed individual in a Civil Service title is practicing beyond the scope of practice, such as one LMSW supervising another LMSW providing clinical social work and psychotherapy to sex offenders in State correctional facilities.

Conclusion. Titles should be created and duties set forth by the Department of Civil Service to conform to Title VIII of the Education Law where they do not currently exist, or where there is confusion or lack of specificity within titles. This would include supervision of an individual who is only authorized to practice under supervision, (e.g., LMSW providing clinical services), as well as providing promotional opportunities (e.g., LMSW to LCSW to LCSW Supervisor).

The adoption of Civil Service titles that reflect the Education Law will assist programs operated by the State and local governments in hiring appropriately qualified staff, but will also “flow-down” to the voluntary, not-for-profit sector which may not use Civil Service titles but will have clear direction about qualified practitioners.

Topics for Discussion -- Mental Health Practitioners

As with social work, the Education Law was amended to clarify activities that do not require licensure as a permanent exemption from practice. The following section updates the 2012 recommendations for consideration by policy makers in the areas of:

1. clarification of practice
2. delegation of professional services

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3. occupational exemptions
4. alternative pathways
5. extension of broad-based exemptions from licensure
6. Civil Service titles

MHP1. Clarification of practice. Since the enactment of the laws to license individuals under Article 163, a major concern of the professional associations, educators, and employers has been the absence of the term “diagnosis” within the scope of practice for each of the four professions. While the law authorizes a licensee to complete an assessment and evaluation and to use accepted classification systems, including the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association, it does not specify “diagnosis.” In discussions with the professional associations, educators, and exempt agencies, it has been pointed out that the absence of this term has a negative effect on employment opportunities and may create an artificial shortage of qualified professionals. Although legislation was introduced in prior sessions, the law has not been amended to include diagnosis within the practice of these four professions.

The Office of the Professions has reviewed the education requirements (masters or higher degree) including specified course work in the assessment, evaluation and treatment of individuals, couples and families, including psychopathology and the use of the DSM. An applicant for licensure must complete supervised internships in the practice of the profession as part of the degree program, as well as post-degree supervised practice under licensed professionals, and pass a clinical examination. These requirements are similar to other mental health professions, including the LMSW and LCSW, who often practice side-by-side with individuals licensed as a mental health counselor, marriage and family therapist, creative arts therapist or psychoanalyst. The current law also appears to have an internal contradiction if it did not intend to include “diagnosis,” since it requires that individuals with a specific diagnosis, e.g., schizophrenia, be referred to a physician for an evaluation by the practitioner.

Conclusions. Some stakeholders see “diagnosis” as a function that could be appropriately provided by individuals licensed under Article 163, although this term is not included in the scope of practice for each profession. The Legislature could provide clarity by amending Article 163 to define diagnosis within the practice of the professions or provide guidance that an interpretation of the existing language to include diagnosis would be consistent with the legislative intent.

The Board of Regents and the Education Department, in conjunction with the State Board for Mental Health Practitioners, has the responsibility to clarify the practice of the professions, to reflect the training and preparation received by individuals entering these professions. This can provide increased access to services for individuals in all parts of New York, and hold accountable under the Education Law and

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Regents Rules those individuals who provide services without appropriate education, experience or training.

MHP 2. Delegation of professional services. The issues identified in the social work section would apply to the delegation of services provided under Article 163. There are no further comments or recommendations at this time.

MHP 3. Occupational exemptions. Article 163 contains the same occupational exemptions as those discussed in regard to social work (Article 154), therefore, the same comments would apply and are not repeated here.

MHP 4. Alternative pathways. Chapter 676 of the Laws of 2002 allowed the Department to license individuals on or after January 1, 2005 but did not require a license until January 1, 2006, to allow the Department to license qualified persons. This includes those who met “special provisions” as authorized by law and in regulations promulgated by the Department. There were 2,254 individuals licensed and registered to practice in the professions starting in September 2005 and ending on April 1, 2006, compared to 8,878 as of April 1, 2014:

<u>April 1, 2006</u>		<u>April 1, 2014</u>	
Mental Health Counseling	1,250	Mental Health Counseling	5,496
Marriage and Family Therapy	181	Marriage and Family Therapy	999
Creative Arts Therapy	463	Creative Arts Therapy	1,575
Psychoanalyst	360	Psychoanalyst	808
Total	2,254		8,878

There is consensus that many individuals in exempt agencies have not applied for licensure, due to the continuing exemptions. Therefore, the ending of the exemption may disenfranchise those individuals and programs, particularly if the long-time practitioner does not meet the current requirements for licensure.

Conclusion. A significant number of long-time practitioners did not seek licensure, particularly under the special provisions in 2005 and, now must be appropriately licensed by the time the exemptions expire. As in the social work professions, it may be appropriate to establish standards for education and experience as part of a time-limited, alternative pathway to licensure to avoid disruptions in the work force.

MHP 5. Extension of broad-based exemptions from licensure. The same concerns and issues that were expressed in regard to social work would apply to the mental health practitioners. This includes a commitment from the Department to work with stakeholders to collaborate in addressing practice questions raised by the exempt agencies and other stakeholders.

MHP 6. Civil Service titles. Since the four professions of mental health counseling, marriage and family therapist, creative arts therapist and psychoanalyst did

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not exist prior to 2006, the Civil Service titles do not include these professions. This has presented challenges to state agencies and programs, as well as the voluntary providers, in determining the services to be provided by individuals in these new professions. In many cases, a licensee is placed in a social work or recreation therapy title, for instance, because those were used prior to the establishment of these professions.

Conclusion. There is agreement that the Department of Civil Service should revise job titles to reflect the new professions established in Article 163 and require an applicant to be licensed in order to hold a Civil Service position, in order to ensure the health, safety and welfare of the public.

The creation of appropriate titles will provide opportunities for qualified licensees seeking to provide services in state or local government programs, as well as in the voluntary not-for-profit sector.

Topics for Discussion -- Psychology

Policymakers may want to consider proposals related to Psychology (P) in the areas of:

1. clarification of practice
2. delegation of professional services
3. occupational exemptions
4. alternative pathways
5. extension of broad-based exemptions from licensure
6. Civil Service titles
7. new professions

P1. Clarification of practice. Paragraph 10 of section 7605 was added to the exemptions in the psychology act (Article 153), pursuant to Chapter 57 of the Laws of 2013. This provided similar clarification of practice as noted in the social work and mental health practitioners. No other changes were suggested, however, concern was noted about the potential impact of changes to related professions and the need to ensure such proposals to not have an unintended adverse impact on the practice of psychology.

Conclusion. The Legislature has established requirements for licensure in each of the professions that ensure public protection through standards for entry to the profession, competent practice within the authorized scope and oversight by the Board of Regents to hold the licensee accountable for professional services provided directly or under supervision. There is agreement that any changes in law or regulation should minimize disruptions in service and protect the health, safety and welfare of the public.

P2. Delegation of professional services. The issues identified in the social work section would apply to the delegation of services provided under Article 153. There are no further comments or recommendations at this time.

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P3. Occupational exemptions. Section 7605 of The Education Law states that nothing in the licensing law for psychologists shall “be construed to affect or prevent the activities, services, and use of the title of psychologist, or any derivation thereof, on the part of a person in the employ of a federal, state, county or municipal agency, or other political subdivision, or a chartered elementary or secondary school or degree-granting educational institution insofar as such activities and services are a part of the duties of his salaried position.” This exemption does not expire. In most instances, excluding degree-granting institutions, such positions are commonly filled by persons meeting Civil Service defined positions, certification requirements, or specific exemptions.

Conclusion. There is agreement that this long-standing exemption should remain, since it has applied solely to persons who are salaried employees of entities that are operated by state, federal, regional or municipal agencies where such persons commonly hold a minimum of a master’s degree or higher in psychology and whose job descriptions define their services; this has existed since 1956 without evidence of harm and remains supported by professional associations.

This exemption does not extend to individuals who are employed in programs operated by the voluntary sector. It has been suggested in the past that this exemption should be extended to those voluntary, not-for-profit providers to whom the State delegates the care and treatment of certain populations, including those with developmental disabilities..

Conclusion. The extension of the exemption to not-for-profit providers could be seen as a waiver of licensure in all settings for individuals who receive services through the OPWDD or other state agencies. Accordingly, there is concern that individuals seeking professional services will receive varying levels of care depending on the setting where those services are provided, specifically those who are more affluent may be able to obtain the services of licensees and those with few resources may be provided care by unlicensed persons

P4. Alternative pathways. When Chapter 676 took effect on September 1, 2003, there were no changes in the requirements for licensure or the creation of an alternative pathway since the only change in the law was the addition of the scope and a section on limited permits. The State Board for Psychology has suggested that if an alternative pathway was established, those with a doctoral degree in psychology, and a certain number of years of experience, including an attestation of competency from the applicant’s supervisor(s), and no history of discipline could be licensed without examination, if all requirements are met by a date established in law.

Conclusion. The law could provide an alternative pathway, for a limited time period, for individuals who meet all requirements for licensure as a psychologist, as described above, except examination.

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This would be consistent with other efforts to provide a time-limited alternative pathway to licensure for long-time practitioners who may not meet the current requirements/examination for licensure in the profession but whose work has been declared competent by a supervisor(s).

P5. Extension of broad-based exemptions from licensure. The same issues and concerns that were raised in regard to the social work professions would apply in regard to psychology. The health, safety and welfare of the public is served best when individuals providing services have met requirements for licensure and are accountable to the public for their actions

P6. Civil Service titles. The Department would support efforts to provide appropriate titles and requirements for Civil Service titles. As noted earlier, the long-standing regulation of psychology and the exemption in section 7605 of the Education law have resulted in a relatively clear understanding of the requirements and practice of psychology in agencies operated by government entities subject to Civil Service or federal oversight.

P7. New profession. In 2012, the OPWDD recommended that the Education law be amended to provide licensure as a behavioral health practitioner for an individual with appropriate education, experience and examination. OPWDD suggests that the appropriate education would include a master's in psychology. This proposal was based in part on the need to authorize the practice of individuals with Board-Certification as a Behavioral Analyst (BCBA) who currently provide services to children with autism or other disorders under the exemption. The activities that are performed by these individuals fall within the restricted practice of psychology and could only be provided in an exempt setting by an unlicensed person.

Applied Behavior Analysis. Chapter 554 of 2013, as amended by Chapter 8 of 2014, defines the new professions of Licensed Applied Behavior Analyst and Certified Applied Behavior Analyst Assistant, effective July 1, 2014. While this addresses some of the issues identified in 2012, it has also become apparent that many certified school psychologists, specifically those who practice under the exemption in section 7605 of the Education Law, have been providing multi-disciplinary evaluations outside of the exempt setting (e.g., public school). In order to avoid delays in the evaluation of children under the age of 5 years under the federal IDEA, it may be necessary to consider licensure or a broader exemption for such providers.

Conclusion. The requirements for licensure under Title VIII in each profession include specific education, examination and, in many cases supervised experience that reflect the practice of the specific profession. Policymakers, in consultation with the State Board for Psychology, the Education Department and the Board of Regents, may want to consider alternative levels of licensure for certain psychologists, to ensure that providers meet minimum standards for education, experience and examination.

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The 2012 report included other topics for further study; there has been legislative action on a number of these topics, as shown in the table below.

Continuing Education	Mandatory continuing education for social workers, starting 1/1/2015 and mental health practitioners, starting 1/1/2017
Workforce planning	No action but on-going discussions with Center for Health Workforce Studies
Privileged communication	No action
Limited permits	Amended Article 163 to provide an initial 24-month permit and the possibility of two, one-year extensions, effective October 2013.
New professions	Other than the Applied Behavior Analysts referenced above, no legislation was enacted to create other professions under Title VIII.

Continuing Education. Chapter 443 of the Laws of 2013 requires that each LMSW and LCSW complete 36 hours of continuing education acceptable to the Department in the triennial registration period, starting on January 1, 2015. The enactment of these laws will improve the knowledge, skills and abilities of licensees in a rapidly changing practice environment. The Board of Regents adopted regulations to implement the social work requirement in April 2014. At this time, the State Board for Social Work is approving providers to offer courses and educational activities to LMSWs and LCSWs starting on January 1, 2015.

Chapter 486 of the Laws of 2013, as amended by Chapter 15 of the Laws of 2014, requires each mental health counselor, marriage and family therapist, creative arts therapist and psychoanalyst, starting on January 1, 2017, to complete 36 hours of continuing education, acceptable to the Department in the triennial registration period. At this time, the State Board for Mental Health Practitioners is collecting information to assist the Department with the development of proposed regulations to implement the law. It is anticipated that the regulations will be adopted in early 2016, to allow sufficient time to notify licensees, employers and prospective providers of the new law, prior to the January 1, 2017 effective date.

Workforce Planning. The Office of the Professions does not collect specific information from applicants or licensees in the psychology, social work or mental health professions about the licensee's practice setting, population served, and time in the field. This type of information is collected for the professions of medicine, nursing, dentistry and midwifery, when a licensee registers to practice. The licensee is directed to an online website, developed and maintained by the Center for Health Workforce Studies (CHWS) at the University at Albany. The data is collected and analyzed by CHWS for workforce planning and is available to employers, regulators and the public in order to make educated decisions about policy.

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There have been initial discussions between the CHWS, professional social work associations and the Office about collecting similar information about licensed social workers. Some of this information is available from the data collected by the national organizations, but collecting it relative to our State licensed psychologists would ensure accuracy and pertinence. It should be noted that this information, collected when a licensee registers to practice every three years, is a voluntary activity and not all licensees complete the survey. In order to mandate participation by social workers or other licensees, the Education Law would have to be amended to require the completion of the survey in order to complete the registration process. This could result in licensees who do not have access to a computer or do not wish to provide information, failing to complete the registration process in a timely way and, therefore, not be authorized to practice the profession and use the title. Further discussion and consideration of the planned and unintended consequences are needed before any decisions are made about including these professions in the survey process.

As the Office of the Professions moves to implement an electronic licensing system, the process for collecting data from licensees at the time of triennial registration may be incorporated. This process could provide email addresses that could be used by the Department to encourage participation, including reminders, in order to increase the quantity and the quality of responses.

Privileged Communication. The Civil Practice Laws and Rules (CPLR) provide privileged communications for licensed social workers and psychologists. There are no similar provisions for individuals licensed in the Article 163 professions. Although the Regents Rules define unprofessional conduct to include sharing confidential patient information without consent, the privilege may provide stronger protections for patients and practitioners. The Department does not develop legislative proposals, but could provide technical assistance, at the request of the Legislature, if appropriate.

Limited Permits. The limited permit may be issued by the Department to an applicant for licensure who has met all requirements except experience and/or examination. The permit allows the applicant to practice in an authorized setting, under a qualified supervisor, as defined in law and regulation. The applicant completes supervised experience and the examination for licensure while under the permit.

Article 163 originally provided a two-year initial permit for applicants in mental health counseling and one-year permits for applicants in marriage and family therapy, creative arts therapy and psychoanalysis; it also provided the opportunity for a one-year extension in each profession, to provide a maximum of three years under a permit for mental health counseling applicants, who must complete 3,000 supervised hours, and two years for applicants in the other professions, who must complete 1,500 supervised hours.

Due to a difficult job market that made full-time employment difficult, there were a significant number of applicants who exhausted the maximum time on a permit without having met the experience and/or examination requirements. Chapter 485 of the Laws of 2013 amended Article 163 to provide an initial two year permit and the possibility of two, one-year extensions for applicants in all four professions. The Board of Regents

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adopted regulations in October 2013 to implement the law and the Office of the Professions administratively extended existing permits. This provides additional time to applicants, even those who had applied prior to the effective date of the law, in order to protect the public and allow qualified applicants time to meet the final requirements for licensure.

Article 154 provides a one-year permit to an applicant for licensure as an LMSW or LCSW, who has met all requirements, except the examination. This allows the applicant up to three opportunities to take the ASWB examination in the calendar year. However, if the applicant does not meet the examination in the one-year period, he/she may not practice the profession, even under supervision. There has been no legislation to increase the time available to an LMSW or LCSW under a limited permit, to allow additional time to complete the examination.

Article 153 provides for two limited permits – a one year limited permit for psychologists who have been licensed in other jurisdictions and meet all by the examination requirement in NYS for licensure. Since most jurisdictions use the same examination, this is infrequently issued, but has been useful in a few instances. The other limited permit is issued for an aggregate of three years to enable the applicant to meet the supervised experience requirement. There is the possibility of extending this permit for one year for good cause as determined by the Department. This is rarely used.

Cost Considerations

Chapters 130 and 132 of the Laws of 2010 required that the plans submitted by the exempt agencies include estimates of the costs of licensure, including costs associated with employing only licensed or authorized personnel to perform tasks and functions that require licensure under Article 154, 153 or 163 and the cost associated with providing support for individuals who are seeking appropriate licensure. OMH, OASAS, OPWDD and OCFS made an assumption that individuals in existing job titles would all require licensure as a Licensed Clinical Social Worker and/or a salary equal to the average LCSW salary.

The cost-estimates and projections made by the agencies in 2012 appear to assume a worst-case scenario, including the replacement of unlicensed staff with licensees earning thousands of dollars more each year. In reviewing the agencies' projections, the Education Department focused on factors that could mitigate the effect on existing staff and salaries. These factors include clarification of duties that do not require licensure (e.g., case management) and those individuals who will continue to be exempt under the law (e.g., CASAC) so that there would be no fiscal increase to retain those staff members. A more realistic cost estimate was proposed by SED in 2012 by considering those factors. It is worthy of note that the expanded use of licensed professionals as part of the multi-disciplinary team may increase third-party

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reimbursement for services and result in a revenue-neutral implementation, if not the possibility of revenue.

Agency	Basis of cost estimates from the exempt agencies
OMH	\$9,236 differential between salary paid to currently unlicensed staff and \$47,275 average of LMSW and LCSW salary
OASAS	\$16,253 differential between salary paid to currently unlicensed staff and \$47,690 LCSW salary
OPWDD	Cost to replace unlicensed staff with an LMSW, starting at \$44,000 or replace an ABSS with licensed psychologist at \$76,000
OCFS	Estimate \$10,000 differential between unlicensed social worker and LMSW
DOH	None indicated as DOH expects programs to employ licensed staff.
SOFA	\$14,331 difference between case manager and licensed professional
DOCCS	\$52,555 difference between employees and the need to contract with appropriately licensed individuals

Conclusion. The assumption that all currently unlicensed staff would have to be licensed as an LCSW or another profession and paid a salary that is equivalent to the \$47,000 average is not supported by the data. When the Legislature enacts licensure, it is to establish minimum standards for education, examination and experience for those who will provide services that are restricted under the law; it is not guarantee of increased salaries. The use of licensed professionals to provide basic health, including behavioral health services, as shown in many research studies, will aide in reducing recidivism, providing more effective and efficient care, and ensure that an assessment of all factors that relate to the health/mental health issues are identified and pursued.

The exempt agency reports in 2012 suggested that many of the services that would be restricted to a licensed or authorized person can only be provided by an LCSW or licensed psychologist. This assumption did not consider the role of other mental health practitioners licensed under Article 163 who are authorized by law to provide similar services, including psychotherapy. As noted earlier in the report, the scope of practice for those professions could be clarified to include “diagnosis” within the practice of each profession. Legislative action would be necessary to clarify the role of mental health practitioners in the professional workforce.

The New York State Department of Civil Service is responsible for developing the classified titles and salary plan to define the qualifications for a class of titles and the job duties. Those titles that would provide some or all of the services that are provided by the State-operated exempt programs are listed below, along with the 2014 hiring salary. These titles and salaries do not apply to programs and agencies that are regulated, approved or funded by the State agencies; however, they may use similar titles to describe the individuals responsible for providing services to patients and consumers.

Classified Civil Services Title and Salary Plan (http://www.cs.ny.gov/tsplan/tsp.html)	Occupation Code	Salary Grade	2014 Salary Hiring Rate
Alcohol & Substance Abuse Treatment Program Assistant	8113500	14	\$41,993
Addictions Counselor 1	8339100	16	\$46,859

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Classified Civil Services Title and Salary Plan (http://www.cs.ny.gov/tsplan/tsp.html)	Occupation Code	Salary Grade	2014 Salary Hiring Rate
Addictions Counselor 2	8339200	18	\$52,293
Addictions Counselor 2	8339300	21	\$61,022
Addictions Program Specialist 1	8303100	18	\$52,293
Addictions Program Specialist 2	8303200	23	\$67,703
Addictions Program Specialist 3	8303300	25	\$75,243
Addictions Program Specialist 4	8303400	M-2	\$74,213
Mental Health Therapy Aide	5571300	9	\$31,805
Offender Rehabilitation Coordinator	838200	19	\$55,126
Supervising Offender Rehabilitation Coordinator	838300	22	\$64,302
Psychology Assistant 3	6161230	16	\$46,859
Psychologist 1	6160110	21	\$61,022
Psychologist 2	6160120	23	\$67,703
Associate Psychologist	6160400	23	\$67,703
Rehabilitation Counselor 1*	8341260	17	\$49,488
Rehabilitation Counselor 2*	8341270	19	\$55,126
State Veterans Counselor	8445200	18	\$52,293
Senior State Veterans Counselor	8445550	21	\$61,022
Social Work Assistant 1*	8159110	12	\$37,527
Social Work Assistant 2*	8159120	14	\$41,993
Social Work Assistant 3*	8159130	17	\$49,488
Social Worker 1*	8159210	18	\$52,293
Social Worker 2*	8159220	20	\$57,949
Medical Social Worker A	8108202	15	\$44,370
Medical Social Worker B	8108203	18	\$52,293
Senior Medical Social Worker	8108300	20	\$57,949
Supervising Medical Social Worker	8018500	22	\$64,302
Treatment Team Leader (Mental Retardation)	5255210	M-1	\$66,914
Treatment Team Leader (Children & Youth Services)	5255220	M-1	\$66,914
Treatment Team Leader (Mental Health)	5255230	M-1	\$66,914
Vocational Rehabilitation Counselor	8346200	19	\$55,126
Youth Counselor 1	8175000	18	\$52,293
Youth Counselor 2	8175100	21	\$61,022
Youth Counselor 3	8175200	23	\$67,703
Youth Counselor 4	8175300	27	\$83,493
Intensive Case Manager	81144300F	22	\$64,302
Coordinator Intensive Case Management Services	5293500	25	\$75,243
Licensed Master Social Worker 1*	8156100	18	\$52,293
Licensed Master Social Worker 2*	8156200	20	\$57,949

* Tentative titles that are subject to revisions

The Civil Service titles listed above are comparable to the titles used by the non-profit programs and agencies, as found in the results of the surveys. It is impossible to make a reliable estimate of the costs of licensure, without knowing the job titles and

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salaries for the State-operated and not-for-profit programs. Even if the job titles were provided by survey respondents, the Department has not received a full accounting of the number of individuals who are providing services, so we cannot make a cost estimate.

The Legislature established seven professions (psychology, social work and mental health practitioners) to ensure public protection and expand access to psychotherapy and related services for individuals, families and groups. The laws also establish requirements for licensure, to ensure that practitioners meet minimum requirements for entry to practice in any setting, including one operated or regulated by a State agency, and to ensure that the licensees are accountable for their services under the Education Law and Regents Rules. There may be increased costs associated with the use of licensed personnel, but the continued clarification of activities that do not require licensure can minimize these costs and reduce the possibility of reactionary reductions in the workforce.

The surveys have provided a listing of the occupational titles that are used in exempt agencies/programs to provide services that, if not for the July 1, 2016 exemption, could only be performed by individuals licensed and registered under the Education Law or otherwise authorized. These include individuals with a master's degree (e.g., rehabilitation counselors, master's level psychologists), a bachelor's degree (e.g., baccalaureate of social work), an associate's degree or a high school/GED diploma. When the Legislature established licensure for social workers and mental health practitioners which included the practice of psychotherapy, the master's degree was established as the minimum education. In the case of psychology, only the doctoral degree has been acceptable since 1957, apart from the original grand-parenting provisions.

The Legislature and Governor may consider whether to add new professions to provide health and mental health services, as currently defined in Articles 153, 154 and 163 of the Education Law. This could include professions that part of the existing professions, such as the B.S.W. who is now authorized to practice under the supervision of an LMSW or LCSW, or the master's level psychologist who is only authorized in certain settings, defined in law. It could also include other professions and occupations, within the Education Department, whose practice and regulation would be consistent with the existing professions.

Conclusion. There are financial and logistical barriers that face employees in completing the education, training and experience that may be required for licensure or credential. The Department is willing to work with the exempt agencies and licensure-qualifying programs, to explore distance learning and other formats that may facilitate the education process for individuals who choose to seek licensure in social work or another profession. The Legislature and Executive may wish to expand existing loan forgiveness and scholarship programs that provide incentives to new graduates to provide services in under-served communities.

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The direct costs of licensure are borne by individuals who complete graduate education programs to prepare for practice and then apply for licensure through the Education Department. The Education Department uses the application and registration fees to conduct the review and evaluation of an applicant's qualifications; to receive, investigate and prosecute complaints of unprofessional conduct or illegal practice to protect the public; and to support the activities of more than 30 State Boards and committees that assist in the license, practice and discipline of the professions. The fees for licensure and registration in these professions are found in Table 6; the registration fee is paid every three years, after initial licensure.

Profession	Application fee	Permit fee	Triennial registration fee	Examination fee paid to vendors	Total
Psychology	\$115	\$70	\$179	\$519	\$883
LMSW	\$115	\$70	\$179	\$230	\$594
LCSW	\$115	\$70	\$179	\$260	\$624
LCAT	\$175	\$70	\$196	\$235 (ATCB) \$220 (CBMT) \$780 (Narrative)	\$676 \$661 \$1,221
LMFT	\$175	\$70	\$196	\$245	\$686
LMHC	\$175	\$70	\$196	\$200	\$641
LP	\$175	\$70	\$196	\$780 (Narrative)	\$1,221
LBA	\$150	\$70	\$175	TBD	\$395 + exam
CBAA	\$200	\$70	\$100	TBD	\$370 + exam

The costs for licensure are paid by the individual, although these costs may be reimbursed by an employer. While unlicensed staff would not incur the costs for licensure and registration, these unlicensed staff may qualify for credentials, e.g., CASAC, that would impose costs on the individual and/or the employer. If licensure were to be established for other professions, it would be reasonable to expect similar costs to the applicant, although fees would be established by the Legislature in law.

Next steps. The Commissioners of the exempt agencies are invited to provide alternative recommendations and comments on the report. Summaries of the responses to the Department surveys are attached to this report for information.

The exemption from licensure will be repealed, as of July 1, 2016, absent any statutory changes. The Education Department, with the assistance of the State Boards for the professions, will provide technical assistance, as requested by the Executive and Legislature in the months prior to repeal, to ensure a smooth and timely transition.

Appendices: Summary of Responses to the 2013 Survey
 Summary of Responses to the 2014 Survey

Summary of Responses to the 2013 Survey

The Office of the Professions (OP), in partnership with the agencies defined as exempt from the social work, mental health and psychology licensing laws developed a survey mandated by Chapter 57 of the Laws of 2013. This survey was designed to collect from affected agencies and programs the number of unlicensed individuals who provided certain, restricted services that would be restricted to those licensed or authorized under the law, if not for the exemption provided until July 1, 2016 for an employee of a program that is operated, regulated, funded or approved by one or more of the exempt agencies. The survey was posted on Survey Monkey to allow on-line completion by the programs that were invited to participate by the exempt agency that has regulatory authority over the program. This document is a summary of the 860 responses submitted by January 15, 2014.

The survey identifies five major functions that are within the scopes of professional practice that may be provided in the program by unlicensed individuals under the July 1, 2016 exemption. The survey included definitions of these restricted functions:

- diagnosis of mental, emotional, behavioral, addictive and developmental disabilities;
- patient assessment and evaluation within a professional practice;
- psychotherapeutic treatment;
- treatment other than psychotherapeutic treatment; and
- development of assessment-based treatment plans.

To help respondents answer the survey, the Office of the Professions provided examples of services and activities that will be restricted to licensed individuals, beginning July 1, 2016. Respondents were asked to review these definitions and examples before responding to questions about the individuals working in his or her program.

For each of the functions, respondents were asked to indicate the number of unlicensed individuals (if any) in each of the occupational titles provided by the respondent's agency or program. This includes all individuals who work in the programs, whether they are employed directly by the agency or work under a contract arrangement. Respondents had the option to add up to 4 additional occupational titles and to provide with each title the number of individuals providing the service. If an individual holds more than one title, the individual should only be identified once, preferably under the title in which he or she performs most of the services.

The survey instructions included a reminder that, pursuant to a permanent exemption in the laws that define the restricted practice of psychology, social work and mental health practitioners, unlicensed individuals may perform activities that would be restricted to individuals licensed or authorized, until July 1, 2016.. Respondents were directed to exclude from the reporting those individuals that are performing tasks that do not require licensure as defined in the Education law (subdivisions 10 of section 7605, 7 of section 7706, and 8 of section 8410). Licensure is not required for tasks such as:

- 1) performing assessments such as basic information collection, gathering of demographic data, and informal observations;
- 2) screening and referral used for general eligibility for a program or service;
- 3) determining the functional status of an individual for the purpose of determining need for services unrelated to a behavioral health diagnosis or treatment plan;
- 4) creating, developing or implementing a service plan **unrelated to a behavioral health diagnosis or treatment plan** (including plans related to job training and employability, housing, general

2013 Survey Responses

public assistance, in home services and supports or home-delivered meals, investigations conducted or assessments made by adult or child protective services, adoption home studies and assessments, family service plans, transition plans and permanency planning activities, de-escalation techniques, peer services or skill development);

5) participation as a member of a multi-disciplinary team to implement a behavioral health services or treatment plan; provided, however, that such team shall include one or more licensed professionals providing services within their scope of practice. However, an unlicensed team member should be counted in the survey if he or she engages in any of the following activities:

- diagnosis,
- patient assessment and evaluation,
- psychotherapeutic treatment,
- treatment other than psychotherapy,
- development and/or implementation of assessment-based treatment plans.

Before answering the questions, respondents were asked to review the examples of activities that **DO NOT require licensure** within each of these five areas, e.g., helping a consumer complete an intake form. Those activities will not require licensure after July 1, 2016.

Respondents were asked to indicate the total staff, including administrative and direct care, employed in the program. Figure 1 indicates that 750 respondents provided information about the total staff. A preliminary review of responses indicated that there may be differences in staffing patterns based on the total staff size. Therefore, we categorized the respondents into three groups based on the number of staff: 50 or fewer staff (35.6%), 51 to 500 staff (43.5%), and 501 or more staff (20.9%). This categorization will be used in analyzing other survey responses to identify any difference in the use of unlicensed staff based on the total staff in an exempt program.

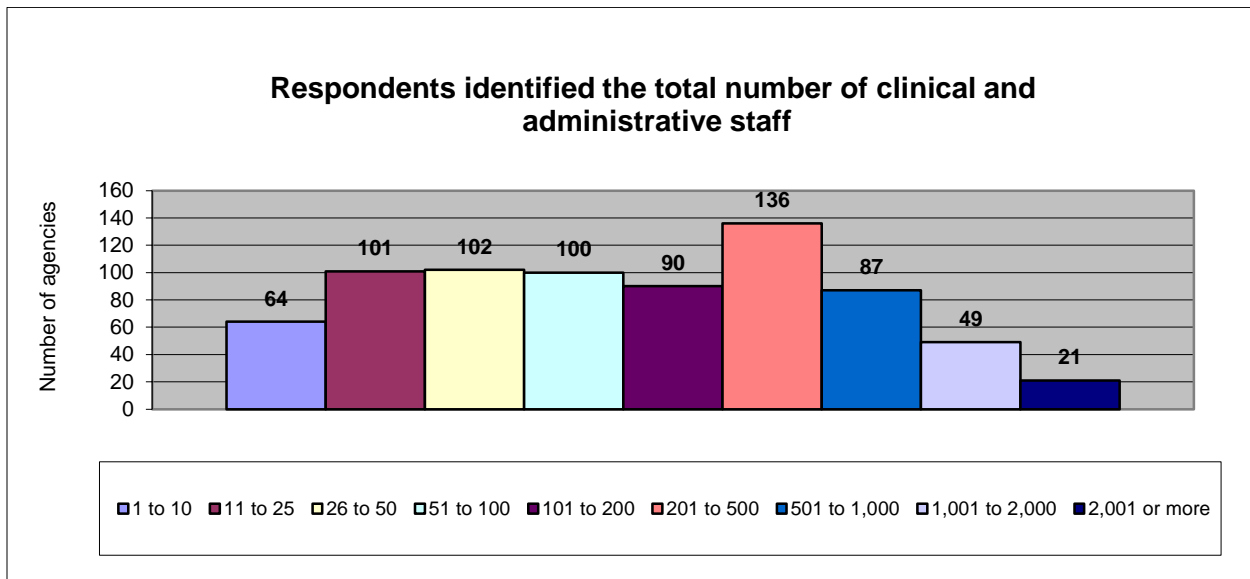


Figure 1. Responses were submitted by agencies from small to large and those responses were used to categorize respondents into small, medium and large based on total staff.

Respondents were asked to indicate the counties in New York State in which the program offered services that would be restricted to those licensed or authorized, if not for the exemption from the law

2013 Survey Responses

(Figure 1). An entity may provide services in more than one county, so the total number of locations exceeds the 860 survey respondents.

County	No. of responses	County	No. of responses	County	No. of responses
Albany	32	Herkimer	23	Richmond	50
Allegany	22	Jefferson	21	Rockland	33
Bronx	120	Kings	125	Saratoga	25
Broome	22	Lewis	22	Schenectady	29
Cattaraugus	28	Livingston	22	Schoharie	19
Cayuga	18	Madison	24	Schuyler	28
Chautauqua	33	Monroe	43	Seneca	22
Chemung	23	Montgomery	19	St. Lawrence	23
Chenango	18	Nassau	74	Steuben	27
Clinton	15	New York	142	Suffolk	80
Columbia	21	Niagara	39	Sullivan	19
Cortland	17	Oneida	31	Tioga	21
Delaware	15	Onondaga	39	Tompkins	23
Dutchess	29	Ontario	26	Ulster	55
Erie	53	Orange	38	Warren	18
Essex	18	Orleans	26	Washington	17
Franklin	18	Oswego	24	Wayne	22
Fulton	30	Otsego	18	Westchester	61
Genesee	18	Putnam	22	Wyoming	24
Greene	23	Queens	108	Yates	16
Hamilton	12	Rensselaer	25		

Figure 2. Respondents operate programs in all counties of New York (multiple answers allowed).

Programs and agencies that responded to this survey are under the regulatory authority of one or more state or local government agencies, which extends the exemption from licensure to individuals in that program or agency. Figure 3 provides an overview of the relationship between respondents and the regulatory agencies defined in Chapter 57 of the Laws of 2013. These relationships could include operation of the program by the oversight agency; regulation of the program (e.g., an operating certificate or license); approval of the program by an oversight agency; and/or funding of the program, at any level, by the regulatory agency.

State/local government oversight	Operated	Regulated	Approved	Funded
NYS Office of Mental Health (OMH)	58	357	234	208
NYS Office for People with Developmental Disabilities (OPWDD)	46	307	271	280
NYS Office of Alcoholism & Substance Abuse Services (OASAS)	9	108	61	61
NYS Office of Children & Family Services (OCFS)	4	94	67	66

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NYS Office for the Aging (OFA)	0	10	7	14
NYS Department of Health (DOH)	11	191	115	100
NYS Office of Temporary & Disability Assistance (OTDA)	0	26	27	51
NYS Department of Corrections & Community Supervision (DOCCS)	1	1	4	4
Local Social Services District (LSSD)	1	45	10	97
Local Mental Hygiene District (LMHD)	8	66	72	98

Figure 3. Respondents had a relationship with at least one of the exempt agencies as defined in statute.

In developing the 2011 survey of programs under the exempt state agencies, the Office of the Professions collaborated with the exempt executive agencies to develop a working definition for each of the five restricted activities. The collaborators also provided examples of specific activities that would either fall within the restricted scope, if not for the exemption, and activities that would not require licensure, if the exemption expired. These definitions and examples were used in the current survey for a consistent approach in collecting information from respondents.

Participants in the current survey were provided with the definition of the restricted activity, e.g., diagnosis, and asked to provide the number of unlicensed individuals in the program who engaged in the activity on July 1, 2013. If no unlicensed staff provided the service, respondents were asked to enter “0”. In order to clarify the activities that these unlicensed individuals perform, the survey then presented examples from the 2011 survey that could only be performed by a licensed or authorized person, if not for the exemption, and asked to indicate whether or not the unlicensed staff engaged in that activity. *Our intention was to identify activities that may need to be clarified through an amendment of law, rule or regulation, in order to restrict those activities to licensed or authorized individuals after July 1, 2016.*

After identifying the number of unlicensed individuals who engage in the restricted practice and the specific activities these individuals perform, the participants were presented with a list of 29 occupational titles and asked to identify the titles under which those unlicensed individuals engage in the restricted activity, e.g., diagnosis. The occupational titles were taken from the 2011 survey to provide consistency and to facilitate the survey completion. The participants could indicate whether individuals in other occupational titles engage in the restricted activity and could add up to four titles.

The responses to the survey, as outlined above, will be presented for each of the five restricted activities: diagnosis, patient assessment and evaluation, psychotherapeutic treatment, treatment other than psychotherapy, and the development and/or implementation of assessment-based treatment plans. Participants also completed a summary table (Figure 4) that indicates the type of activities performed by unlicensed staff in each of the occupational titles; if unlicensed staff in any occupational title did not provide the service, the participant indicated it was not applicable. The numbers in the table indicate the number of responses, not the number of unlicensed individuals. These numbers should not be added for each title, as one unlicensed psychologist could be performing all of the activities or none of them. Additional information

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about the number of unlicensed individuals in each occupational title is provided in Appendices I, II and III of this report.

Occupational Title	Diagnosis	Assess Evaluate	Psychotherapy	Other Treatment	Assess-based planning	Average
Unlicensed Psychologist (MA/MS)	449	719	654	702	713	647
Unlicensed Psychologist (Ph.D.)	145	147	134	123	132	136
Unlicensed Bachelor of Social Work (BSW)	49	78	93	113	102	87
Unlicensed Masters of Social Work (MSW)	441	547	531	522	544	517
Unlicensed Mental Health Counselor (MHC)	230	247	228	206	221	226
Unlicensed Marriage and Family Therapist (MFT)	30	26	28	27	13	25
Unlicensed Creative Arts Therapist (CAT)	17	22	18	20	21	20
Unlicensed Psychoanalyst	31	25	26	1	25	22
Rehabilitation Counselor	69	99	69	91	76	81
Case Manager	232	725	429	601	928	583
Counselor or Residential Program Aide	516	1,035	754	1,077	1,296	936
Mental Health Therapy Aide or Assistant	13	48	57	106	52	55
Recreation Therapist	40	78	47	64	74	61
Totals	2,262	3,796	3,068	3,653	4,197	2,782

Figure 4. Respondents completed a chart to indicate whether or not unlicensed staff in 29 occupational titles performed the restricted activity.

Diagnosis

Diagnosis is the identification of a disorder on the basis of its signs and symptoms and an analysis of the underlying mental, nervous, emotional, behavioral, developmental and addictive disorders, impairment and disabilities to determine their cause and potential treatments. Such diagnoses are commonly made consistent with acceptable classification systems, e.g., the Diagnostic and Statistical

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Manual of Mental Disorders (DSM). Statutory definitions of "diagnosis" may be found in Title VIII of the Education Law (www.op.nysed.gov/title8).

Respondents were asked to enter the number of unlicensed staff who employed in the program on July 1, 2013 who makes a diagnosis, as defined above. If no unlicensed staff makes a diagnosis, respondents were asked to enter a 0 in the corresponding box. **Responses were provided by 708 programs; 509 of respondents (80.6%) indicated that no unlicensed staff makes a diagnosis.** Figure 5 provides the number of unlicensed staff in the 199 programs that utilize unlicensed staff to make a diagnosis. The individual responses have been categorized as one to five; six to 10; and 11 or more staff, based on a review of the responses to all questions. The most frequent response was one to five staff (N=112 or 56%), whether the agency was small, medium, or large.

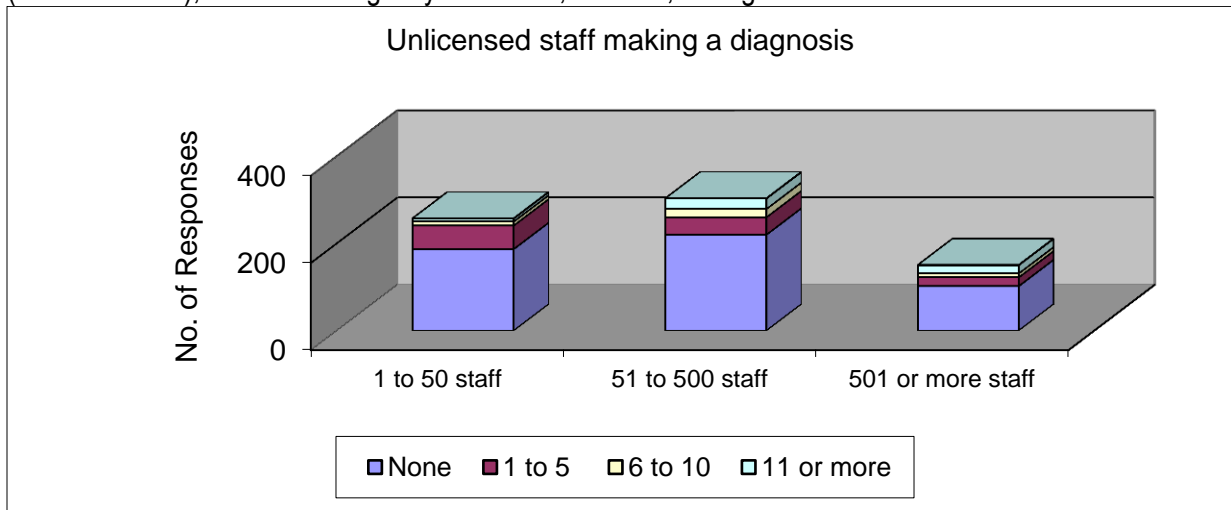


Figure 5. Regardless of total staff in the agency, the majority of respondents indicated that no unlicensed staff makes a diagnosis, as defined in statute and the survey.

The 199 respondents who indicated that one or more unlicensed staff make a diagnosis, as defined above, were then asked to indicate by a check mark those specific activities that are part of "diagnosis" that are performed by unlicensed staff. Figure 6 indicates the number of responses. **The responses suggest that programs using unlicensed staff to make a diagnosis have those individuals engaged in activities that, if not for the exemption, would be restricted to individuals who are licensed or otherwise authorized to make a diagnosis.**

The activities that constitute making a diagnosis that are performed by unlicensed staff, as allowed under the 2016 exemption from licensure.	1 to 50 staff	51 to 500 staff	501 or more staff	Total
a. Evaluating information that is gathered regarding the consumer's health, mental health, social, and developmental status directly from the consumer or in consultation with others, to make a behavioral health diagnosis using the DSM or similar classification system.	70	76	48	194
b. Engaging in clinical interviews and clinical testing to gather, interpret and evaluate information from appropriate sources, to identify signs and symptoms and causes of behaviors for purpose of making a mental health diagnosis.	64	69	40	173

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The activities that constitute making a diagnosis that are performed by unlicensed staff, as allowed under the 2016 exemption from licensure.	1 to 50 staff	51 to 500 staff	501 or more staff	Total
c. The application of professional judgment based on the clinical evaluation, which could include relevant information received from consumer and others, including direct care staff, to reach a diagnosis of the consumer's disorder or dysfunction and identifying it using the DSM or other classification system.	68	68	47	183

Figure 6. More than three quarters of the unlicensed staff identified as making a diagnosis are engaged in one or more activity that constitutes making a diagnosis, as defined in the law.

Figure 7 provides the occupational titles that are used for the 2,262 unlicensed individuals who make a diagnosis in the agencies that use unlicensed staff to engage in an activity that, if not for the 2016 exemption, would be restricted under the Education Law. A full list of the occupational titles by agency size for each of the five functions may be found in Appendix I to this report. **It should be noted that there is a permanent exemption from licensure in the psychology practice act (Article 153) for an individual employed in a salaried position in a psychology title in a government-operated program; this exemption does not apply to those programs that are regulated, funded or approved by the exempt agencies.**

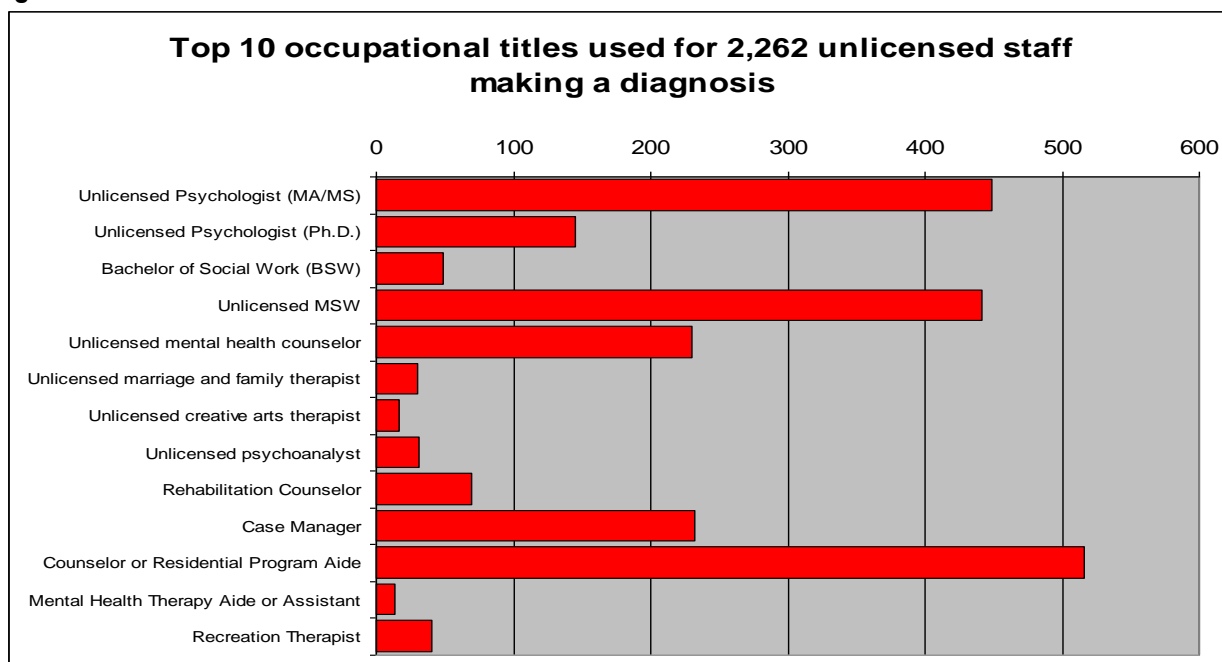


Figure 7. The top occupational titles for unlicensed staff making a diagnosis under the 2016 exemption from licensure.

It is notable that individuals in six of the titles (doctoral-educated psychologist, MSW, MHC, MFT, CAT or LP) appear to hold degrees in professions that are licensed under the Education Law, but the programs employ unlicensed individuals in those titles. The next survey will ask agencies employing individuals in those titles whether the individuals have applied for licensure and, if not licensed, what requirements remain in order to receive the license.

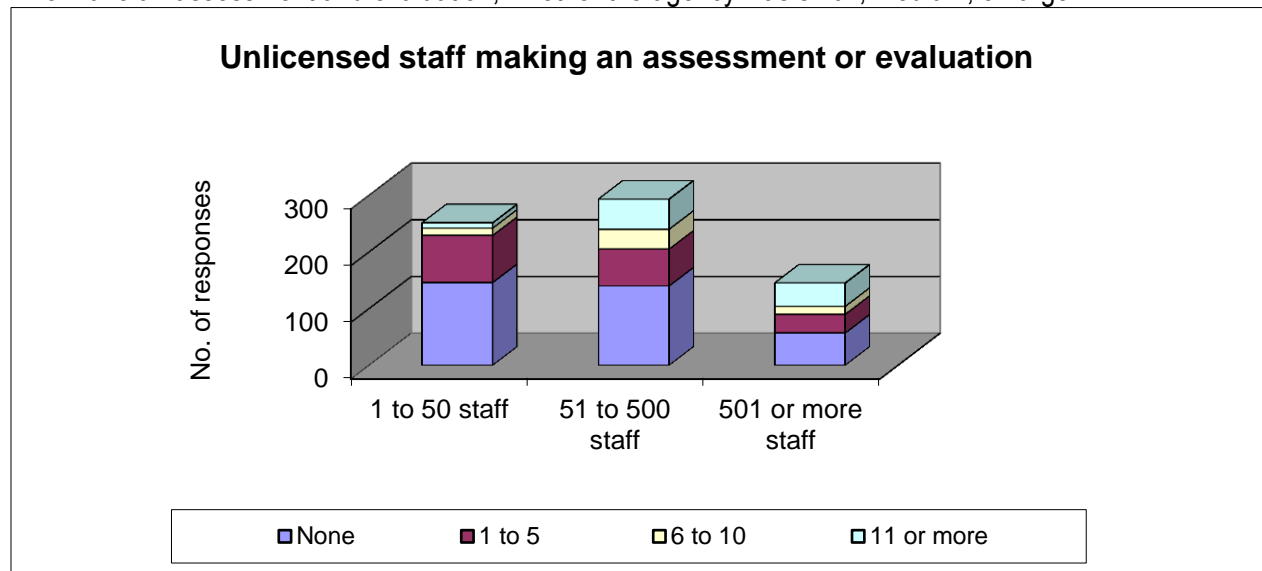
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Twenty-seven of the respondents indicated that individuals in other occupational titles provided a diagnosis and provided the titles and number of staff in those titles. Although the title was included on the list of occupations, 10 of the 27 indicated that Credentialed Alcoholism and Substance Abuse Counselors (CASAC), accounting for 50-plus staff. The other titles that were identified included 36 social services supervisors, 22 home finders, 22 socio-therapists, 20 case aides and 10 individuals with a master's degree in education. This response pattern for unlicensed providers will be repeated in the other five restricted activities. A complete list of the occupational titles for each of the functions may be found in Appendix II of this report.

Patient Assessment and Evaluation in a Professional Practice

Patient assessment and evaluation in the practice of the professions includes collecting information through clinical interviews; psychological and psychosocial tests and measures, contacts with members of the consumer's family and educational, employment, and/or health care settings/providers for the purpose of determining a behavioral health diagnosis and/or appropriate behavioral management, discharge, or treatment plan for the consumer. This includes the administration and interpretation of psychological tests and procedures including measures of cognitive, language, sensory-motor, and physical functioning to identify developmental disorders and disabilities in young children, and to determine levels of growth and delay for purposes of treatment, training and placement for adolescents and adults.

Respondents were asked to enter the number of unlicensed staff employed in the program on July 1, 2013, who made an assessment and evaluation within a professional practice, as defined above. If there are no unlicensed staff in a program making an assessment and evaluation, respondents were asked to enter a 0 in the corresponding box. Responses were provided by **689** programs; **343 of respondents (49.7%) indicated that unlicensed staff do not make an assessment or evaluation within a professional practice.** Figure 8 provides the number of unlicensed staff in the 346 programs that utilize unlicensed staff to make an assessment and evaluation within a professional practice. The individual responses have been categorized and 181 of the 346 programs (52.3%) employ one to five unlicensed staff who make an assessment and evaluation, whether the agency was small, medium, or large.



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Figure 8. Regardless of total staff in the agency, the majority of respondents indicated that no unlicensed staff make an assessment or evaluation, as defined in statute and the survey.

The 346 programs that indicated unlicensed employees make an assessment and evaluation within a professional practice, as defined above, then were asked to indicate by a check mark those specific activities provided by unlicensed individuals in the program. Figure 9 shows the number of responses for each of the restricted activities. **The results indicate that as many as 331 staff in the 346 agencies (95.6%) conduct clinical interviews, which are part of an assessment or evaluation, as defined in the survey and, if not for the 2016 exemption, would be restricted to individuals licensed or authorized under the law.** At least 50 percent of the respondents utilize unlicensed staff to provide one or more of the functions that constitute the restricted activity. This suggests the need to further clarify the activities that may only be performed by an individual who is licensed or authorized under the Education Law, so that after July 1, 2016, those unlicensed individuals are not engaged in restricted activities.

The activities that constitute the performance of an assessment and evaluation within a professional practice, that may be performed by unlicensed staff, as allowed under the 2016 exemption from licensure.	1 to 50 staff	51 to 500 staff	501 or more staff	Total
a. Clinical interviews with the consumer and/or collateral parties to collect information necessary to determine the consumer's level of function for persons with mental, emotional, nervous, behavioral and developmental needs, for the purpose of establishing a diagnosis or completing or modifying a treatment plan.	101	146	84	331
b. Determining the consumer's psychological and developmental progress, through the administration and scoring of appropriate instruments, including clinical interviews with the consumer, family members, and others	72	104	71	247
c. Using written text, art, music, photographs, or other media to evaluate how the consumer expresses emotions, thoughts, or behaviors, in order to develop or modify the diagnosis or treatment plan.	49	76	43	168
d. Administering, scoring and interpreting clinical tests and measures of psychosocial, developmental, and psychological functioning and reviewing the results of the evaluation with a consumer to establish a behavioral health service treatment plan.	50	77	59	186

Figure 9. Between 52 and 95 percent of the respondents indicated that their agencies utilize unlicensed individuals to perform functions that constitute the restricted performance of an assessment and evaluation within a professional practice.

Figure 10 provides the occupational titles for 3,796 unlicensed individuals who are most frequently used to perform an assessment and evaluation within a professional practice to engage in an activity that, if not for the 2016 exemption, would be restricted under the Education Law. A full list of the occupational titles by agency size for each of the five functions may be found in Appendix I to this report. **It should be noted that there is a permanent exemption from licensure in the psychology practice act (Article 153) for**

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an individual employed in salaried position in a psychology title in a government-operated program; this exemption does not apply to those programs that are regulated, funded or approved by the exempt agencies.

It is notable that individuals in six of the titles (doctoral-educated psychologist, MSW, MHC, MFT, CAT or LP) appear to hold degrees in professions that are licensed under the Education Law, but the programs employ unlicensed individuals in those titles. The next survey will ask agencies employing individuals in those titles whether the individuals have applied for licensure and, if not licensed, what requirements remain in order to receive the license.

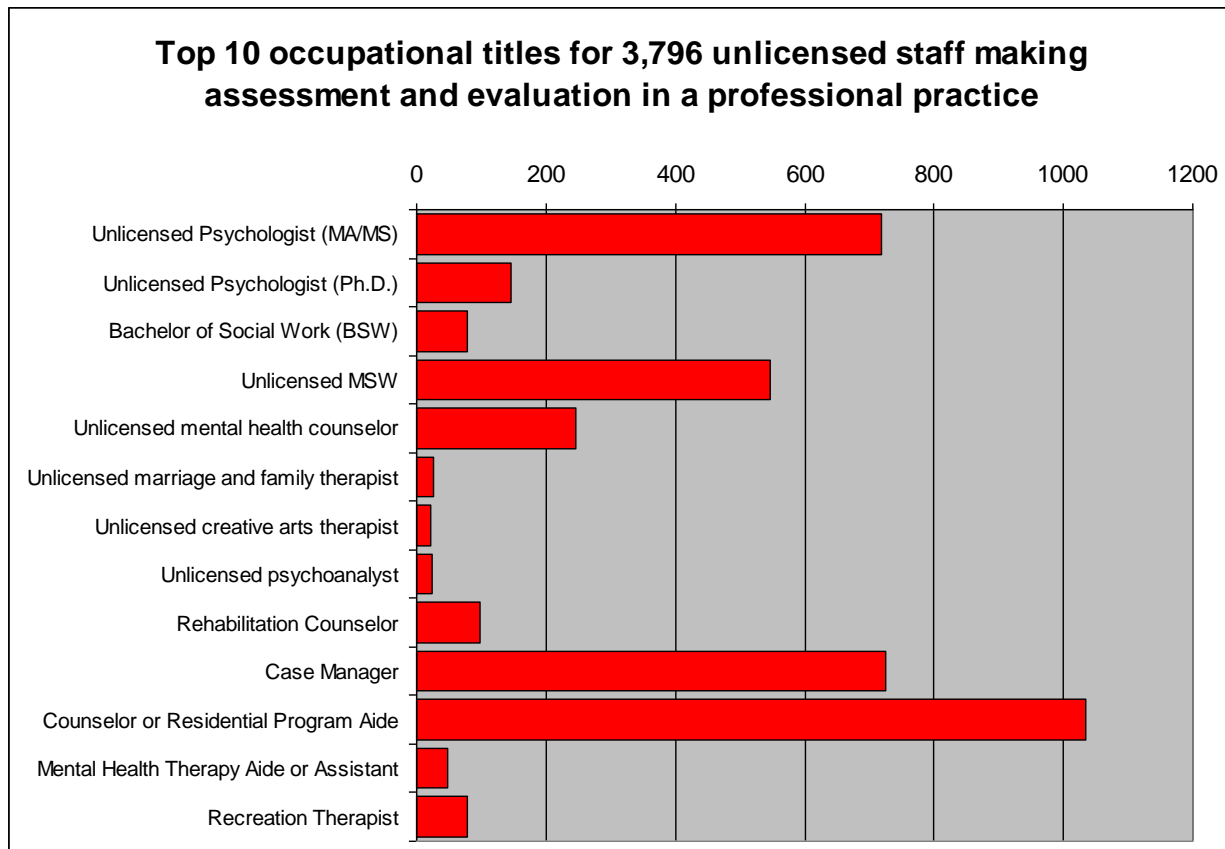


Figure 10. The top occupational titles for unlicensed staff who conduct an assessment or evaluation under the 2016 exemption from licensure.

Fifty-seven of the respondents indicated that individuals in other occupational titles conduct an assessment and evaluation and provided the titles and number of staff in those titles. As with diagnosis, although the title was included on the list of occupations, 10 of the respondents indicated that Credentialed Alcoholism and Substance Abuse Counselors (CASAC), accounting for 50-plus staff. The other titles that were identified with staff included 68 offender rehabilitation coordinator ASAT, 36 social services supervisors, 22 home finders, 22 socio-therapists, 20 case aides, 14 case coordinators, 10 family specialists, and 10 individuals with a master's degree in education. This pattern of responses was similar to the other restricted activities. A complete list of the occupational titles for each of the functions may be found in Appendix II of this report.

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Psychotherapeutic Treatment

Psychotherapy is defined in section 8401(2) of the Education Law as the treatment of mental, nervous, emotional, behavioral and addictive disorders, and ailments by the use of both verbal and behavioral methods of intervention in interpersonal relationships with the intent of assisting the person's ability to modify attitudes, thinking, affect, and behavior which are intellectually, socially and emotionally maladaptive. There may be other definitions of psychotherapy in federal (e.g., Medicare) or state (e.g., Insurance) laws and in health insurance policies. As in the 2011 survey, this survey used a definition in the Education Law which describes many theoretically-based, scientific systems of activities that are provided directly by individuals licensed or authorized under the Education Law or under an exemption until July 1, 2016.

Respondents were asked to enter the number of unlicensed staff employed in the program on July 1, 2013 who provided psychotherapeutic treatment, as defined above. If no unlicensed staff provided psychotherapeutic treatment, respondents were asked to enter a 0 in the corresponding box. Responses were provided by 682 programs; **358 of respondents (52.4%) indicated that no unlicensed staff provided psychotherapeutic treatment.** Figure 11 provides the number of unlicensed staff in the 324 programs that use unlicensed staff to provide psychotherapy. The individual responses have been categorized as one to five; six to 10; and 11 or more staff, based on a review of responses to all questions. The most frequent response was one to five staff (N=169/324 or 52.1%), whether the agency was considered to be small, medium or large, in relation to total staff.

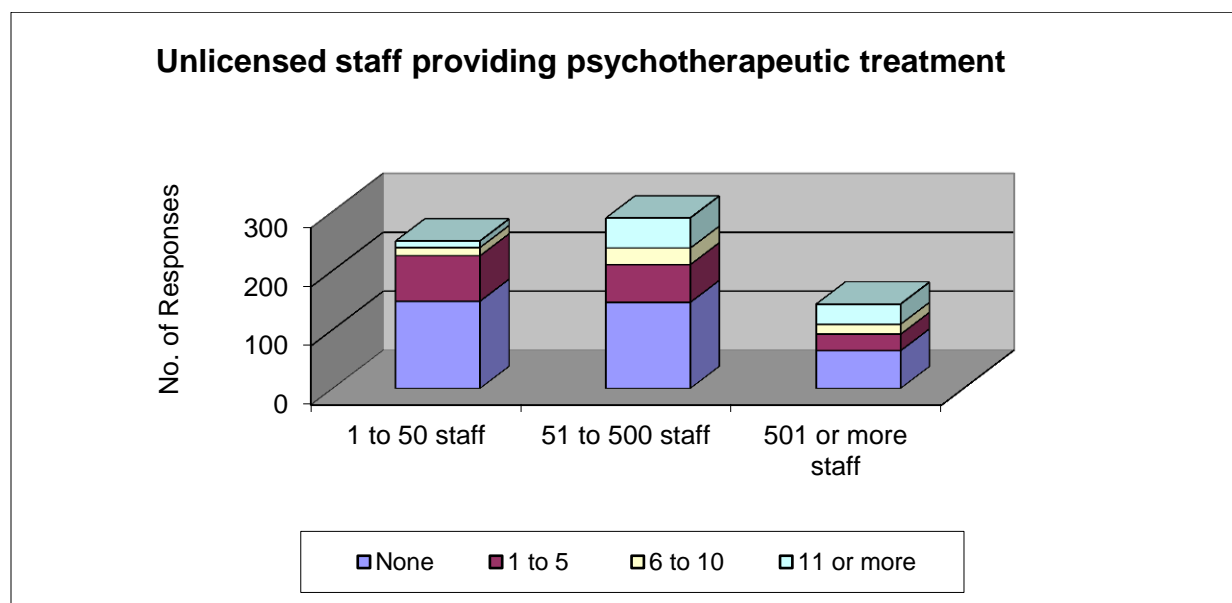


Figure 11. Regardless of total staff in the agency, the majority of respondents indicated that no unlicensed staff provide psychotherapy, as defined in statute and the survey.

The 324 programs that indicated unlicensed employees provided psychotherapeutic treatment, as defined above, were asked to indicate by a check mark those specific activities provided by unlicensed individuals in the program. Figure 12 shows the number of responses for each function. The responses suggest that 24% (79/324) of unlicensed staff in agencies provide psychotherapy using the creative arts (d).

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However, the other psychotherapy functions were performed by unlicensed staff in at least two-thirds of the programs, in the case of (b) behavior modification (213/324 or 65%) and more than 80% used directive techniques to provide psycho-education to consumers and others (e).

The activities that constitute psychotherapeutic treatment that are performed by unlicensed staff, as allowed under the 2016 exemption from licensure.	1 to 50 staff	51 to 500 staff	501 or more staff	Total
a. Providing individual, family or group therapy based on a professional assessment and as part of a behavioral health treatment plan developed by the individual licensed under Education Law.	80	91	61	232
b. Planning, approving and/or overseeing the development or modification of a reward-based behavior modification treatment plan to reinforce positive behaviors (e.g., abstinence) or discourage negative behaviors (e.g., substance abuse). The licensed professional is responsible for determining the type and amount of psychotherapy that is needed, but may seek and consider information from direct care staff	65	86	62	213
c. Providing direct treatment to the consumer (alone or in group therapy) based on various psychotherapy models (e.g., Cognitive-Behavioral Therapy or psychoanalysis).	83	98	60	241
d. Conducting and leading art or music therapy group sessions to assess and/or treat the consumer's mental health needs. Licensee can use appropriately trained staff to provide support for these activities, such as assisting consumers with movements or playing an instrument.	23	36	20	79
e. Utilizing directive techniques to educate the consumer so that he/she can (1) learn and understand their symptoms and the purpose and goals of the treatment of their mental illness or other conditions and (2) develop/strengthen coping skills and personal strengths to more fully engage in treatment and life activities.	85	121	66	272

Figure 12. Psychotherapeutic treatment activities performed by unlicensed individuals in exempt programs.

Figure 13 provides the occupational titles for the 3,068 unlicensed individuals who are most frequently used to provide psychotherapeutic treatment in the agencies that use unlicensed staff to engage in an activity that, if not for the 2016 exemption, would be restricted under the Education Law. A full list of the occupational titles by agency size for each of the five functions may be found in Appendix I to this report. **It should be noted that there is a permanent exemption from licensure in the psychology practice act (Article 153) for an individual employed in a salaried position in a psychology title in a government-operated program; this exemption does not apply to those programs that are regulated, funded or approved by the exempt agencies.**

It is notable that individuals in six of the titles (doctoral-educated psychologist, MSW, MHC, MFT, CAT or LP) appear to hold degrees in professions that are licensed under the Education Law, but the

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programs employ unlicensed individuals in those titles. The next survey will ask agencies employing individuals in those titles whether the individuals have applied for licensure and, if not licensed, what requirements remain in order to receive the license.

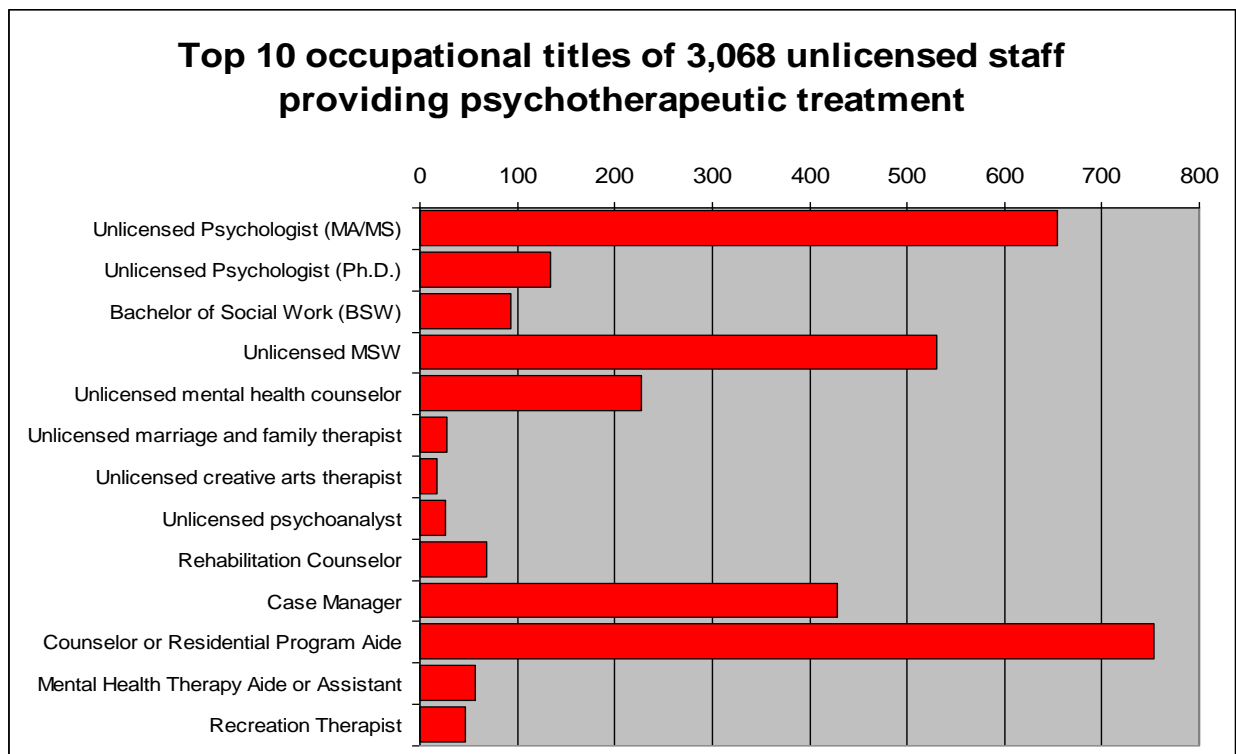


Figure 13. The top occupational titles for unlicensed staff providing psychotherapeutic treatment as allowed under the 2016 exemption.

Fifty-one of the respondents indicated that individuals in other occupational titles provide psychotherapeutic treatment and provided the titles and number of staff in those titles. As with other restricted activities, although the title was included on the list of occupations, 10 of the respondents indicated that Credentialed Alcoholism and Substance Abuse Counselors (CASAC), accounting for 50-plus staff. The other titles that were identified included 68 offender rehabilitation coordinator ASAT, 36 social services supervisors, 22 home finders, 22 socio-therapists, 14 case coordinators, 10 family specialists, and 10 individuals with a master's degree in education. This pattern of responses was similar to the additional titles identified for other restricted activities. A complete list of the occupational titles for each of the functions may be found in Appendix II of this report.

Provision of treatment other than psychotherapeutic treatment

Treatment is a broad term that can be used to describe certain restricted activities performed by professionally licensed individuals, as well as non-restricted activities performed by those who are not licensed. It is difficult to define the term in such a way as to clearly draw a distinction between restricted and non-restricted activities. For purposes of this survey, professional treatment refers to activities and services that are based on the exercise of professional judgment in the provision of mental health services and are within the scopes of practice of psychology, social work, mental health counseling, creative arts

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therapy, marriage and family therapy, and psychoanalysis. Examples of treatment are provided below.

Counseling is included in the scopes of practice of several professions and the term, when used in a professional context, is often used interchangeably with “psychotherapy” and “treatment”. Please note, however, that there are activities described as “counseling” (e.g., career counseling) that do not fall within the restricted scopes of practice of mental health professionals. There are also specific permanent exemptions in the Education Law for credentialed attorneys, rape crisis counselors, credentialed alcoholism and substance abuse counselors and for clergy members providing pastoral counseling when acting within their respective authorities (Education Law sections 8410 (2) and (4)). Additionally, Education Law section 8410(5) states that licensure is not required to provide instruction, advice, support, encouragement, or information to individuals, families, and relational groups.

Respondents were asked to enter the number of unlicensed staff employed in the program on July 1, 2013 providing treatment other than psychotherapeutic treatment, as defined above. If no unlicensed staff provides treatment other than psychotherapeutic treatment, respondents were asked to enter a 0 in the corresponding box.

Responses were provided by 673 programs; **330 of respondents (49.0%) indicated that no unlicensed staff provides treatment other than psychotherapeutic treatment.** Figure 14 provides the number of unlicensed staff in the 343 programs that utilize unlicensed staff to provide treatment other than psychotherapy. The individual responses have been categorized as one to five; six to 10; and 11 or more staff, based on a review of the responses to all questions. The most frequent response was one to five staff (N=179 or 52.1%), whether the agency was small, medium or large.

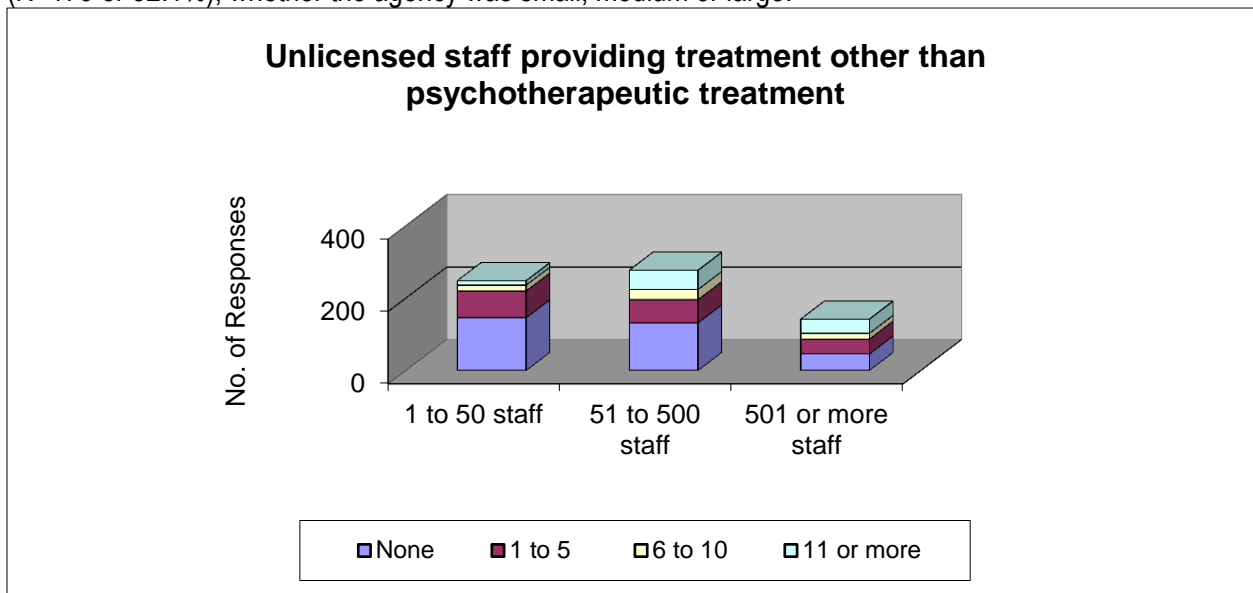


Figure 14. Regardless of total staff in the agency, the majority of respondents indicated that no unlicensed staff provide treatment other than psychotherapy, as defined in statute and the survey.

The 343 programs that indicated unlicensed employees provide treatment other than psychotherapeutic treatment, as defined above, then were asked to indicate by a check mark those specific activities provided by unlicensed individuals in the program. Figure 15 indicates the number of responses for each of the functions.

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The activities that constitute treatment other than psychotherapy that are performed by unlicensed staff, as allowed under the 2016 exemption from licensure.	1 to 50 staff	51 to 500 staff	501 or more staff	Total
a. Developing a mental health treatment plan based on an assessment/evaluation of a person's psychological, social and developmental functions, of supports and services to address addictive or behavioral disorders and conditions leading to purposeful behavioral change	86	117	70	273
b. Using psychological interventions to modify behavior for the purpose of preventing or eliminating symptomatic, maladaptive, or undesired behavior; to enhance interpersonal relationships, personal, group or organizational effectiveness, or work and/or life adjustment; or to improve behavioral or mental health.	77	120	85	282
c. Assessing the consumer's disability when developing a treatment plan based on that assessment/evaluation using the DSM or similar classification systems that may include counseling, job training and access to technology and services, that assists the patient in achieving maximum participation in work and social activities.	68	82	56	206
d. Providing individual, couple, family, relational and group therapy by following a behavioral health treatment plan that is based on an assessment/evaluation implementing change in the overall, long-term mental well-being of individuals, couple, families and those in other relationships, considering the nature and roles of individuals in relation to others, particularly in the family system	73	90	56	219
e. Using creative arts (e.g., dance, art, music) to care for the consumer who are assessed and evaluated using the DSM or similar classification systems and are following a treatment plan that by design seeks to increase awareness of self and others, cope with the symptoms of stress, illness and trauma, and enhance cognitive abilities through the creation of and reflection on art and the artistic process to improve self-esteem, develop more effective communications skills and relationships, gain insight into patterns of behavior, and create new options for coping with problems.	28	39	25	92
f. Providing professional clinical interventions or professional counseling services to change or improve a consumer's behavioral health related to addictions, such as alcohol or substance abuse; compliance with treatment programs for physical illnesses, such as cardiac rehabilitation regimens; or recognizing and controlling behavior leading to spousal or child abuse.	56	83	54	193

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The activities that constitute treatment other than psychotherapy that are performed by unlicensed staff, as allowed under the 2016 exemption from licensure.	1 to 50 staff	51 to 500 staff	501 or more staff	Total
g. Providing recommendations for mental and physical rehabilitation activities based on neuropsychological testing related to traumatic brain injury, disturbances of memory, thought, and attention, and/or sensorimotor functioning.	31	30	25	86
h. Establishing and conducting behavior modification groups with the intent of changing the harmful behavior of persons	40	59	56	155

Figure 15. Respondents identified the activities that constitute treatment other than psychotherapeutic treatment activities and if those are performed by unlicensed individuals.

Fewer than one-half of respondents indicated that unlicensed staff (g) recommend mental and physical rehabilitation (86/343 or 25%); use creative arts therapy (e) (26.8% or 92/343) and behavior modification (h) (155/343 or 45.2%). On the other hand, unlicensed staff in more than four of five respondents (282/343 or 82.2%) use psychological interventions to modify behavior (b) and a nearly equal number (273/343 or 79.%) develop a mental health treatment plan (a). These findings suggest that unlicensed staff do not engage in functions that are clearly identified with licensed professions, such as behavior modification or the use of creative arts therapy. However, the large number of unlicensed individuals engaged in the use of psychological interventions and developing a mental health treatment plan that would be restricted from engaging in those activities if not for the 2016 exemption.

Figure 16 provides the occupational titles for 3,653 unlicensed individuals who provide a treatment other than psychotherapeutic treatment in the agencies that use unlicensed staff to engage in an activity that, if not for the 2016 exemption, would be restricted under the Education Law. A full list of the occupational titles by agency size for each of the five functions may be found in Appendix I to this report. **It should be noted that there is a permanent exemption from licensure in the psychology practice act (Article 153) for an individual employed in a psychology title in a salaried position in a government-operated program; this exemption does not apply to those programs that are regulated, funded or approved by the exempt agencies.**

It is notable that individuals in six of the titles (doctoral-educated psychologist, MSW, MHC, MFT, CAT or LP) appear to hold degrees in professions that are licensed under the Education Law, but the programs employ unlicensed individuals in those titles. The next survey will ask agencies employing individuals in those titles whether the individuals have applied for licensure and, if not licensed, what requirements remain in order to receive the license.

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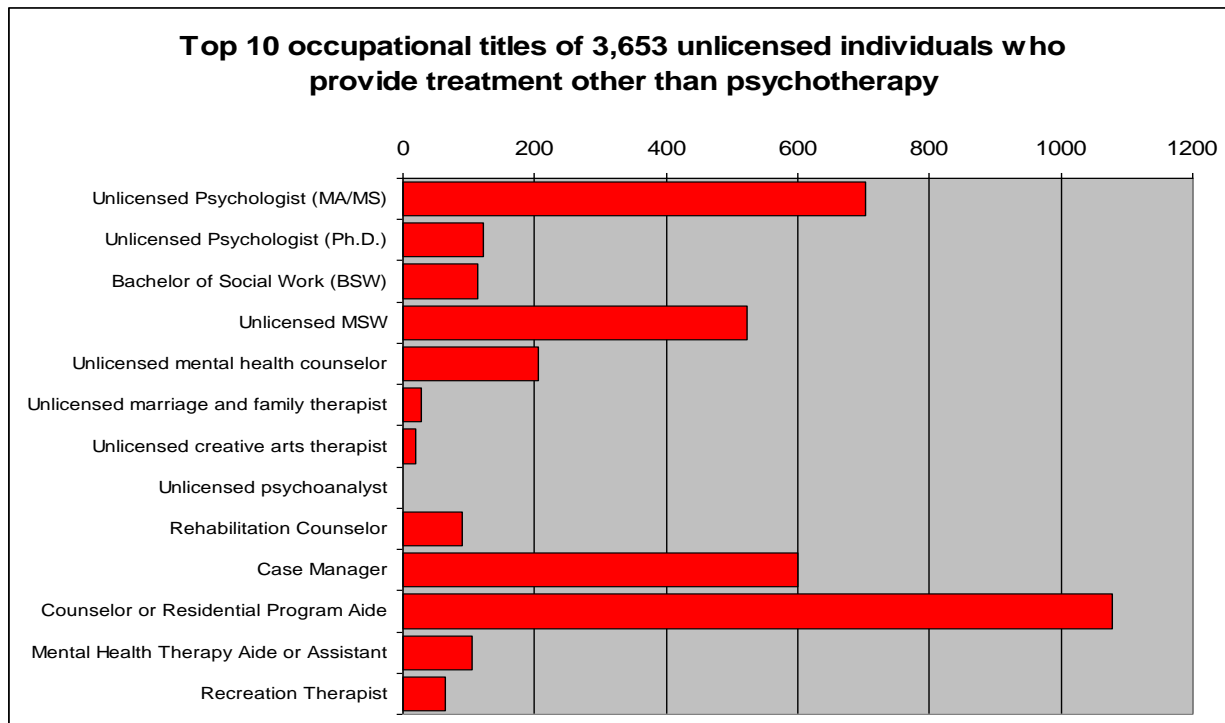


Figure 16. The top occupational titles for unlicensed staff who provide treatment other than psychotherapeutic treatment as allowed under the 2016 exemption.

Fifty-six of the respondents indicated that individuals in other occupational titles provide treatment other than psychotherapeutic treatment and provided the titles and number of staff in those titles. As with other restricted activities, although the title was included on the list of occupations, 10 of the respondents indicated that Credentialed Alcoholism and Substance Abuse Counselors (CASAC), accounting for 50-plus staff. The other titles that were identified included 68 offender rehabilitation coordinator ASAT, 36 social services supervisors, 20 home finders, 19 sociotherapists, 18 case aides, and 10 individuals with a master's degree in education. This pattern of responses was similar to the other restricted activities. A complete list of the occupational titles for each of the functions may be found in Appendix II of this report.

Development of Assessment-Based Treatment Plans

Assessment-based treatment planning is described as the development of an integrated plan of prioritized interventions that is based on the diagnosis and psychosocial assessment of the consumer, to address mental, emotional, behavioral, developmental and addictive disorders, impairments and disabilities, reactions to illnesses, injuries, disabilities and impairments, and social problems. Assessment-based treatment planning is used to determine when professional services should be initiated, altered, reduced or eliminated.

Respondents were asked to enter the number of unlicensed staff employed in the program on July 1, 2013, and who develop assessment-based treatment plans, as defined above. If no unlicensed staff develops assessment-based treatment plans, respondents were asked to enter a 0 in the corresponding

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box. Responses were provided by 669 programs; 336 of the programs (50.2%) indicated that no unlicensed staff develop assessment-based treatment plans.

Figure 17 provides the number of unlicensed staff in the 333 programs that utilize unlicensed staff to develop assessment-based treatment plans. The individual responses have been categorized as one to five; six to 10; and 11 or more staff, based on a review of the responses to all questions. The most frequent response from those agencies that use unlicensed staff was one to five (N=180 or 54.0%), whether the agency was small, medium, or large.

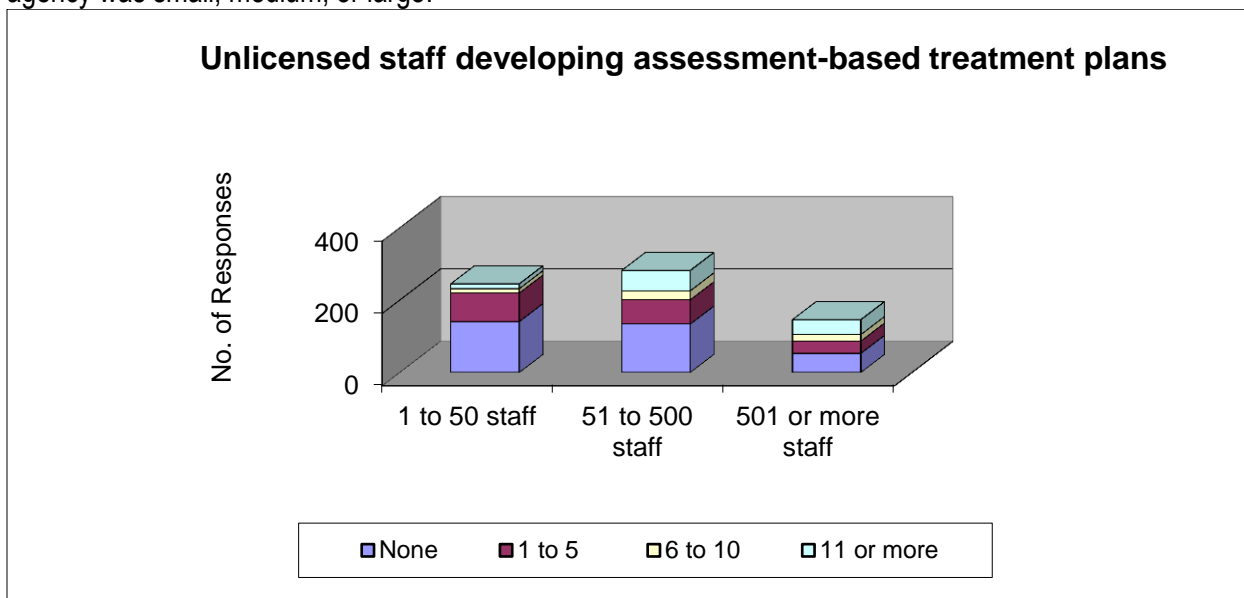


Figure 17. Regardless of total staff in the agency, the majority of respondents indicated that no unlicensed staff develop assessment-based treatment plans, as defined in statute and the survey.

The 333 programs that indicated unlicensed employees develop assessment-based treatment plans, as defined above, then were asked to indicate by a check mark those specific activities provided by unlicensed individuals in the program. Figure 18 indicates the number of responses for each function. At least 65.4% of the respondents (218/333) indicated that unlicensed staff conduct family or corollary group meetings (c) and a similar number (220/333 or 66.0%) of respondents use unlicensed staff to determine the appropriate psychotherapy and mental health services to be provided to a consumer (e). More than nine out of 10 respondents indicated that unlicensed staff engaged in each of two functions that are at the core of assessment-based treatment planning: 92.1% of programs (307/333) use unlicensed staff to establish or approve recommended treatment goals (a) and 90.6% of programs (302/333) use unlicensed staff to conduct the on-going re-assessment and revision of a treatment plan (b). Overall, more than two-thirds of all respondents use unlicensed staff to perform one or more of these six functions that are within the restricted practice of the professions and, if not for the 2016 exemption, could only be performed by a person licensed or authorized under the law.

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The activities that constitute the development of assessment-based treatment plans that are performed by unlicensed staff, as allowed under the 2016 exemption from licensure.	1 to 50 staff	51 to 500 staff	501 or more staff	Total
a. Using professional knowledge and judgment to establish or approve recommended treatment goals with the consumer that reflect long- and short-term objectives for the purpose of improving mental health.	98	124	85	307
b. Ongoing re-assessment and revision of a treatment plan related to a consumer's progress toward achieving treatment goals based on information obtained from the consumer, from psychosocial tests and measures, from appropriately trained staff, and from collateral sources.	92	126	84	302
c. Conducting family or other corollary group meetings, alone or with the assistance of staff, to assess and integrate family interactions with the consumer into a long-term mental health treatment plan. This meeting is part of the treatment planning process, rather than family meetings concerning daily activities.	70	86	62	218
d. Determining the appropriate psychotherapy and mental health services to be provided to a consumer.	79	89	52	220
e. Developing an integrated plan of prioritized interventions, that is based on the diagnosis and psychosocial assessment of the client, to address mental, emotional, behavioral, developmental and addictive disorders, impairments and disabilities, reactions to illnesses, injuries, disabilities and impairments, and social problems.	84	106	69	259

Figure 18. Tasks within the definition of developing assessment-based treatment plans are performed by unlicensed individuals under the 2016 exemption by no less than 60% of respondents.

Figure 19 provides the occupational titles that are used for the 4,197 unlicensed individuals who develop assessment-based treatment plans in the agencies that use unlicensed staff to engage in an activity that, if not for the 2016 exemption, would be restricted under the Education Law. A full list of the occupational titles by agency size for each of the five functions may be found in Appendix I to this report. **It should be noted that there is a permanent exemption from licensure in the psychology practice act (Article 153) for an individual employed in a psychology title in a salaried position in a government-operated program; this exemption does not apply to those programs that are regulated, funded or approved by the exempt agencies.**

It is notable that individuals in six of the titles (doctoral-educated psychologist, MSW, MHC, MFT, CAT or LP) appear to hold degrees in professions that are licensed under the Education Law, but the programs employ unlicensed individuals in those titles. The next survey will ask agencies employing individuals in those titles whether the individuals have applied for licensure and, if not licensed, what requirements remain in order to receive the license.

2013 Survey Responses

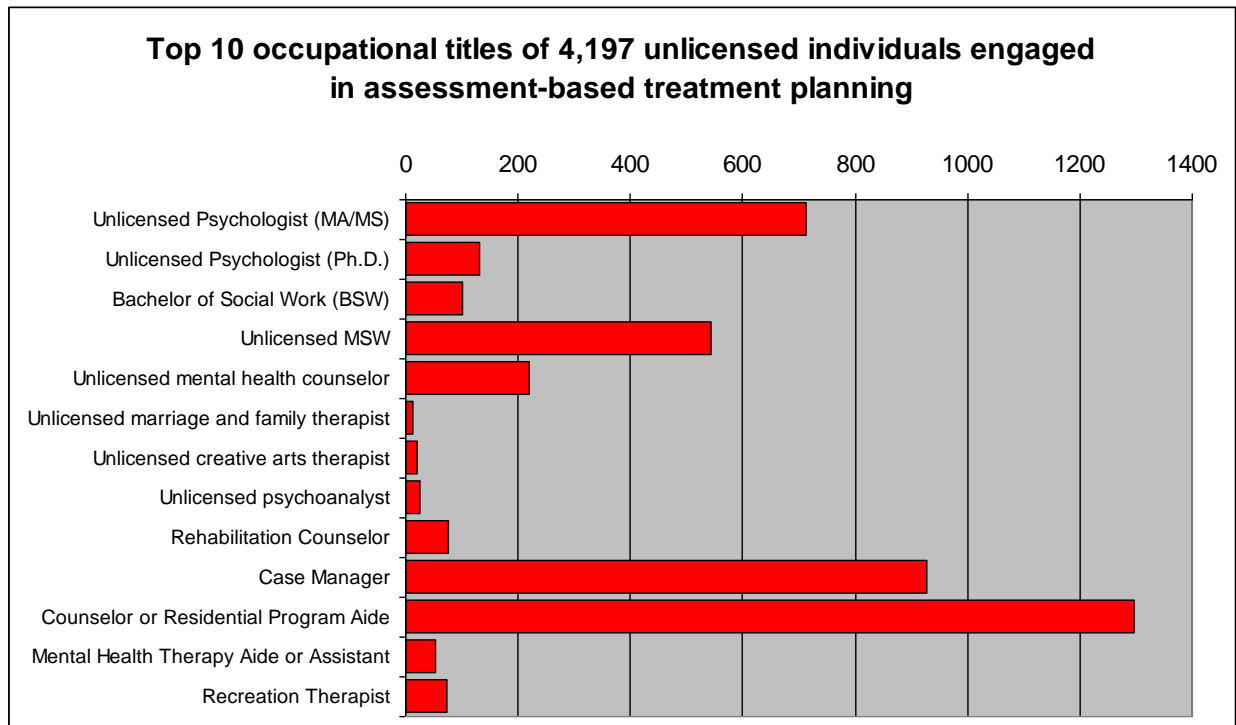


Figure 19. The top occupational titles for unlicensed staff who develop an assessment-based treatment plan as allowed under the 2016 exemption.

Fifty-nine of the respondents indicated that individuals in other occupational titles develop assessment-based treatment plans and provided the titles and number of staff in those titles. As with other restricted activities, although the title was included on the list of occupations, 10 of the respondents indicated that Credentialed Alcoholism and Substance Abuse Counselors (CASAC), accounting for 50-plus staff. The other titles that were identified included 68 offender rehabilitation coordinator ASAT, 36 social services supervisors, 20 home finders, 19 sociotherapists, 18 case aides, 13 case coordinators, 10 case workers and 10 individuals with a master's degree in education. This pattern of responses was similar to the other restricted activities. A complete list of the occupational titles for each of the functions may be found in Appendix II of this report.

Summary information from respondents

After providing information about the occupational title of individuals engaged in each of the five activities, the respondents were asked to indicate the activities performed by individuals in each title. Figure 20 provides the number of responses, not the number of individuals performing the function.

Occupational Title	Diagnose	Assess/ Evaluate	Psycho- therapy	Other Treatment	ABT Planning	N/A
Unlicensed Psychologist (M.A./M.S.)	78	137	120	117	131	283
Unlicensed Psychologist (Ph.D./Psy.D.)	58	103	87	65	90	295
Unlicensed Bachelors of Social Work (B.S.W.)	14	39	30	40	44	311

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Occupational Title	Diagnose	Assess/ Evaluate	Psycho- therapy	Other Treatment	ABT Planning	N/A
Unlicensed Masters of Social Work (M.S.W.)	125	182	164	141	192	254
Unlicensed Social Work Case Manager	11	19	18	22	22	326
Unlicensed Social Work Case Worker	4	14	10	19	17	330
Unlicensed Masters in Mental Health Counseling (M.H.C.)	79	102	97	82	103	294
Unlicensed Masters in Marriage & Family Therapy (M.F.T.)	14	17	17	13	18	226
Unlicensed Masters in Creative Arts Therapy (C.A.T.)	13	25	25	26	25	325
Unlicensed Psychoanalyst	2	3	4	3	3	340
Rehabilitation Counselor	13	28	22	28	25	317
Vocational Counselor	0	15	6	20	13	325
Care Coordinator	3	12	6	19	22	324
Case Manager	5	34	17	43	45	311
Case Worker	1	5	3	9	13	329
Youth Counselor	1	4	2	5	6	335
Applied Behavior Analyst *	4	24	17	25	26	322
Applied Behavior Analyst Asst *	2	6	3	6	5	333
Counselor or Residential Program Aide	5	22	20	31	16	313
Mental Health Therapy Aide/Asst	2	7	6	10	8	331
Prevention Counselor	1	2	0	1	2	337
Recreation Therapist	1	19	10	23	21	321
Service Coordinator	1	10	7	10	13	333
Correction Officer	0	0	0	0	0	341
Correction Sergeant	0	0	0	0	0	340
Correction Captain	0	0	0	0	0	341
ASAT Program Assistant	0	1	1	1	1	340
Supervising Correction Counselor (ASAT)	0	1	1	1	1	340
Supervising Correction Counselor	0	0	0	0	0	337
TOTAL Agency Responses	437	831	693	760	862	9,254

* At the time of the survey, the law did not provide licensure for these titles; an amendment to the Education Law now allows for licensure of qualified individuals. It is not known what percentage of unlicensed individuals in such titles will qualify for licensure.

Figure 20. Summary table of activities performed by unlicensed individuals in specified occupational titles (Question 31)

Respondents were provided an opportunity (Question 33) to identify any other occupational titles for unlicensed staff in the agency that provides one or more of the restricted services:

- Diagnosis of mental, emotional, behavioral, addictive, and developmental disabilities;

2013 Survey Responses

- Patient assessment and evaluation within a professional practice;
- Psychotherapeutic treatment;
- Treatment other than psychotherapeutic treatment; and
- Development of assessment-based treatment plans.

The comments that were received are found in Appendix III of this report; the respondents did not indicate which of the functions were performed by the unlicensed staff.

Respondents were provided an opportunity (Question 34) to make additional comments or information. The comments that were received are found in Appendix IV of this report.

Next Steps

The results of this survey are being shared with each of the agencies defined as exempt from the licensing laws, pursuant to Chapter 57 of the Laws of 2013:

- Office of Mental Health
- Office for People With Developmental Disabilities
- Office of Alcoholism and Substance Abuse Services
- Office of Children and Family Services
- Department of Corrections and Community Supervision
- Office of Temporary and Disability Assistance
- State Office for the Aging
- Department of Health
- Local Social Services District, as defined in section 61 of the Social Services Law
- Local Governmental Unit, as defined in Article 41 of the Mental Hygiene Law.

On or before September 1, 2014, each state agency identified above that operates, regulates, approves or funds programs that employ individuals to provide services that would otherwise be restricted to individuals licensed or authorized under article 153, 154 or 163 of the education law, shall submit to the commissioner of education, in such form and detail as requested by such commissioner, data in relation to: the occupational title of individuals who on July 1, 2014 are not licensed or otherwise authorized under title VIII of the education law, and who are engaged in: the diagnosis of mental, emotional, behavioral, addictive and developmental disorders and disabilities; patient assessment and evaluation; the provision of psychotherapeutic treatment; the provision of treatment other than psychotherapeutic treatment and/or the development and implementation of assessment-based treatment plans, as defined in section 7701 of the education law or as authorized in articles 153, 154 and 163 of the education law.

The agency reports may utilize the data contained in this survey, and other data collected by the agencies, to indicate the occupational title and number of individuals who are not licensed or authorized under Title VIII. Each agency report should indicate the number who have applied for licensure under Title VIII and those who:

1. have not met the education requirements for licensure and/or
2. have not met the experience requirements for licensure and/or
3. have not met the examination requirements for licensure and/or
4. have not met requirements for good moral character and/or

2013 Survey Responses

5. have not met other requirements for licensure established in law.
The agency report shall also include the number of individuals who have not applied for licensure and those whose duties could be restructured to comply with Title VIII of the Education Law.

The law states that agency reports shall not include individuals that are performing tasks that do not require licensure as identified in subdivision 10 of section 7605, subdivision 7 of section 7706, and subdivision 8 of section 8410 of the education law.

After receipt of this data from the agencies identified above, the commissioner of education, in consultation with the affected state agencies, not-for-profit providers, professional associations, consumers and other key stakeholders, shall prepare a report that recommends changes in any laws, rules or regulations necessary to ensure appropriate licensure or other authorization of individuals providing services that are within the restricted practice of professions licensed or otherwise authorized under article 153, 154 or 163 of the education law. The report shall include an estimate of the fiscal impact of any such recommended changes and, to the extent practicable, how such recommendations will result in improved outcomes.

The commissioner of education shall submit the report to the governor, the speaker of the assembly, the temporary president of the senate, and the chairs of the senate and assembly higher education committees by January 1, 2015. Other state agency commissioners shall be provided an opportunity to include statements or alternative recommendations in such report.

Summary of Responses to the 2014 Survey

In 2013, the Education Department, in consultation with the Executive and exempt State agencies (OMH, OPWDD, OASAS, OCFS, OTDA, DOH, DOCCS and OFA), developed an online survey to collect information from programs and agencies that provide one or more of the five restricted services identified in law. The Office of the Professions (OP) compiled the results and shared a summary document with the exempt agencies, the Executive and the Assembly and Senate Higher Education Committees. Each exempt State agency also received the individual responses in an Excel spreadsheet for further review and discussion.

Based on these findings, and the mandate in Chapter 57 of the Laws of 2013, OP has now developed a supplemental survey to collect information from programs and agencies regarding:

- a. whether the number of unlicensed individuals increased or decreased between July 1, 2013 and July 1, 2014;
- b. what requirements have not been met by individuals employed in titles that approximate the licensed professions; and
- c. what requirements could not be met by individuals employed in other occupational titles.

The response to these questions will comply with the statutory requirement that the exempt agencies submit information about the number and occupational title of individuals who are not licensed as of July 1, 2014. Programs and agencies that did not submit the 2013 survey were also given the opportunity to answer those questions when completing the 2014 survey. The survey link was posted on the Office of Professions website on August 1, 2014 and it remained open until October 3, 2014. The following section summarizes information that was submitted by more than 1,200 respondents.

Changes in the number of unlicensed staff

Diagnosis:

Diagnosis is the identification of a disorder on the basis of its signs and symptoms and an analysis of the underlying mental, nervous, emotional, behavioral, developmental and addictive disorders, impairment and disabilities to determine their cause and potential treatments. Such diagnoses are commonly made consistent with acceptable classification systems, e.g., the Diagnostic and Statistical Manual of Mental Disorders (DSM). Statutory definitions of "diagnosis" may be found in Title VIII of the Education Law (www.op.nysed.gov/title8).

1. Please choose the appropriate answer to indicate the change, if any, in the number of unlicensed individuals in your program/agency who made a diagnosis, as defined above, from July 1, 2013 to July 1, 2014.

Answer Options	Response Percent	Response Count
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2014 Survey Responses

Increase in the number of unlicensed individuals	5.3%	60
No change in the number of unlicensed individuals	31.4%	353
Decrease in the number of unlicensed individuals	6.7%	75
Unlicensed individuals do not engage in this activity	56.6%	637
<i>answered question</i>		1125
<i>skipped question</i>		82

Assessment and Evaluation:

Patient assessment and evaluation in the practice of the professions includes collecting information through clinical interviews; psychological and psychosocial tests and measures, contacts with members of the consumer's family and educational, employment, and/or health care settings/providers for the purpose of determining a behavioral health diagnosis and/or appropriate behavioral management, discharge, or treatment plan for the consumer. This includes the administration and interpretation of psychological tests and procedures including measures of cognitive, language, sensory-motor, and physical functioning to identify developmental disorders and disabilities in young children, and to determine levels of growth and delay for purposes of treatment, training and placement for adolescents and adults.

2. Please choose the appropriate answer to indicate the change, if any, in the number of unlicensed individuals in your program/agency who made a patient assessment and evaluation, as defined above, from July 1, 2013 to July 1, 2014.

Answer Options	Response Percent	Response Count
Increase in the number of unlicensed individuals	6.4%	68
No change in the number of unlicensed individuals	35.2%	376
Decrease in the number of unlicensed individuals	7.4%	79
Unlicensed individuals do not engage in this activity	51.0%	544
<i>answered question</i>		1067
<i>skipped question</i>		140

Psychotherapy:

Psychotherapy is defined in section 8401(2) of the Education Law as the treatment of mental, nervous, emotional, behavioral and addictive disorders, and ailments by the use of both verbal and behavioral methods of intervention in interpersonal relationships with the intent of assisting the person's ability to modify attitudes, thinking, affect, and behavior which are intellectually, socially and emotionally maladaptive. There may be other definitions of psychotherapy in federal (e.g., Medicare) or state (e.g., Insurance) laws and in health insurance policies. As in the 2011 survey, this survey used a definition in the Education Law which describes many theoretically-based, scientific systems of activities that are provided directly by individuals licensed or authorized under the Education Law or under an exemption until July 1, 2016.

3. Please choose the appropriate answer to indicate the change, if any, in the number of unlicensed individuals in your program/agency who provided psychotherapeutic treatment, as described above, from July 1, 2013 to July 1, 2014.

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Answer Options	Response Percent	Response Count
Increase in the number of unlicensed individuals	6.1%	64
No change in the number of unlicensed individuals	31.6%	333
Decrease in the number of unlicensed individuals	6.3%	66
Unlicensed individuals do not engage in this activity	56.0%	590
<i>answered question</i>		1053
<i>skipped question</i>		154

Services other than psychotherapy:

Treatment is a broad term that can be used to describe certain restricted activities performed by professionally licensed individuals, as well as non-restricted activities performed by those who are not licensed. It is difficult to define the term in such a way as to clearly draw a distinction between restricted and non-restricted activities. For purposes of this survey, professional treatment refers to activities and services that are based on the exercise of professional judgment in the provision of mental health services and are within the scopes of practice of psychology, social work, mental health counseling, creative arts therapy, marriage and family therapy, and psychoanalysis.

Counseling is included in the scopes of practice of several professions and the term, when used in a professional context, is often used interchangeably with “psychotherapy” and “treatment”. Please note, however, that there are activities described as “counseling” (e.g., career counseling) that do not fall within the restricted scopes of practice of mental health professionals. There are also specific permanent exemptions in the Education Law for credentialed attorneys, rape crisis counselors, credentialed alcoholism and substance abuse counselors and for clergy members providing pastoral counseling when acting within their respective authorities (Education Law sections 8410 (2) and (4)). Additionally, Education Law section 8410(5) states that licensure is not required to provide instruction, advice, support, encouragement, or information to individuals, families, and relational groups.

4. Please choose the appropriate answer to indicate the change, if any, in the number of unlicensed individuals in your program/agency who provided treatment other than psychotherapy, as defined above, from July 1, 2013 to July 1, 2014.

Answer Options	Response Percent	Response Count
Increase in the number of unlicensed individuals	6.8%	71
No change in the number of unlicensed individuals	37.1%	386
Decrease in the number of unlicensed individuals	6.4%	67
Unlicensed individuals do not engage in this activity	49.6%	516
<i>answered question</i>		1040
<i>skipped question</i>		167

Assessment-based treatment planning:

Assessment-based treatment planning is described as the development of an integrated plan of prioritized interventions that is based on the diagnosis and psychosocial assessment of the consumer, to address mental, emotional, behavioral,

2014 Survey Responses

developmental and addictive disorders, impairments and disabilities, reactions to illnesses, injuries, disabilities and impairments, and social problems. Assessment-based treatment planning is used to determine when professional services should be initiated, altered, reduced or eliminated.

5. Please choose the appropriate answer to indicate the change, if any, in the number of unlicensed individuals in your program/agency who engaged in assessment-based treatment planning, as defined above, from July 1, 2013 to July 1, 2014.

Answer Options	Response Percent	Response Count
Increase in the number of unlicensed individuals	7.3%	75
No change in the number of unlicensed individuals	38.5%	395
Decrease in the number of unlicensed individuals	7.0%	72
Unlicensed individuals do not engage in this activity	47.2%	484
<i>answered question</i>		1026
<i>skipped question</i>		181

Occupational title of staff providing services that would be restricted.

The 2013 survey identified titles of unlicensed individuals who were most often providing services that, if not for the 2016 exemption, could only be performed by individuals licensed or authorized under Title VIII of the Education Law.

Question 6 in the survey asked respondents to indicate the restricted activities, defined above, were performed by unlicensed individuals in the program or agency. Individuals in an occupational title may engage in more than one of the restricted activities, therefore the count of responses is greater than the number of survey responses (N= 1,207). Respondents were asked to exclude individuals who are specifically exempt from licensure, e.g., permit holders, students completing a supervised internship as part of a degree program leading to licensure, Credentialed Alcohol and Substance Abuse Counselors (CASAC) or a psychologist as defined in Article 153 of the Education Law.

Answer Options	Diagnosis	Patient assessment evaluation	Psychotherapeutic treatment	Treatment other than psychotherapeutic treatment	Develop assessment-based treatment plans	Not applicable	Response Count
Unlicensed Psychologist (MA/MS)	40	90	79	85	120	678	813
Unlicensed Psychologist (Ph.D./PsyD)	30	44	32	33	45	728	778
Bachelors of Social Work (BSW)	18	72	36	73	99	648	782
Unlicensed Masters of Social Work (MSW)	68	137	100	131	178	597	794

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Answer Options	Diagnosis	Patient assessment evaluation	Psychotherapeutic treatment	Treatment other than psychotherapeutic treatment	Develop assessment-based treatment plans	Not applicable	Response Count
Social Work Case Manager	14	42	21	42	57	690	773
Social Work Case Worker	9	32	17	35	53	694	767
Unlicensed Masters in Mental Health Counseling (MHC)	57	98	91	95	115	672	801
Unlicensed Masters in Marriage & Family Therapy (MFT)	16	21	20	21	25	748	776
Unlicensed Masters in Creative Arts Therapy (CAT)	6	14	12	16	13	747	769
Unlicensed Psychoanalysis	1	3	1	1	2	767	771
Rehabilitation Counselor	11	30	17	32	37	723	777
Vocational Counselor	5	30	12	33	39	713	772
Care Coordinator	7	25	8	32	45	699	763
Case Manager	10	41	20	52	90	669	782
Case Worker	7	21	9	22	45	715	771
Youth Counselor	5	9	7	14	16	742	762
Applied Behavior Analyst (ABA)	5	23	10	23	37	732	772
Applied Behavior Analyst Assistant (ABAA)	1	4	1	9	9	754	767
Counselor or Residential Program Aide	13	27	18	43	36	719	777
Mental Health Therapy Aide or Assistant	2	6	1	9	6	756	769
Prevention Counselor	6	16	6	12	17	743	772
Recreation Therapist	5	23	5	22	26	730	775
Service Coordinator	4	17	3	22	47	722	779
Correction Officer	1	1	0	0	1	762	765
Correction Sergeant	1	1	0	0	0	763	765
Correction Captain	1	1	0	0	0	764	766
ASAT Program Assistant	1	2	2	2	2	764	768

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Answer Options	Diagnosis	Patient assessment evaluation	Psychotherapeutic treatment	Treatment other than psychotherapeutic treatment	Develop assessment-based treatment plans	Not applicable	Response Count
Supervising Correction Counselor (ASAT)	1	2	1	2	1	761	765
Supervising Correction Counselor	1	1	0	0	0	759	761
ASAT Program Assistant	1	1	0	0	0	755	757
answered question							912
skipped question							295

Barriers to licensing for individuals employed in occupational titles

The statute requires the Department to determine the barriers to professional licensing that may affect individuals employed by the responding agencies. Questions 7 through 17 asked respondents to indicate the reason(s) an unlicensed individual was not licensed under Title VIII of the Education Law, for individuals in those occupational titles that would appear to overlap with the restricted scopes of practice. For each of the titles, respondents could identify one or more reasons that individuals have not been licensed.

Unlicensed Psychologist.

Since January 1, 2003, Article 153 of the Education Law has defined the practice of psychology and restricts the use of the title and the scope of practice to individuals licensed or authorized under the Education Law.

The requirements for licensure as a psychologist in New York State include:

- file an application and pay the fee of \$294
- be of good moral character
- be at least 21 years of age
- complete a doctoral program in psychology, acceptable to the Department
- pass the Examination for Professional Practice in Psychology (EPPP) developed by the Association of State and Provincial Psychology Boards (ASPPB), with a score acceptable to the Department
- meet experience requirements of two years of full-time supervised experience (defined as 1750 clock hours per year) or the part-time equivalent, consistent with the scope of practice in psychology in [Section 7601-A](#) of the State Education Law and
- complete the Department-approved coursework in the identification and reporting of suspected child abuse or neglect.

As of April 1, 2014, there are 13,117 psychologists licensed and registered to practice.

7. Reasons why doctoral level psychologists are not licensed.	Response Percent	Response Count
SED application pending	14.0%	15

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7. Reasons why doctoral level psychologists are not licensed.	Response Percent	Response Count
Did not apply for license	53.3%	57
Lacks required degree	25.2%	27
Lacks required experience	24.3%	26
Did not pass exam	19.6%	21
Not of good moral character	0.0%	0
Permanent psychologist exemption	3.7%	4
How many incumbents in this title are not licensed		361
<i>answered question</i>		107
<i>skipped question</i>		1100

One hundred and seven respondents indicated that 361 unlicensed individuals are employed in a psychologist title. More than one-half of respondents (57/107) indicated that the primary barrier to licensure for psychologists is failure to apply for licensure. Another 25% of respondents (27/107) indicated that employees do not hold the required degree and a similar number (26/107) do not have the required experience. Just under 20% of respondents (21/107) indicated that employees have not passed the licensing examination and 14% of respondents (15/107) indicated that employees have a pending application for licensure.

It should be noted that there is a permanent exemption from licensure in the psychology practice act (Article 153) for an individual employed in a salaried position in a psychology title in a government-operated program; this exemption does not apply to those programs that are regulated, funded or approved by the exempt agencies. Only 3.7% of the responding programs (4/107) indicated that the professional services were provided by a psychologist practicing under this permanent exemption.

Unlicensed Master of Social Work.

Since September 1, 2004, Article 154 of the Education law has authorized the Department to license applicants in two social work professions—Licensed Master Social Worker (LMSW) and Licensed Clinical Social Worker (LCSW). The LMSW is a generalist, social work practitioner who may only provide clinical social work services under the supervision of a LCSW, licensed psychologist or psychiatrist.

The requirements for licensure as a LMSW in New York State include:

- file an application and pay the fee of \$294
- be of good moral character
- be at least 21 years of age
- complete a master's degree in social work (M.S.W.) acceptable to the Department
- pass the Masters Examination developed by the Association of Social Work Boards (ASWB), with a score acceptable to the Department, and
- complete the Department-approved coursework in the identification and reporting of suspected child abuse or neglect.

As of April 1, 2014, there are 27,949 LMSWs licensed and registered to practice.

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The requirements for licensure as a LCSW in New York State include:

- file an application and pay the fee of \$294
- be of good moral character
- be at least 21 years of age
- complete a master's degree in social work (M.S.W.) with at least 12 semester hours of clinical coursework acceptable to the Department
- complete at least 36 months of post-M.S.W. supervised experience in diagnosis, psychotherapy and assessment-based treatment planning, acceptable to the Department
- pass the Clinical Examination developed by the Association of Social Work Boards (ASWB), with a score acceptable to the Department, and
- complete the Department-approved coursework in the identification and reporting of suspected child abuse or neglect.

As of April 1, 2014, there are 27,323 LCSWs licensed and registered to practice.

9. Reasons why individuals in MSW titles are not licensed	Response Percent	Response Count
SED application pending	18.8%	43
Did not apply for license	66.8%	153
Lacks required degree	11.4%	26
Lacks required experience	14.8%	34
Did not pass examination	37.1%	85
Not of good moral character	0.4%	1
How many incumbents in this title are not licensed		383
<i>answered question</i>		229
<i>skipped question</i>		978

Two hundred and twenty-nine respondents indicated that 383 unlicensed individuals are employed in an M.S.W. title. More than two thirds of respondents (153/229) indicated that the primary barrier to licensure for LMSW and/or LCSW is failure to apply for licensure. 37% of respondents (85/229) indicated that employees did not pass the ASWB examination. Twenty-six of 229 respondents (11.4%) identified the lack of the required degree as a barrier to licensure. Only 18.8% (43/229) have an application for licensure pending with SED and 14.8% (34/229) do not have the required experience. Only one respondent indicated that an unlicensed M.S.W. does not meet the moral character requirement for licensure.

Unlicensed Mental Health Counselor

Since January 1, 2005, Article 163 of the Education Law has defined the practice of mental health counseling and, since January 1, 2010, restricts the use of the title and the scope of practice to individuals licensed or authorized under the Education Law.

The requirements for licensure as mental health counselor in New York State include:

- file an application and pay the fee of \$371

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- be of good moral character
- be at least 21 years of age
- complete a masters or doctoral program in clinical mental health counseling, acceptable to the Department
- complete no less than 3,000 hours of post-graduate supervised experience in the practice of mental health counseling and psychotherapy, acceptable to the Department;
- pass the National Clinical Mental Health Counseling Examination (NCMHCE) developed by the National Board for Certified Counselors (NBCC), with a score acceptable to the Department, and
- complete the Department-approved coursework in the identification and reporting of suspected child abuse or neglect.

As of April 1, 2014, there are 5,496 mental health counselors licensed and registered to practice.

11. Reasons why unlicensed mental health counselors are not licensed	Response Percent	Response Count
SED application pending	28.0%	42
Did not apply for license	46.0%	69
Lacks required degree	14.0%	21
Lacks required experience	42.0%	63
Did not pass examination	16.0%	24
Not of good moral character	0.7%	1
How many incumbents in this title are not licensed		347
<i>answered question</i>		150
<i>skipped question</i>		1057

One hundred and fifty respondents indicated that 347 individuals are not licensed as mental health counselors. Nearly one-half of respondents (69/150) indicated that the primary barrier to licensure for mental health counselors is failure to apply for licensure. Nearly as many respondents (42% or 63/150) indicated that employees do not meet the experience requirement. 28% of respondents indicated that an unlicensed employee has a pending application for licensure with SED. Only 16% of respondents (24/150) indicated that employees have not passed the licensing examination and 14% of respondents (21/150) indicated that unlicensed employees do not have the required degree.

Unlicensed Marriage and Family Therapist

Since January 1, 2005, Article 163 of the Education Law has defined the practice of marriage and family therapy and, since January 1, 2010, restricts the use of the title and the scope of practice to individuals licensed or authorized under the Education Law.

The requirements for licensure as a marriage and family therapist in New York State include:

- file an application and pay the fee of \$371

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- be of good moral character
- be at least 21 years of age
- complete a masters or doctoral program in marriage and family therapy, acceptable to the Department, or a master's or higher degree in an allied mental health field acceptable to the Department, and additional graduate level coursework, determined by the Department to be the equivalent to a marriage and family therapy degree
- pass the Examination in Marital and Family Therapy developed by the Association of Marital and Family Therapy Regulatory Boards (AMFTRB), with a score acceptable to the Department
- meet experience requirements of 1,500 client contact hours in the supervised practice of marriage and family therapy, which may include supervised, internship hours as part of the degree program if the applicant earned the M.F.T. degree in a NYS-registered or nationally accredited program or, if the applicant met the education requirement with a degree in an allied mental health field, at least 1,500 client contact hours of post-masters, supervised experience, acceptable to the Department, and
- complete the Department-approved coursework in the identification and reporting of suspected child abuse or neglect.

As of April 1, 2014, there are 999 marriage and family therapists licensed and registered to practice.

13. Reasons why marriage and family therapists are not licensed	Response Percent	Response Count
SED application pending	20.0%	11
Did not apply for license	52.7%	29
Lacks required degree	23.6%	13
Lacks required experience	34.5%	19
Did not pass examination	21.8%	12
Not of good moral character	0.0%	0
How many incumbents in this title are not licensed		316
<i>answered question</i>		55
<i>skipped question</i>		1152

Fifty-five respondents indicated that 316 unlicensed individuals practice creative arts therapy. More than one-half of respondents (29/55) indicated that the primary barrier to licensure as a marriage and family therapist is failure to apply for licensure. Nearly 35% of respondents (19/55) indicated that employees do not have the required experience and 23% (13/55) do not have the required degree. 20% of respondents (11/55) indicated that employees have an application for licensure pending with SED and a similar number (12/55 or 21.8%) have not passed the licensing examination.

Unlicensed Creative Arts Therapist

Since January 1, 2005, Article 163 of the Education Law has defined the practice of creative arts therapy and, since January 1, 2010, restricts the use of the title and the scope of practice to individuals licensed or authorized under the Education Law.

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The requirements for licensure as a creative arts therapist in New York State include:

- file an application and pay the fee of \$371
- be of good moral character
- be at least 21 years of age
- complete a master's or doctoral degree in creative arts therapy, acceptable to the Department
- pass the "Board Certification" examination administered by the Art Therapy Credentials Board (ATCB) or the "Board Certification" examination administered by the Certification Board for Music Therapist (CBMT) or the New York State Case Narrative Examination administered by CASTLE Worldwide, with a score acceptable to the Department
- meet experience requirements of 1,500 contact hours of post-degree, supervised experience in the practice of creative arts therapy, acceptable to the Department, and
- complete the Department-approved coursework in the identification and reporting of suspected child abuse or neglect.

As of April 1, 2014, there are 1,575 creative arts therapist licensed and registered to practice.

15. Reasons why unlicensed creative arts therapists are not licensed	Response Percent	Response Count
SED application pending	15.9%	7
Did not apply for license	65.9%	29
Lacks required degree	40.9%	18
Lacks required experience	34.1%	15
Did not pass examination	22.7%	10
Not of good moral character	2.3%	1
How many incumbents in this title are not licensed		317
<i>answered question</i>		44
<i>skipped question</i>		1163

Forty-four respondents indicated that 317 unlicensed individuals practice creative arts therapy. Nearly two-thirds of respondents (29/44) indicated that the primary barrier to licensure for creative arts therapists is failure to apply for licensure. 40% of respondents indicated that employees do not hold the required degree (18/44) and 34% of employees (15/44) do not have the required experience. Nearly 23% of respondents (10/44) indicated that employees have not passed the licensing examination and 16% of respondents (7/44) indicated that employees have a pending application for licensure. One respondent indicated that an employee does not meet the moral character requirement for licensure.

Unlicensed Psychoanalyst

Since January 1, 2005, Article 163 of the Education Law has defined the practice of psychoanalysis and, since January 1, 2010, restricts the use of the title and the scope of practice to individuals licensed or authorized under the Education Law.

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The requirements for licensure as a psychoanalyst in New York State include:

- file an application and pay the fee of \$371
- be of good moral character
- be at least 21 years of age
- complete a masters or higher degree from a program in any field that is registered by the Department and complete a program of at least 1,500 clock hours in a program in psychoanalysis, acceptable to the Department
- pass the New York State Case Narrative Examination administered by CASTLE Worldwide, with a score acceptable to the Department
- meet experience requirements of at least 1,500 contact hours of supervised experience in the practice of psychoanalysis, acceptable to the Department, and
- complete the Department-approved coursework in the identification and reporting of suspected child abuse or neglect.

As of April 1, 2014, there are 808 psychoanalysts licensed and registered to practice.

17. Reasons why psychoanalysts are not licensed	Response Percent	Response Count
SED application pending	5.9%	2
Did not apply for license	61.8%	21
Lacks required education	41.2%	14
Lacks required experience	26.5%	9
Did not pass examination	20.6%	7
Not of good moral character	0.0%	0
How many incumbents in this title are not licensed		310
<i>answered question</i>		34
<i>skipped question</i>		1173

Thirty-four respondents indicated that 310 unlicensed individuals practice psychoanalysis. Nearly two-thirds of respondents (21/34 or 61%) indicated that the primary barrier to licensure for psychoanalysts is failure to apply for licensure. 41% of respondents (14/34) indicated that employees do not have the required education. 26% of respondents (9/34) lack the required experience and 20% (7/34) did not pass the examination. On 6% (2/34) individuals have a pending application for licensure.

Qualifications of unlicensed individuals in other occupational titles

The 2013 survey identified certain occupational titles that were most frequently used by individuals who are not licensed under the Education Law, but who provide one or more of the services that, if not for the 2016 exemption, could only be performed by licensed or authorized individuals. The survey asked respondents to indicate the qualifications that were met by unlicensed individuals in these titles (question 19). It should be noted that Article 153 of the Education Law includes a permanent exemption that allows an individual with a Bachelor of Social Work (B.S.W.) degree engage in specified activities that fall within the practice of licensed master social work, under the general supervision of an LMSW or LCSW. This provision does not include clinical social work practice,

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including psychotherapy and the supervision cannot be provided by anyone other than an LMSW or LCSW.

As noted earlier, Article 153 of the Education Law provides a permanent exemption from licensure for an individual employed in a salaried position in a psychology title in a government-operated program; this exemption does not apply to those programs that are regulated, funded or approved by the exempt agencies. These exemptions for B.S.W. practitioners and psychologists will not end on July 1, 2016, with the other exemptions from licensure.

Although legislation has been introduced in previous years to license individuals with a master's degree in psychology (e.g., school psychologist) or a master's in rehabilitation counseling, these titles are not licensed under the Education Law. Although individuals with a B.S.W. degree are licensed in other jurisdictions, there have been no discussions about creating an entry-level license to the social work profession. Individuals employed in a program that is exempt from the licensing requirements until July 1, 2016, therefore, may not engage in the restricted activities, after that date.

After July 1, 2016, unlicensed individuals in the titles of case manager, mental health therapy aide or assistant, or rehabilitation counselor or program aide will not require licensure under Title VIII of the Education law, to engage in activities that do not require licensure, e.g., case management, care coordination and related services. Chapter 57 of the Laws of 2013 amended the exemptions contained in Articles 153 (psychology), 154 (social work) and 163 (mental health practitioners, to allow an unlicensed individual to perform:

assessments such as basic information collection, gathering of demographic data, and informal observations, screening and referral used for general eligibility for a program or service and determining the functional status of an individual for the purpose of determining need for services unrelated to a behavioral health diagnosis or treatment plan. Such licensure shall not be required to create, develop or implement a service plan unrelated to a behavioral health diagnosis or treatment plan. Such service plans shall include, but are not limited to, job training and employability, housing, general public assistance, in home services and supports or home-delivered meals, investigations conducted or assessments made by adult or child protective services, adoption home studies and assessments, family service plans, transition plans and permanency planning activities, de-escalation techniques, peer services or skill development. A license under this article shall not be required for persons to participate as a member of a multi-disciplinary team to implement a behavioral health services or treatment plan; provided however, that such team shall include one or more professionals licensed under this article or articles one hundred thirty-one, one hundred fifty-three or one hundred sixty-three of this chapter; and provided, further, that the activities performed by members of the team shall be consistent with the scope of practice for each team member licensed or authorized under title VIII of this chapter, and those who are not so authorized may not engage in the following restricted practices: the diagnosis of mental, emotional, behavioral, addictive and

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developmental disorders and disabilities; patient assessment and evaluating; the provision of psychotherapeutic treatment; the provision of treatment other than psychotherapeutic treatment; and/or the development and implementation of assessment-based treatment plans as defined in section seventy-seven hundred one of this article. Provided, further, that nothing in this subdivision shall be construed as requiring a license for any particular activity or function based solely on the fact that the activity or function is not listed in this subdivision.

These exemptions would apply to an individual in occupational titles, identified in this question or elsewhere, who provide unrestricted services to individuals, families and groups in a variety of settings.

19. Answer Options	AA/AS degree	BA/BS degree	MA/MS degree	Civil Service test	Certification exam	On-the-job training	Response Count
Bachelors of Social Work (BSW)	9	157	32	14	6	73	180
MA/MS in Psychology	9	38	164	17	23	73	173
Rehabilitation Counselor	15	41	39	5	14	37	85
Case Manager	42	132	43	14	12	85	173
Counselor or Residential Program Aide	40	38	15	4	10	60	92
Mental Health Therapy Aide or Assistant	17	20	6	9	4	26	50
Recreation Therapist	11	61	18	11	15	49	95
answered question							375
skipped question							832

The Respondents provided the full-time equivalent of individuals in each of the titles (question 20). The table below shows the number of responses (count) and the total number of FTEs for each of the specified titles. The average indicates the number of individuals in that title who would be employed in each responding agency, if all agencies had the same number of individuals in the title.

20. Occupational titles	Average FTEs	Total FTEs	Number of Respondents
Bachelor of Social Work (BSW)	2.48	855	345
MA/MS in psychology	2.13	764	358
Rehabilitation Counselor	.66	195	296
Case Manager	3.36	1,162	346
Counselor or Residential Program Aide	3.71	1,102	297
Mental Health Therapy Aide or Assistant	1.01	283	280
Recreation Therapist	0.37	108	291
answered question			471
skipped question			736

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Agency size:

Respondents were asked to indicate the total staff, including administrative and direct care, employed in the program. Figure 1 indicates that 742 respondents provided information about the total staff. A preliminary review of responses indicated that there may be differences in staffing patterns based on the total staff size.

26. Total staff in agency (clinical and administrative)	Response Percent	Response Count
1 to 10	10.9%	81
11 to 25	15.8%	117
26 to 50	10.8%	80
51 to 100	16.2%	120
101 to 200	12.5%	93
201 to 500	18.1%	134
501 to 1,000	9.2%	68
1,001 to 2,000	4.7%	35
2,001 or more	1.9%	14
<i>answered question</i>		742
<i>skipped question</i>		465

As in prior surveys, we have categorized the agencies by size: small is 1 to 50 employees; medium is 51 to 500 employees; and large is 501 or more employees. There were 742 agencies that provided information about the total number of staff. Viewing only the responding agencies, 37.5% were small, 46.8% were medium and 15.8% are large, as listed in the table below. These percentages decrease when considering the respondents against the total same (N=1,207).

Agency Size	Frequency	Percent Answering	Percent of all Rs
Small 1 to 50 (1)	278	37.5%	23.0%
Medium 51 to 500 (2)	347	46.8%	28.7%
Large 501 or more (3)	117	15.8%	9.7%
Did not answer	465		38.5%
Total	1,207		100%

The following two tables indicate that respondents could have one or more relationship with oversight agencies.

Funded by any agency:	456/1207	(37.8%)
Approved by any agency:	508/1207	(42.1%)
Regulated by any agency:	650/1207	(53.9%)
Operated by any agency:	108/1207	(8.9%)

The table below shows that, regardless of the relationship between the oversight state/local government agency and the agency/program responding to the survey, there is a consistent pattern of agency size, except in regard to programs that are operated by the oversight government.

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	Small Program (1-50 staff)	Medium Program (51-500 staff)	Large Program (501 or more staff)	Total
Funded	163/445 (37%)	203/445 (46%)	79/445 (17%)	445
Approved	189/497 (38%)	228/497 (46%)	80/497 (16%)	497
Regulated	224/630 (36%)	299/630 (47%)	107/630 (17%)	630
Operated	46/103 (45%)	40/103 (39%)	17/103 (16%)	103

Relationship between size of the respondent agency/program and the relationship with local or state government agency.

Counties in which programs provide services (multiple responses).

Respondents were asked to indicate the counties in New York State in which the program offered services that would be restricted to those licensed or authorized, if not for the exemption from the law. An entity may provide services in more than one county, so the total number of locations exceeds the total number of survey respondents. The table below presents the responses, including the percentage of the entire sample size (N=1,207).

27. Counties in which agency provides services	Yes	No	Percent of all respondents (1,207)
Albany	40	1,125	3.3
Allegany	21	1,186	1.7
Bronx	130	1,097	10.8
Broome	20	1187	1.7
Cattaraugus	24	1183	2.0
Cayuga	22	1185	1.8
Chautauqua	31	1176	2.6
Chemung	28	1179	2.3
Chenango	18	1189	1.5
Clinton	19	1188	1.6
Columbia	27	1180	2.2
Cortland	13	1194	1.1
Delaware	19	1188	1.6
Dutchess	36	1171	3.0
Erie	54	1153	4.5
Essex	16	1191	1.3
Franklin	19	1188	1.6
Fulton	23	1184	1.9
Genesee	20	1187	1.7
Greene	32	1175	2.7
Hamilton	9	1198	0.7
Herkimer	20	1187	1.7
Jefferson	17	1190	1.4
Kings	113	1094	9.4
Lewis	17	1190	1.4
Livingston	17	1190	1.4
Madison	22	1185	1.8
Monroe	65	1142	5.4
Montgomery	21	1186	1.7

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27. Counties in which agency provides services	Yes	No	Percent of all respondents (1,207)
Nassau	90	1117	7.5
New York	145	1062	12.0
Niagara	40	1167	3.3
Oneida	19	1188	1.6
Onondaga	34	1173	2.8
Ontario	25	1182	2.1
Orange	34	1173	2.8
Orleans	19	1188	1.6
Oswego	17	1190	1.4
Otsego	21	1186	1.7
Putnam	27	1180	2.2
Queens	109	1098	9.0
Rensselaer	36	1171	3.0
Richmond	53	1154	4.4
Rockland	32	1175	2.7
Saratoga	34	1173	2.8
Schenectady	39	1168	3.2
Schoharie	27	1180	2.2
Schuyler	22	1185	1.8
Seneca	22	1185	1.8
St. Lawrence	23	1184	1.9
Steuben	28	1179	2.3
Suffolk	71	1136	5.9
Sullivan	16	1191	1.3
Tioga	22	1185	1.8
Tompkins	16	1191	1.3
Ulster	36	1171	3.0
Warren	29	1178	2.4
Washington	25	1182	2.1
Wayne	25	1182	2.1
Westchester	85	1122	7.0
Wyoming	16	1191	1.3
Yates	18	1189	1.5
answered question		747	460
skipped question		460	

Relationship with oversight agencies

Programs and agencies that responded to this survey are under the regulatory authority of one or more state or local government agencies, which extends the exemption from licensure to individuals in that program or agency. The table below provides an overview of the relationship between respondents and the regulatory agencies defined in Chapter 57 of the Laws of 2013. These relationships could include operation of the program by the oversight agency; regulation of the program (e.g., an operating certificate or license); approval of the program by an oversight agency; and/or funding of the program, at any level, by the regulatory agency.

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According to the respondents, agencies/programs that are funded with the exempt state and local oversight agencies are also approved, regulated or operated by the same agency. The law has never provided a definition of “funded by” so that it could apply to an agency that receives a few thousand dollars in a grant from one of the exempt agencies or an agency that receives Medicaid funding for services provided to eligible individuals. If the exemptions are continued, it may be appropriate to eliminate the “funded by” category, as it seems to capture the other relationships..

28. Relationships with oversight agencies (more than one possible response)	Operated by	Regulated by	Approved by	Funded by	Percent all (n=1207)
NYS Office of Mental Health (OMH)	31	163	116	113	193 (16%)
NYS Office for People with Developmental Disabilities (OPWDD)	38	208	182	200	247 (20.%)
NYS Office of Alcoholism & Substance Abuse Services (OASAS)	21	132	108	96	149 (12.3%)
NYS Office of Children and Family Services (OCFS)	5	83	75	66	106 (8.8%)
NYS Office for the Aging (OFA)	4	29	30	36	42 (3.5%)
NYS Department of Health (DOH)	13	313	195	99	345 (28.6%)
NYS Office of Temporary & Disability Assistance (OTDA)	0	42	29	52	70 (5.8%)
NYS Department of Corrections and Community Supervision (DOCCS)	1	4	6	8	10 (0.8%)
Local Social Services District	2	39	51	92	115 (9.5)
Local Mental Hygiene District	5	34	37	59	76 (6.3)
answered question					725 (60%)
skipped question					482

We also looked at the relative size of the responding programs and agencies, based on the oversight agencies with which the respondent has a relationship. As in other questions, an agency/program could have more than one type of relationship with a single oversight agency (e.g., regulated and approved) and/or relationships with more than one oversight agencies (e.g., OMH and DOH).

Relationship with oversight agencies (more than one response possible)	Small Program (1-50 staff)	Medium Program (51-500 staff)	Large Program (501 or more staff)	Total
NYS Office of Mental Health (OMH)	53	88	44	185
NYS Office for People with Developmental Disabilities (OPWDD)	60	104	71	235
NYS Office of Alcoholism & Substance Abuse Services (OASAS)	74	59	13	146
NYS Office of Children and Family Services (OCFS)	17	61	27	105

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NYS Office for the Aging (OFA)	22	12	8	42
NYS Department of Health (DOH)	93	175	66	334
NYS Office of Temporary & Disability Assistance (OTDA)	25	39	6	70
NYS Department of Corrections and Community Supervision (DOCCS)	1	7	2	10
Local Social Services District	28	65	22	115
Local Mental Hygiene District	20	45	11	76

Respondents who had not completed the 2013-14 survey were provided an opportunity to answer the same questions at this time. Fewer than 10% of all respondents indicated that they would complete the additional questions, designed to identify the specific tasks that are performed by unlicensed individuals in the exempt programs and agencies.

Answer Options	Response Percent	Response Count
I want to answer the earlier survey	9.6%	78
I am done with the survey	90.4%	734
<i>answered question</i>		812
<i>skipped question</i>		395

Unlicensed staff making a diagnosis

Thirty-eight respondents indicated that a total of 33 unlicensed individuals in an exempt program make a diagnosis, as defined elsewhere in this report. This includes programs that indicate no unlicensed staff makes a diagnosis. Respondents were then asked to identify which activities that fall within the definition of a diagnosis, are performed by unlicensed staff as allowed under the 2016 exemption from licensure. These sub-skills were provided in an effort to identify activities that may require clarification in order to help agencies and programs assign restricted activities only to those licensure or authorized, in the event that the exemption ends on July 1, 2016, as scheduled. Only 7 respondents provided a response, making it impossible to generalize to a larger population of regulated programs and agencies.

Q.32. Answer Options	Response Percent	Response Count
a. Evaluating information that is gathered regarding the consumer's health, mental health, social, and developmental status directly from the consumer or in consultation with others, to make a behavioral health diagnosis using the DSM or similar classification system.	100.0%	7
b. Engaging in clinical interviews and clinical testing to gather, interpret and evaluate information from appropriate sources, to identify signs and symptoms and causes of behaviors for purpose of making a mental health diagnosis.	85.7%	6
c. The application of professional judgment based on the	85.7%	6

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clinical evaluation, which could include relevant information received from consumer and others, including direct care staff, to reach a diagnosis of the consumer's disorder or dysfunction and identifying it using the DSM or other classification system.

<i>answered question</i>	7
<i>skipped question</i>	1200

Respondents were then asked to identify the occupational title of unlicensed individuals who make a diagnosis, as defined in the survey, and the number of individuals in that title. It should be noted that 23 programs responded to the question, even though only 7 provided information about the activities that are performed by unlicensed staff.

Q. 33 Answer Options	Response Total	Response Count
Psychologist (MA/MS)	2	22
Psychologist (Ph.D./PsyD)	1	19
Bachelors of Social Work (BSW)	18	21
Unlicensed Masters of Social Work (MSW)	3	20
Social Work Case Manager	1	20
Social Work Case Worker		20
Unlicensed Masters in Mental Health Counseling (MHC)	2	21
Unlicensed Masters in Marriage & Family Therapy (MFT)	1	21
Unlicensed Masters in Creative Arts Therapy (CAT)		20
Unlicensed Psychoanalysis		20
Rehabilitation Counselor		20
Vocational Counselor	1	20
Care Coordinator	1	20
Case Manager		20
Case Worker		20
Youth Counselor		20
Applied Behavior Analyst (ABA)		20
Applied Behavior Analyst Assistant (ABAA)		20
Counselor or Residential Program Aide		20
Mental Health Therapy Aide or Assistant	132	20
Prevention Counselor		20
Recreation Therapist	8	20
Service Coordinator		20
Correction Officer		20
Correction Sergeant		20
Correction Captain		19
ASAT Program Assistant		19
Supervising Correction Counselor (ASAT)		19
Supervising Correction Counselor		19
<i>answered question</i>		23
<i>skipped question</i>		1184

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Assessment and Evaluation within a professional practice

Respondents were asked to provide the number of unlicensed individuals who, under the July 2016 exemption, make a professional assessment and evaluation, as defined elsewhere in this survey. Forty respondents answered this question and indicated a total of 188 unlicensed individuals engaged in this activity; please remember that respondents could indicate no unlicensed staff makes an assessment or evaluation.

Q.38 Answer Options	Response Percent	Response Count
a. Clinical interviews with the consumer and/or collateral parties to collect information necessary to determine the consumer's level of function for persons with mental, emotional, nervous, behavioral and developmental needs, for the purpose of establishing a diagnosis or completing or modifying a treatment plan.	89.5%	17
b. Determining the consumer's psychological and developmental progress, through the administration and scoring of appropriate instruments, including clinical interviews with the consumer, family members, and others.	84.2%	16
c. Using written text, art, music, photographs, or other media to evaluate how the consumer expresses emotions, thoughts, or behaviors, in order to develop or modify the diagnosis or treatment plan.	36.8%	7
d. Administering, scoring and interpreting clinical tests and measures of psychosocial, developmental, and psychological functioning and reviewing the results of the evaluation with a consumer to establish a behavioral health service treatment plan.	52.6%	10
<i>answered question</i>		19
<i>skipped question</i>		1188

Nineteen respondents indicated the activities that fall within an assessment or evaluation that, if not for the 2016 exemption, could only be performed by licensed or authorized individuals. More than 80% of respondents indicated that unlicensed staff performed clinical interviews and/or administered and scored psychological tests; these activities would clearly constitute the practice of a profession. Although the sample size is small, the findings are consistent with earlier surveys and suggest that additional clarification about professional practice is required in law, regulation or guidance from the Education Department and State Boards for the professions.

Thirty respondents indicated the occupational title and the number of unlicensed individuals who make a professional evaluation or assessment, as defined in the survey. Consistent with earlier surveys, a majority of the unlicensed staff are in titles that approximate a profession that is licensed under Title VIII of the Education Law. Others are in generic titles like case manager or service coordinator.

Q.39. Answer Options	Response Total	Response Count
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Psychologist (MA/MS)	11	25
Psychologist (Ph.D./PsyD)	1	19
Bachelors of Social Work (BSW)	6	22
Unlicensed Masters of Social Work (MSW)	9	22
Social Work Case Manager	1	20
Social Work Case Worker	3	21
Unlicensed Masters in Mental Health Counseling (MHC)	7	22
Unlicensed Masters in Marriage & Family Therapy (MFT)	1	21
Unlicensed Masters in Creative Arts Therapy (CAT)		20
Unlicensed Psychoanalysis		20
Rehabilitation Counselor		20
Vocational Counselor		20
Care Coordinator		20
Case Manager	5	21
Case Worker		20
Youth Counselor		20
Applied Behavior Analyst (ABA)	8	21
Applied Behavior Analyst Assistant (ABAA)	3	21
Counselor or Residential Program Aide		20
Mental Health Therapy Aide or Assistant		20
Prevention Counselor		20
Recreation Therapist	3	20
Service Coordinator	5	21
Correction Officer		19
Correction Sergeant		19
Correction Captain		19
ASAT Program Assistant		19
Supervising Correction Counselor (ASAT)		19
Supervising Correction Counselor		19
<i>answered question</i>		30
<i>skipped question</i>		1177

Psychotherapeutic Treatment

Thirty-seven respondents indicated that a total of 105 unlicensed individuals provide psychotherapeutic treatment, as allowed under the July 1, 2016. The number of staff in any program/agency could include “0”. Respondents were then asked to identify the tasks that fall within the practice of psychotherapy that are performed by individuals who are not licensed or authorized under Title VIII of the Education Law. More than 90% of the 12 respondents indicated that unlicensed staff engaged in activities that constitute psycho-education (e) and directive techniques that, if not for the exemption, could only be provided by individuals licensed or authorized under Title VIII.

Q.44 Answer Options	Response Percent	Response Count
a. Providing individual, family or group therapy based on a professional assessment and as part of a behavioral health treatment plan developed by the individual licensed under	75.0%	9

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Education Law.		
b. Planning, approving and/or overseeing the development or modification of a reward-based behavior modification treatment plan to reinforce positive behaviors (e.g., abstinence) or discourage negative behaviors (e.g., substance abuse). The licensed professional is responsible for determining the type and amount of psychotherapy that is needed, but may seek and consider information from direct care staff.	58.3%	7
c. Providing direct treatment to the consumer (alone or in group therapy) based on various psychotherapy models (e.g., Cognitive-Behavioral Therapy or psychoanalysis).	66.7%	8
d. Conducting and leading art or music therapy group sessions to assess and/or treat the consumer's mental health needs. Licensee can use appropriately trained staff to provide support for these activities, such as assisting consumers with movements or playing an instrument.	16.7%	2
e. Utilizing directive techniques to educate the consumer so that he/she can (1) learn and understand their symptoms and the purpose and goals of the treatment of their mental illness or other conditions and (2) develop/strengthen coping skills and personal strengths to more fully engage in treatment and life activities.	91.7%	11
<i>answered question</i>		12
<i>skipped question</i>		1195

Respondents were then asked to identify the occupational title of the unlicensed individuals who provide psychotherapy, as allowed under the July 1, 2016 exemption from licensure. The largest number of unlicensed individuals (24) are in the title of Recreation Therapist; individuals in this title are not eligible for licensure. However, anecdotal information suggests that, in the absence of a title for licensed creative arts therapists, many individuals in those fields are employed under a "recreation therapist" title. There is not sufficient information in the responses to determine if this is the case in these responses.

Q.45 Answer Options	Response Total	Response Count
Psychologist (MA/MS)	1	18
Psychologist (Ph.D./PsyD)	1	16
Bachelors of Social Work (BSW)		17
Unlicensed Masters of Social Work (MSW)	6	19
Social Work Case Manager		17
Social Work Case Worker	3	18
Unlicensed Masters in Mental Health Counseling (MHC)	2	18
Unlicensed Masters in Marriage & Family Therapy (MFT)	1	18
Unlicensed Masters in Creative Arts Therapy (CAT)		17
Unlicensed Psychoanalysis		17
Rehabilitation Counselor	24	18
Vocational Counselor	1	18
Care Coordinator	1	18
Case Manager	2	18

2014 Survey Responses

Case Worker	5	18
Youth Counselor	4	18
Applied Behavior Analyst (ABA)	8	18
Applied Behavior Analyst Assistant (ABAA)	3	18
Counselor or Residential Program Aide		17
Mental Health Therapy Aide or Assistant		17
Prevention Counselor		17
Recreation Therapist		17
Service Coordinator	7	18
Correction Officer		17
Correction Sergeant		17
Correction Captain		17
ASAT Program Assistant		17
Supervising Correction Counselor (ASAT)		17
Supervising Correction Counselor		17
<i>answered question</i>		23
<i>skipped question</i>		1184

Treatment other than psychotherapeutic treatment

A total of 303 unlicensed individuals provide treatment other than psychotherapy, as defined in the survey. A total of 37 agencies/programs responded to this question; if no unlicensed staff performs this activity, respondents were directed to enter "0". Sixteen of the respondents identified tasks that unlicensed individuals perform under the July 2016 exemption that constitute the provision of treatment other than psychotherapy. More than 93% of respondents indicated that unlicensed staff uses psychological interventions to modify behavior, enhance interpersonal relationships or work/life adjustment or improve behavioral or mental health. These activities, if not for the exemption, could not be provided by unlicensed individuals, even under supervision.

Q50. Answer Options	Response Percent	Response Count
a. Developing a mental health treatment plan based on an assessment/evaluation of a person's psychological, social and developmental functions, of supports and services to address addictive or behavioral disorders and conditions leading to purposeful behavioral change.	81.3%	13
b. Using psychological interventions to modify behavior for the purpose of preventing or eliminating symptomatic, maladaptive, or undesired behavior; to enhance interpersonal relationships, personal, group or organizational effectiveness, or work and/or life adjustment; or to improve behavioral or mental health.	93.8%	15
c. Assessing the consumer's disability when developing a treatment plan based on that assessment/evaluation using the DSM or similar classification systems that may include counseling, job training and access to technology and services, that assists the patient in achieving maximum participation in work and social activities.	43.8%	7

2014 Survey Responses

d. Providing individual, couple, family, relational and group therapy by following a behavioral health treatment plan that is based on an assessment/evaluation implementing change in the overall, long-term mental well-being of individuals, couple, families and those in other relationships, considering the nature and roles of individuals in relation to others, particularly in the family system.	56.3%	9
e. Using creative arts (e.g., dance, art, music) to care for the consumer who are assessed and evaluated using the DSM or similar classification systems and are following a treatment plan that by design seeks to increase awareness of self and others, cope with the symptoms of stress, illness and trauma, and enhance cognitive abilities through the creation of and reflection on art and the artistic process to improve self-esteem, develop more effective communications skills and relationships, gain insight into patterns of behavior, and create new options for coping with problems.	12.5%	2
f. Providing professional clinical interventions or professional counseling services to change or improve a consumer's behavioral health related to addictions, such as alcohol or substance abuse; compliance with treatment programs for physical illnesses, such as cardiac rehabilitation regimens; or recognizing and controlling behavior leading to spousal or child abuse.	37.5%	6
g. Providing recommendations for mental and physical rehabilitation activities based on neuropsychological testing related to traumatic brain injury, disturbances of memory, thought, and attention, and/or sensorimotor functioning.	25.0%	4
h. Establishing and conducting behavior modification groups with the intent of changing the harmful behavior of persons.	37.5%	6
<i>answered question</i>		16
<i>skipped question</i>		1191

Twenty-seven respondents indicated that occupational title and number of individuals in the occupational title, who provide treatment other than psychotherapy, as allowed under the July 2016 exemption.

Q. 51 Answer Options	Response Total	Response Count
Psychologist (MA/MS)	7	21
Psychologist (Ph.D./PsyD)	1	16
Bachelors of Social Work (BSW)	4	18
Unlicensed Masters of Social Work (MSW)	8	19
Social Work Case Manager	1	17
Social Work Case Worker	3	18
Unlicensed Masters in Mental Health Counseling (MHC)	5	19
Unlicensed Masters in Marriage & Family Therapy (MFT)	1	18
Unlicensed Masters in Creative Arts Therapy (CAT)		17
Unlicensed Psychoanalysis		17
Rehabilitation Counselor	24	18
Vocational Counselor	1	18
Care Coordinator	1	18
Case Manager	2	18

2014 Survey Responses

Case Worker	9	19
Youth Counselor	4	18
Applied Behavior Analyst (ABA)	8	18
Applied Behavior Analyst Assistant (ABAA)	3	18
Counselor or Residential Program Aide		17
Mental Health Therapy Aide or Assistant		17
Prevention Counselor		17
Recreation Therapist		17
Service Coordinator	7	18
Correction Officer		17
Correction Sergeant		17
Correction Captain		17
ASAT Program Assistant		17
Supervising Correction Counselor (ASAT)		17
Supervising Correction Counselor		17
<i>answered question</i>		27
<i>Skipped question</i>		1180

As in earlier responses, a significant number of recreation therapists provide treatment other than psychotherapy in the exempt programs. There are also a significant number of unlicensed MSWs and doctoral level psychologists providing these services. In the case of the psychologist, there is a permanent exemption for individuals employed in certain government operated programs; the exemption does not extend to individuals in not-for-profit programs that are regulated, approved or funded by the specified oversight agencies.

Development and assessment of assessment-based treatment plans

The most responses were made on this question, with 38 respondents indicating that 323 unlicensed individuals engaged in the restricted activity that, if not for the July 1, 2016 exemption, could only be performed by individuals licensed or authorized under the law. Nearly 90% of the 18 respondents indicated that unlicensed staff uses professional knowledge to establish or approve a treatment plan or to re-assess the patient and revise the treatment plan. Two-thirds of respondents indicated that unlicensed staff conducted family or group meetings, determined the appropriate psychotherapeutic intervention and develops an integrated plan of interventions.

There may continue to be confusion about assessment-based treatment planning, which requires professional knowledge and decision making, and case management or service coordination, which does not require such knowledge. While a licensed professional may provide case management services, to link the patient to necessary services, including direct treatment, housing, employment, etc., case management is not a restricted activity under the scopes of practice for these professions. These findings, in conjunction with the responses from the larger sample in the May 2014 report, suggest the need to clarify the distinction between these functions for consumers, provider agencies, licensed professionals and payers.

2014 Survey Responses

Q.56 Answer Options	Response Percent	Response Count
a) Using professional knowledge and judgment to establish or approve recommended treatment goals with the consumer that reflect long- and short-term objectives for the purpose of improving mental health.	88.9%	16
b) Ongoing re-assessment and revision of a treatment plan related to a consumer's progress toward achieving treatment goals based on information obtained from the consumer, from psychosocial tests and measures, from appropriately trained staff, and from collateral sources.	88.9%	16
c) Conducting family or other corollary group meetings, alone or with the assistance of staff, to assess and integrate family interactions with the consumer into a long-term mental health treatment plan. This meeting is part of the treatment planning process, rather than family meetings concerning daily activities.	61.1%	11
d) Determining the appropriate psychotherapy and mental health services to be provided to a consumer.	61.1%	11
e) Developing an integrated plan of prioritized interventions, that is based on the diagnosis and psychosocial assessment of the client, to address mental, emotional, behavioral, developmental and addictive disorders, impairments and disabilities, reactions to illnesses, injuries, disabilities and impairments, and social problems.	66.7%	12
<i>answered question</i>		18
<i>skipped question</i>		1189

Once again, respondents indicated that 24 rehabilitation counselors provide assessment-based treatment planning, as do case managers, case workers, applied behavior analysts and service coordinators. As discussed above, there may be confusion between the assessment-based planning that is defined in Article 154 of the Education Law as a restricted activity within the lawful scope of clinical social work, as opposed to case management which, under section 7702 of Article 154, does not require licensure.

Q.57 Answer Options	Response Total	Response Count
Psychologist (MA/MS)	6	21
Psychologist (Ph.D./PsyD)	3	18
Bachelors of Social Work (BSW)	3	18
Unlicensed Masters of Social Work (MSW)	7	20
Social Work Case Manager	1	18
Social Work Case Worker	3	19
Unlicensed Masters in Mental Health Counseling (MHC)	3	19
Unlicensed Masters in Marriage & Family Therapy (MFT)		18
Unlicensed Masters in Creative Arts Therapy (CAT)		18
Unlicensed Psychoanalysis		18
Rehabilitation Counselor	24	19
Vocational Counselor	1	19
Care Coordinator	1	19
Case Manager	6	19
Case Worker	9	20

2014 Survey Responses

Youth Counselor	4	19
Applied Behavior Analyst (ABA)	8	19
Applied Behavior Analyst Assistant (ABAA)	3	19
Counselor or Residential Program Aide		18
Mental Health Therapy Aide or Assistant		18
Prevention Counselor		18
Recreation Therapist		18
Service Coordinator	7	19
Correction Officer		18
Correction Sergeant		18
Correction Captain		18
ASAT Program Assistant		18
Supervising Correction Counselor (ASAT)		18
Supervising Correction Counselor		18
<i>answered question</i>		27
<i>skipped question</i>		1180

*State Education Department (SED)
Report Pursuant to
Chapter 57 of the Laws of 2013*

*State Agencies Response
Submitted on behalf of:*

*Office for the Aging
Office of Alcoholism and Substance Abuse Services
Office of Children and Family Services
Department of Corrections and Community Supervision
Office for People With Developmental Disabilities
Department of Health
Office of Mental Health
Office of Temporary and Disability Assistance*

January 28, 2015

Introduction

Chapter 57 of the Laws of 2013 requires the New York State Education Department (SED) to develop, in consultation with affected State agencies, professional associations, providers and those receiving services, a report to the Legislature regarding licensure and certain exemptions from scope of practice provisions impacting the following seven mental health professions: psychologist, clinical social worker, master of social work (MSW), creative arts therapist, marriage and family therapist, mental health counselor and psychoanalyst. Pursuant to Chapter Law, the State Office for the Aging (SOFA), the Office of Alcoholism and Substance Abuse Services (OASAS), the Office of Children and Family Services (OCFS), the Department of Corrections and Community Supervision (DOCCS), the Department of Health (DOH), the Office of Mental Health (OMH), the Office for People With Developmental Disabilities (OPWDD), and the Office of Temporary and Disability Assistance (OTDA) submit this response to the SED report. This document presents an overview of the issues that warrant further analysis and consideration regarding efforts to address enforcement of the various scopes of these professions established by Chapter 420 and 676 of the Laws of 2002.

From the perspective of the State agencies, the intent of the initial long term exemption, and the enactment of the subsequent exemptions, was to provide time to address concerns that the original statute was overbroad in its application to programs licensed, operated, funded or approved by the State agencies. Specifically, the State agencies believe the statute was originally enacted to prevent the potential for abuse by individuals who could inappropriately establish private practice or deliver services without proper licensure or regulatory oversight. The State agencies support that intent. From the outset, however, State agencies have continued to believe that the statutory constraints, federal and state regulations, certification requirements, program and performance reviews, and general oversight of programs delivered under their auspices are sufficient to ensure appropriate delivery of services. Moreover, the agencies and stakeholders believe that continuation of the exemption is warranted to ensure the flexibility needed to deliver high quality services associated with ongoing operations and transformational changes to the State's health and human services delivery systems.

History

Chapters 420 and 676 of the Laws of 2002 broadly defined the professional practices for licensure of seven mental health professions and restricted the practices of psychotherapy to licensees in those professions, as well as physicians, physician assistants, and registered nurses and nurse practitioners.

The 2002 statutes created an exemption from licensure until January 1, 2010, for individuals working in programs and services that are regulated, operated, funded or approved by OMH, OPWDD, OASAS, or a local governmental unit as defined in the Mental Hygiene Law. The original exemptions in the 2002 law were expanded by

Chapter 433 of the Laws of 2003 to include individuals delivering services in programs approved by OCFS or a Local Social Services District.

The enactment of Chapters 130 and 132 of the Laws of 2010 extended the exemption to July 1, 2013, and broadened the scope of the exemption to include DOH, SOFA, and DOCCS. Chapter 57 of the Laws of 2013 further extended the exemption until July 1, 2016, and extended it to OTDA.

Clarification of Practice

Chapter Law 57 of the Laws of 2013 clarified some of the activities that do not require licensure in order to reduce the impact of licensing laws on the exempt state and local government agencies and associated providers.

The clarifications included in Chapter 57 of the Laws of 2013 have provided guidance regarding a number of activities such as the collection and gathering of basic information and screenings that are unrelated to a behavioral health diagnosis or treatment plan that can be performed by unlicensed professionals. Specifically, Chapter 57 allows a person without a license to:

- perform an assessment for the purpose of collecting basic information, gathering demographic data, and informal observations;
- conduct screenings for eligibility to provide appropriate referrals to other programs or services; and
- determine the functional status of an individual for the purpose of developing a plan for services unrelated to a behavioral health diagnosis or treatment plan.

Licensure is not required to create, develop or implement a service plan unrelated to a behavioral health diagnosis or treatment plan. For example, unlicensed professionals may develop service plans related to job training and employability, housing, general public assistance, in-home services and supports or home delivered meals. In addition, unlicensed professionals may conduct investigations or assessments made by adult or child protective services, perform adoption home studies and assessments, develop family service plans and transition plans and engage in permanency planning activities, de-escalation techniques, peer services and skill development.

Additionally, these provisions do not require staff to be licensed in order to participate as a member of a multi-disciplinary team to implement behavioral health services or a treatment plan when such teams include one or more licensed professionals and each team member is practicing within his or her authorized scope of practice.

SED concludes that the clarifications made in Chapter 57 are creating confusion amongst stakeholders regarding which functions can be performed without a license. To address this, SED may seek amendments to the Education Law to reinterpret professional practice and those activities that can be performed by unlicensed persons. The State agencies find no evidence of confusion generated by these clarifications to

scopes of practices. Furthermore, potential changes that result in licensure being required to provide certain services that presently do not require licensure may increase the cost of providing services without any meaningful benefit. The State agencies will work with SED, the Board of Regents and the legislature to further refine clarifications made by Chapter 57.

Regulatory Assurance / Public Protection

The exempt State agencies oversee delivery and monitor the quality of services provided directly by the state employed workforce or through a network of highly regulated providers. All are committed to ensuring provision of care by appropriately qualified individuals. Pursuant to federal and State law and regulation, State agencies require professionals charged with the care and treatment of individuals to be well trained and prepared for their professional responsibilities.

Programs licensed, certified, or funded by the State agencies are subject to oversight, monitoring and regulation. Programs must comply with detailed requirements established in each agency's regulations and applicable federal regulations and standards. State agencies' oversight structures include, but are not limited to, regulatory compliance monitoring, prior approval and review, inspection and certification, criminal history background checks for employment, and quality assurance processes. Ongoing certification reviews and surveys of State and voluntary providers and programs monitor compliance with applicable federal and State regulations and related policies. These certification and oversight requirements may exceed standards for services provided by private licensed practitioners. Incident management protocols are another means of monitoring and protecting the health and safety of individuals.

Given the limited number of individuals licensed by SED in relevant professions across all of these programs, allowing the expiration of the exemption would result in an insufficient qualified pool of candidates.

Quality Assurance

Many licensed, certified or funded programs use multi-disciplinary teams as a quality control mechanism. Teams may be composed of staff with different training, education and expertise, including psychiatrists, licensed therapists and trained and un-licensed peers. Teams use a multi-disciplinary approach to establish treatment objectives. Appropriately licensed and experienced team members provide supervision and final sign-off on care plans and treatment. Professional staff members of the team have overall responsibility for treatment plan implementation.

State agencies' standards of care for clinical programs establish statewide baseline quality requirements which must be incorporated into provider policies. These standards address staffing, training and best practices.

Programs may be licensed or certified by one or more state agencies, and required to meet standards of the oversight entities. In addition, programs and providers may receive additional oversight and review from a variety of independent oversight organizations, including:

- U.S. Department of Health and Human Services (audits and inspections);
- Centers for Medicare and Medicaid Services;
- U.S. Department of Justice;
- U.S. Department of Housing and Urban Development;
- New York State Office of Medicaid Inspector General;
- New York State Office of State Comptroller (program audits);
- New York State Justice Center for the Protection of People with Special Needs;
- Mental Hygiene Legal Service (MHLS) funded by the Office of Court Administration;
- independent accreditation agencies, such as The Joint Commission and the Commission on Accreditation of Rehabilitation Facilities;
- New York State Attorney General;
- New York State Family Court; and
- Local Governments.

Innovations / System Change

State agencies and providers are leading system changes and innovations at the state and national level. Transformational changes to the state's health and human services system are being driven by the Medicaid Redesign Team (MRT), the Affordable Care Act (ACA), the Delivery System Reform Incentive Payment (DSRIP) program, and the State Health Innovation Plan (SHIP). The behavioral health and health care systems are undergoing significant realignments to promote high quality care, improve care coordination, reduce unnecessary hospitalizations and expand the capacity of community based providers. These rapid-paced changes have the potential to dramatically improve the quality of care provided to all New Yorkers, while decreasing costs.

The impact of allowing the expiration of the exemption must be analyzed against the back drop of these efforts. Key to the success of these initiatives, that are the foundation of the future health and human services delivery systems, will be the increased availability of both behavioral health and health care services that are provided by licensed and unlicensed professionals.

Specific system changes are described in the attached appendices prepared by each of the agencies.

Fiscal Impact

Each State agency, with the use of data received from not-for-profit entities that provide services under their guidance and regulation, completed an updated analysis of the

fiscal impact of removing the existing exemption. That detailed analysis is included in Appendix A. Roughly 16,000 individuals would require licensure under existing SED regulations if the longstanding current exemption lapsed. Assuming these individuals would now receive the same pay and benefits as currently licensed individuals, this would result in increased costs of \$344 million annually. This is comparable to the \$325 million annual cost provided in the 2013 State agency analysis provided to SED. The employees who would now require licensure if the exemption ended include individuals currently employed as case managers, rehabilitation, vocational and prevention counselors, social work assistants, MSWs, and social services specialists.

The revised analysis does reflect amendments contained in Chapter 57 of the Laws of 2013, so that the numbers of employees and costs expected to be impacted by licensure requirements were eliminated for programs funded by SOFA, and reduced for programs that are licensed, certified approved or funded by OASAS and DOCCS. At the same time, the updated analysis shows that the expiration of the exemption would have an additional impact for programs overseen by OTDA, and more costly impacts for programs overseen by OCFS as described in Appendix A. This revised analysis assumes that SED will not make regulatory changes to address “clarifying” issues with Chapter 57 that would require certain functions to again require licensure.

SED indicates that the projected costs by the State agencies may be overstated, in part because of its view that a requirement for licensure is not a guarantee of increased salaries. While State agencies and the Division of Budget (DOB) agree that any salary increases are not guaranteed, basic market forces will inevitably require that individuals with the same licensure requirements receive the same salary and benefit levels.

SED also notes that costs may be overstated because the hiring of additional licensed professionals may shorten the period of care or reduce or prevent recidivism and relapse. State agencies and DOB believe that the existing oversight, regulation, licensing, and performance standards required by all the affected State agencies and the use of the multi-disciplinary team already help ensure high quality and efficient care. In addition, the ongoing transition to the provision of care coordination by health homes and behavioral health organizations as approved by the MRT and that will be implemented as part of DSRIP, provide the continued promise of high quality care that prevents recidivism, relapse and unnecessary care.

The projected cost of \$344 million annually of allowing the exemption to lapse does not take into account additional factors including the cost of recruitment, selection and training of new employees and unemployment insurance and related costs for State and not-for-profit (NFP) employees who may be removed from employment because they cannot achieve the required licensing standards.

Consistent with the efforts of Chapter 57, the State agencies agree with SED that continued clarification of activities that do not require licensure can minimize these costs and reduce the possibility of reductions in the workforce. The State agencies also

agree with SED that additional statutory changes that provide permanent exemptions to existing positions such as case managers would reduce some of these costs as well.

Data

Given the low survey response rate, the SED survey results only represent a limited perspective and may not present a balanced view. The 2014 survey responses comprise less than ten percent of the impacted programs and services under the agencies' jurisdiction.

Conclusions

- The oversight role of State agencies and independent monitoring organizations can insure quality of care and access to services.
- Changes in the health care delivery system are generating innovation, specifically related to the MRT, HARPs, DSRIP, and SHIP, requiring flexibility in the workforce to ensure the success of these endeavors.
- DSRIP is a five year program and allowing the expiration of the exemption would be disruptive to this initiative.
- Care coordination, cross-system integration, and expanded utilization of community support services will create a significant increase in the demand for workers to ensure access to behavioral health care.
- The sunset of the current exemption in 2016 could undermine efforts to implement system changes that will be transformational in New York State.
- The disruption of the current delivery system of providing services through treatment teams made up of licensed and unlicensed practitioners would not demonstrably improve quality or increase access to care.
- Cost of the elimination of the current exemptions is projected to exceed \$344 million annually.

Recommendation

The State agencies request that the Legislature authorize the exemptions on a permanent basis. Information from the respective State agencies should be shared with SED and the Legislature every four years on progress toward maintaining and improving high quality care and access to services, and ensuring the appropriate, and likely increasing, use of licensed professionals as part of the health and human service delivery system. The State agencies look forward to working with SED, the Board of Regents and the Legislature regarding how best to deliver care in these service settings.

Appendices

Appendix A – Division of the Budget

Appendix B - Office for the Aging

Appendix C - Office of Alcoholism and Substance Abuse Services

Appendix D - Office of Children and Family Services

Appendix E - Department of Corrections and Community Supervision

Appendix F - Office for People With Developmental Disabilities

Appendix G - Department of Health

Appendix H - Office of Mental Health

Appendix I - Office of Temporary and Disability Assistance

Appendix A – Division of Budget Professional Licensing Fiscal Impact

Background:

Chapters 420 and 676 of the Laws of 2002 broadly defined the professional practices for licensure of seven mental health professions and restricted the practices of psychotherapy to licensees in those professions, as well as physicians, physician assistants, and registered nurses and nurse practitioners. The 2002 statutes enacted an exemption from licensure until January 1, 2010 for individuals working in programs and services that are regulated, operated, funded or approved by Office of Mental Health (OMH), Office for People with Developmental Disabilities (OPWDD), Office of Alcoholism and Substance Abuse Services (OASAS). The original exemptions in the 2002 law were expanded and extended in subsequent legislation enacted in 2003, 2010 and 2013. The following provides a fiscal analysis of the impact of allowing the longstanding exemption to expire.

Fiscal Analysis:

Each State agency, with the use of data received from not-for-profit entities that provide services under their guidance and regulation, completed analyses of the fiscal impact of removing the existing exemption.

The process used to complete the fiscal analyses, initially in 2013 and again in 2015, is relatively straightforward. The first step was to identify the number of individuals in positions employed by the State or not-for-profit entities that would require licensure if the exemption was eliminated. The second step was to calculate the cost of salaries and benefits currently paid to those individuals and compare that to the cost of salaries and benefits for individuals currently employed as licensed professionals. The differential in costs for existing licensed and non-licensed staff was multiplied by the number of impacted positions to calculate the fiscal impact of exemption elimination.

The revised analysis shows that there are roughly 16,000 individuals who are used as part of the multi-disciplinary and ongoing service teams of the State and NFP providers who perform tasks that would require licensure if the longstanding exemption lapsed. Assuming these individuals would now receive the same pay and benefits as currently licensed individuals, it would result in increased costs of \$344 million annually. This is comparable to the \$325 million annual cost provided in the 2013 State agency analysis provided to SED.

The first chart below shows a summary of the analysis provided in 2013 which concluded that elimination of the longstanding exemption would result in additional costs of \$325M.

**Appendix A – Division of Budget
Professional Licensing Fiscal Impact**

Original 2013: Annual Fiscal Impact of Exemption Elimination

Agency	State Impacted FTE	State Cost*	NFP Impacted FTE	NFP Cost**	Total Impacted FTE	Total Cost
OMH	622	\$11,387,464	4,999	\$84,428,964	5,621	\$95,816,428
OPWDD	515	8,643,709	3,459	99,063,025	3,974	107,706,734
OASAS	77	3,245,676	2,374	67,315,840	2,451	70,562,516
OCFS	0	0	2,663	43,178,735	2,663	43,178,735
DOCCS	1,060	6,057,139	0	0	1,060	6,057,139
Aging	0	0	530	2,225,677	530	2,225,677
TOTAL	2,274	\$29,334,988	14,026	\$296,212,240	16,300	\$325,547,229

*Includes Fringe (51.68%) and Indirect Costs (2.69%).

**NFP data and salaries are from the Consolidated Fiscal Report (CFR) and include a 28% Fringe Rate.

The revised analysis below reflects the impact of amendments contained in Chapter 57 of the laws of 2013. This results in a reduced number of impacted employees and costs for programs run by the Department of Aging and OASAS. Specifically, CASAC's employed by OASAS regulated programs and in-home services, home delivered services and assessment services by NYSOFA's network of county providers were made permanently exempt from licensure by the 2013 amendments.

At the same time, the updated analysis shows new fiscal impacts for programs run by the OTDA, and more costly impacts for programs run by OCFS. Specifically, OTDA providers notified the State that the 2013 analysis did not reflect the impact of potential licensure for services provided by their case managers and others providing homeless housing services, and we agree with that assessment. Similarly, the counts of potentially impacted OCFS-funded NFP staff has been increased to reflect updated input from NFP providers.

As a result, over 15,900 individuals would be impacted, at an annual fiscal impact of \$344 million, if the exemption was eliminated.

Revised 2015: Annual Fiscal Impact of Exemption Elimination

Agency	State Impacted FTE	State Cost*	NFP Impacted FTE	NFP Cost**	Total Impacted FTE	Total Cost
OMH	710	\$12,720,554	4,506	\$61,896,917	5,216	\$74,617,472
OPWDD	384	7,193,498	3,459	99,063,025	3,843	106,256,523
OASAS	0	0	1,911	51,196,032	1,911	51,196,032
OCFS	0	0	2,881	71,904,370	2,881	71,904,370
DOCCS	299	6,074,497	0	0	299	6,074,497
OTDA	0	0	1,776	34,099,200	1,776	34,099,200
Aging	0	0	0	0	0	0
TOTAL	1,393	\$25,988,549	14,533	\$318,159,544	15,926	\$344,148,093

*Includes Fringe (55.88%) and Indirect Costs (2.53%).

**NFP data and salaries are from the Consolidated Fiscal Report (CFR) and includes a 28% Fringe Rate

Appendix A – Division of Budget Professional Licensing Fiscal Impact

Similar to the 2013 analysis, employees who would now require licensure if the exemption ended include individuals currently employed as case managers, rehabilitation, vocational and prevention counselors, social work assistants, MSW's, and social services specialists.

State Delivered Services: If the existing exemption is not extended, the total State impact would be approximately \$26 million annually. The most impacted titles are:

<u>Title</u>	<u>2013</u> <u>FTE</u>	<u>2015</u> <u>FTE</u>
Social Worker Assistant 1, 2, 3	413	318
Alcohol & Substance Abuse Treatment Aide *	0	299
Recreational Therapist	349	272
Rehabilitation Counselor 1 & 2	214	209
Security Hospital Senior Treatment Assistant	72	77
Offender Rehabilitation Coordinator/Supervisor	1,044	0

* Due to the laws of 2013, the Offender Rehabilitation Coordinator/Supervisor titles are no longer impacted. However, Alcohol and Substance Abuse Treatment Aides are impacted.

NFP Delivered Services: If the existing exemption is not extended, the total NFP impact would be approximately \$318 million annually. The most impacted titles include:

<u>Title</u>	<u>2013</u> <u>FTE</u>	<u>2015</u> <u>FTE</u>
Case Manager	4,075	4,999
Social Worker	1,960	2,258
Psychologist / Psychology Worker	1,213	1,063
Social Worker Master's Level	1,118	964
Other Clinical Staff/Assistants	902	850
Clinical Dev. Disabilities Specialist	883	715

Discussion of Fiscal Analysis

The projection of additional costs from the licensure requirements, or any other change that would dramatically alter the current health and human services delivery systems, is necessarily subject to uncertainty. The following provides some additional discussion for consideration.

SED indicates that the projected costs by the State agencies summarized above may be overstated, in part because of their view that a requirement for licensure is not a guarantee of increased salaries. State agencies and the Division of Budget agree that any projected salary increases associated with licensure are not guaranteed. However, the analysis above assumes that basic market forces will inevitably require that individuals with the same licensure requirements will receive the same salary and benefit levels.

SED also notes that the costs may be overstated because the hiring of additional licensed professionals may shorten the period of care or reduce or prevent recidivism and relapse. State agencies and DOB believe that the existing oversight, regulation, licensing, and performance standards required by all the State agencies and these multi-disciplinary teams already ensure high quality and efficient care. In addition, the ongoing transition to the provision of care coordination by health homes and behavioral

Appendix A – Division of Budget Professional Licensing Fiscal Impact

health organizations as approved by the MRT and that will be implemented as part of DSRIP, provide the continued promise of high quality care that prevents recidivism, relapse and unnecessary care.

It should be noted that the projected additional costs of \$344 million annually do not take into account additional factors including the cost of recruitment, selection and training of new employees and unemployment insurance and related costs for State and NFP employees who may be removed from employment because they cannot achieve the required licensing standards.

Consistent with the efforts of Chapter 57 of the Laws of 2013, the State agencies agree with SED that continued clarification of activities that do not require licensure can minimize these costs and reduce the possibility of reactionary alterations in the workforce. The State agencies also agree with SED that additional statutory changes that provide permanent exemptions to existing positions such as case managers would reduce some of these extra taxpayer costs.

**New York State Office for the Aging Appendix to Unified Statement
Response to SED Report – Office of the Professions as required
pursuant to Chapter 57 of the Laws of 2013**

The New York State Office for the Aging (NYSOFA) has reviewed the Draft Report developed by the State Education Department (SED) Office of the Professions pursuant to Chapter 57 of the Laws of 2013.

The information contained in SED's report represents the culmination of an effort that has been underway by state agencies, the office of the profession and the legislature to ensure the continuity of mental health services provided to consumers who are being served directly by certain state agencies and the networks they regulate, approve or fund and their local government partners.

This document provides an overview of NYSOFA's network, how programs are regulated and administered and offers comments in response to some of the findings contained in the report.

EXECUTIVE SUMMARY

Description of NYSOFA, the Aging Network, and Aging Network Services:

New York State Office for the Aging

The New York State Office for the Aging (NYSOFA), established in 1965 by Article 19-J of the Executive Law (now, New York State Elder Law, Article II, Title 1), is federally designated as New York's lead agency in promoting, coordinating, and administering Federal, State, and local programs and services for older New Yorkers. NYSOFA administers federal Older Americans Act programs and services, state-funded programs, and grant-related initiatives, and also plays a central role in advocating on behalf of the 3.7 million adults aged 60 and older and their families living in our State. NYSOFA collaborates with public and private organizations and agencies in order to achieve common goals to better serve older New Yorkers. In addition, NYSOFA is involved in facilitating and guiding policy development to improve the quality of life of older New Yorkers, and assuring the delivery of high quality services in communities across the State to help older adults remain as independent as possible for as long as possible and engaging older adults, their families, and other stakeholders in this process.

Aging Services Network Overview

The cornerstone of aging services can be found within the Older Americans Act (OAA). The programs supported by OAA funds are central to providing older New Yorkers with a high quality of life and maintaining older adults in their preferred community living environment. New York State's investment in core programs and work to find new and better ways of delivering services demonstrates NYSOFA's commitment to services and community involvement to foster improvement in the lives of older persons. By design these efforts help NYSOFA fully participate in all aspects of society and community life,

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be able to maintain their health and independence, and remain in their own homes and communities for as long as possible.

Through the 1965 federal OAA and subsequent amendments, NYSOFA administers funds to a network of 59 local Area Agencies on Aging (AAA) that cover all counties of New York State. Nearly all AAAs are based within county government; in 52 counties the AAA is a unit of county government (including two counties, Warren and Hamilton, which have combined to support one AAA). In four additional counties, the AAA is part of the voluntary sector. In New York City, the New York City Department for the Aging (DFTA) serves the five boroughs that comprise the City. Two Native American Reservations, the St. Regis Mohawk and the Seneca Nation of Indians Reservations, also are designated Area Agencies on Aging.

The 59 AAAs utilize a local service delivery subcontractor network of approximately 1,400 community-based organizations to deliver a wide array of services in their communities. In addition, thousands of volunteers, mostly older persons, are providing various services to older people who need them – such as transportation, respite; health insurance counseling and assistance, home delivered meals, etc. New York’s aging services network consists of a vast array of diverse public and private organizations and volunteers serving older New Yorkers and their families in every county, town, village, hamlet, and community throughout the state.

AGING NETWORK SERVICES

The Older Americans Act (OAA) and state funds administered by NYSOFA are used by New York’s aging network to provide supportive services including: personal care; case management and care coordination; in-home services; transportation; adult day care; legal assistance; home and congregate meals; comprehensive and objective information, assistance, and screening; options counseling; chronic disease self-management assistance; transitions through critical clinical and non-clinical pathways, and a range of additional services. Two examples are below that directly related to the scope of practice issues, which could be potentially limited as discussions continue about clarifying functions that are protected by the scope of practice.

Case Management:

Case management is at the center of wellness and autonomy for older adults. The standard service definition for Case Management is: “a comprehensive process that helps older people with diminished capacity, and/ or their caregivers gain access to and coordinate appropriate services, benefits, and entitlements.” Case management consists of assessment and re-assessment, care planning, arranging for services, follow-up and monitoring, and discharge. These activities must be provided by or under the direction of the designated case manager or case manager supervisor.

Case management or care coordination is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet an older person’s health and human service needs. The federally-funded Older Americans Act (Title III-B) and the state-funded Expanded In-home Services for the

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Elderly Program (EISEP) and Community Services for the Elderly (CSE) program include person-centered case management/care coordination provided by Area Agencies on Aging and/or their local contract providers as a core component to gaining access to selected aging network services. Further, case management provides advocacy, access, assessment, planning, communication, education, resource management, and service coordination.

Options Counseling:

Options counseling is an essential component of the No Wrong Door (NWD) /Single Entry Point (SPE) approach to long term services and supports that is the centerpiece of long term care reform at the national, state, and local levels. In New York, NY Connects, administered by NYSOFA, is the state's federally designated Aging and Disability Resource Center (ADRC), which is a central element of the Balancing Incentive Program (BIP). BIP provides enhanced FMAP (+2%) to participating states to rebalance Medicaid LTSS expenditures from institutions to community settings and requires 3 structural changes which include:

- No Wrong Door/Single Entry Point network
- Core Standardized Assessment Instruments
- Conflict-Free Case Management

Options Counseling builds on Information and Assistance (I&A), and is an interactive decision-support process whereby consumers, family members and/or significant others are supported in their deliberations to determine appropriate long-term care choices in the context of the consumer's needs, preferences, values, and individual circumstances. Formal protocols and training have been established by NYSOFA for staff and NWD partners providing this assistance. NYSOFA will set minimum qualifications for education and/or work experience to perform options counseling consistent with national, state and local requirements. Options counseling specific requirements include competencies in the domains of decision support, person-centered planning, cultural competency, communication, participant direction, and quality assurance. A bachelor's degree in human services will be required, and states may include a certification requirement. Licensure of such personnel is not required. NYSOFA has been participating in the U.S. Administration on Aging's development of national options counseling standards and it is anticipated that a national training curriculum and certification process will be developed (See Attachment 1, Draft National Options Counseling Standards).

Additional Aging Network Services:

The following is a partial list of NYSOFA's core services and programs funded through Older Americans Act and dedicated state funding sources. The services that make up the core programs and services require staff to engage in activities that use similar or the same terminology as used in restricted scopes of practice, and may be specifically related to scope of practice functions such as counseling, evaluating, assessing, and providing case management services. Details regarding the following programs and services are posted on NYSOFA's website.

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- Information and Assistance
- NY Connects: Choices for Long Term Care (NY Connects)
- Health Insurance Information and Counseling and Assistance Program (HIICAP)
- In-Home Contact and Support Services – state funded
 - Expanded In-home Services for the Elderly Program
 - Community Services for the Elderly Program
- Nutrition Program for the Elderly
- Disease Prevention and Health Promotion Services
- Evidence- Based Disease and Disability Prevention Programs
- Medication Management
- Caregiver Supports
- Respite Services
- Social Adult Day Services
- Older Americans Act Core Services – Innovations Grants

DATA COLLECTION FINDINGS

The New York State Office for the Aging has reviewed the data interpreted in the report developed by the New York's SED Office of the Professions, that was provided for review to the affected state agencies in December of 2014.

While SED provided a general overview of survey data findings in their Report, a key component that affects NYSOFA is regarding the stated need by SED for additional clarifications of taxonomy/terminology and tasks that fall within the restricted scopes of practice. Included may be critical functions that affect the delivery of case management and options counseling by non-licensed personnel in particular, and potentially, for other activities undertaken through NYSOFA programs and services. Several of these programs functions could be restricted to the licensed professions depending on interpretation of the scope of the functions that would be restricted.

During the 2013 Legislative Session some clarification was provided regarding the activities that do not require licensure that were enacted however, by Chapter 57 of the Laws of 2013. This action has proven helpful as it has prevented any disruption in services provided by the aging network's workforce. The activities that do not require licensure pursuant to Chapter 57 of 2013 - include providing an assessment for the purpose of collecting basic information, gathering of demographic data, and informal observations, screenings for a referral used for general eligibility for a program or service and determining the functional status of an individual for the purpose of determining need for services unrelated to a behavioral health diagnosis or treatment plan. In addition, licensure is not required to create, develop or implement a service plan unrelated to a behavioral health diagnosis or treatment plan. Such services plans are of importance to older adults, and help people access -- in home services and supports of home delivered meals, peer services or skills development, job training and employability, housing, general public assistance, investigations conducted or assessments made by adult protective services, adoption home studies and permanency planning activities.

The findings of the SED report, however state these changes are generating confusion about certain tasks and activities that are not clearly defined in law.

QUALITY OF CARE ASSURANCE

NYSOFA does not license its provider network. However, NYSOFA has a variety of mechanisms in place to assure quality of staff that performs functions that may fall within the scope of practice of the discipline of social work, although not within the restricted scope of practice as currently defined. Selected programs and services that are part of the Aging Network's complement of services in which staff receive certification (e.g., LTC Ombudsman), and plans for certification of Options Counselors using national certification standards is being reviewed and considered. NYSOFA has monitoring requirements in place for ensuring the provision of quality services by Area Agencies on Aging. Furthermore, NYSOFA has standard service definitions and requirements for case management staff, which are provided, below:

Case Management Standard Service Definition:

In NYSOFA's standard service definition, case management includes the following:

- A comprehensive process that helps older people with diminished functioning capacity, and /or their caregivers,
- A comprehensive MDS-compliant assessment includes the collection of information about a person's situation and functioning, and that of his/her caregivers, which allows identification of the person's specific strengths and needs in the major functional areas.
- A care plan is the formal agreement between the client and case manager and, if appropriate, the client's caregivers regarding strengths and problems, goals and the services to be pursued in the support of goals.
- Implementation of the care plan (arranging and authorizing services) includes contacting services providers, conducting case conferences and negotiating with providers for the delivery of needed services to the client as stated in the care plan.
- Follow-up and monitoring is ongoing and regular contact with the client and service providers to ensure that service delivery is meeting the client's needs and being delivered at the appropriate levels and quality.
- Re-assessment is the formal re-examination of the client's situation and functioning and that of his/ her caregivers to identify changes which occurred since the initial assessment / last assessment and to measure progress toward goals outlined in the care plan. It is done at least annually and more frequently as needed. Changes are made to the care plan as necessary.
- Discharge is the termination of case management services. Reasons for discharge may include the client requesting discharge, the attainment of goals described in the care plan, the client needing a type of service other than case management or ineligibility for the service.
- Care managers may also be functioning in the role of support coordinator or consultant. In this role, the case manager may be acting as a teacher, networker, counselor and/ or family guide.

Case Management Regulations:

The following are the regulations authorizing a case manager to engage with clients independently without the sign off or approval of a licensed professional on service plans and the credentials they must possess.

- NYSRR 6654.16 (g) - An assessment is required to be conducted for identifying the older person's problems and care needs in the major function area. Including information necessary to determine the individual's functional level and to identify unmet care needs.
- 6654.16 (h) – The case manager shall arrange for additional medical, nutritional, mental health or housing assessments to be conducted if the assessment pursuant to subdivision (g) of this indicates a need for such additional assessments.
- 6654.1616 (y) A designated case manager or case management supervisor or staff responsible for conducting an assessment and/ or reassessments, developing care plans, authorizing services or terminating or discharging clients from the program shall, at the time of assuming such responsibilities:
 - (i) be graduated from a regionally accredited college or university, or a New York State registered four-year college or university, with a bachelor's degree and, to be a case management supervisor, have two additional years of related experience; or
 - (ii) be a registered nurse with one year of satisfactory full-time paid experience in that profession and, to be a case management supervisor, have two additional years of related experience; or
 - (iii) possess the full-time equivalent of four years and, to be a case management supervisor, have two additional years of satisfactory experience:
 - (a) in social casework;
 - (b) in social work in a community or social action program;
 - (c) teaching in an accredited school; or
 - (d) as a community services worker or case aide in a human services agency;
 - (iv) possess a satisfactory equivalent combination of the foregoing training and experience; or
 - (v) until six months following the effective date of this regulation, in the case of staff responsible for conducting assessments and/or reassessments, have been employed for a period of at least one year by an aging services agency to conduct client assessments. Nothing herein, however, is intended to change the qualifications of a designated case manager or case manager supervisor who carries out the responsibilities specified elsewhere in this section.

NYSOFA also has delineated assessment requirements in a Minimum Data Set (MDS) for six community-based long term care services when funded with Aging Services Network funds (i.e., funds that are administered by NYSOFA and managed locally by Area Agencies on Aging). NYSOFA's MDS is an established set of items that must be addressed during an assessment/ reassessment of an individual seeking/ receiving any

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of the following services: case management, personal care level I, personal care level II, home health aide services, home delivered meals and social adult day services. The MDS applies to these services whether provided directly by an Area Agency on Aging or under subcontract with a community based organization.

INNOVATIONS

The impact of allowing the expiration of the exemption should be analyzed against the back drop of efforts currently being undertaken to transform how services are being provided by the health and human services networks of New York. For example, NYSOFA and other State agencies are leading system changes and innovations that are nationally recognized. The behavioral health and health care systems are undergoing significant improvements to promote high quality care, including the ongoing transition to care coordination by health homes and behavioral health organizations as approved by the Medicaid Redesign Team (MRT). In addition, systemic changes to New York's health care system are going to be driven by the Delivery System Reform Incentive Payment (DSRIP) Program. The federal government has awarded New York \$6.42 billion to support projects that will seek to fundamentally restructure the health care delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospital use by 25% over 5 years. Aging services providers are being integrated into many of the local projects getting underway across New York.

Current trends and improvements to the service delivery framework may require flexibility in the parameters used to govern our professions that serve as the foundation for our health and human services workforce to ensure that changes being contemplated remain sustainable.

Within NYSOFA, a new innovation is to advance more effective service delivery to individuals through the function of Options Counseling, which is a key element of BIP. Additionally, amending the clarification exemption from licensure established pursuant to Chapter 57 of the Laws of 2013 could impact NYSOFA's ability to serve individuals through the groundbreaking Medicaid 1115 waiver as a cost effective service provider. This waiver would provide New York the flexibility to drive innovations in the health and human service delivery system and serve individuals through new, cost effective service delivery models, including those available through the aging network.

PROFESSION OF SOCIAL WORK

The following are responses by NYSOFA that are specific to the conclusions included by SED in the Report that pertain to the profession of social work:

SED SW (1): "Clarification of practice: Chapter 57 of the Laws of 2012 added a new paragraph 7 to section 7706 of the Education Law to clarify additional activities that do not require licensure. The Board of Regents and the Education Department with the assistance of the State Board for Social Work will continue to provide further clarification of terms and functions within the law. In some circumstance, it would be appropriate for the Department to seek amendments to the Education Law to ensure the practice of the

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professions is consistent with education and examination requirements to protect the public.”

NYSOFA Response: NYSOFA is committed to working with the Board of Regents and the SED in this effort. These discussions about practice and clarification of terms will be critical to the future of long term services and supports delivery, which, under the administration of Governor Cuomo, are moving toward integrated delivery systems. This approach requires the full participation of all providers working together to serve the needs of the individual.

Changes that were enacted as part of Chapter 57 of the Laws of 2013, NYSOFA believes were very useful and clarified the role of the current aging network workforce to perform services that are not restricted. As New York moves further into the expansion of health homes as an innovative way of improving care, along with the implementation of the MRT recommendations, DSRIP and BIP, if NYSOFA is to play a role, flexibility will be needed to ensure the effective delivery of care.

SED SW (3): “Occupational Exemptions:”

“(Conclusion 1) There should be further discussion about the certified or credential individuals who may engage in activities that overlap with the restricted practice of the profession. It may be appropriate to clarify whether the statutory exemption should apply to individuals in specific occupational titles, or those who perform functions that are not currently defined as exempt under Article 154.”

“(Conclusion 2) The overarching concern of professional licensing relates to the protection of the public. Accordingly, many have expressed concerns about any exemption to allow unlicensed persons to provide services that the laws restrict to individuals licensed or authorized (e.g., students, permit holders and interns under supervisions). The statutory restriction on the practice of the professions seeks to ensure that defined services are provided by qualified individuals, licensed under the Education Law and accountable for their practice without regard to the setting in which the services are provided.”

NYSOFA Response: NYSOFA remains open to continuing discussions with SED and the Board of Regents about clarifying the role individuals who may engage in activities that overlap with the restricted practice of the a profession. The enactment of Chapter 57 of the Laws of 2013 provided clarification regarding activities/ services that are approved, regulated and funded by NYSOFA and the OAA. These changes ensured that activities/ services provided by the aging network would not be disrupted because of workforce challenges created by having to hire only licensed professionals.

Regarding public protection – a variety of mechanisms are place that are designed to assure quality of staff that performs functions that may fall within the scope of practice of the discipline of social work, although not within the restricted scope of practice as currently defined. Programs and services that are part of the Aging Network’s complement of services, require that staff receive certification (e.g., LTC Ombudsman),

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and include plans to train/ and certify Options Counselors using national certification standards that are being reviewed. In addition, NYSOFA has monitoring requirements in place, and Area Agencies on Aging are required to maintain staff disciplinary procedures. Furthermore, NYSOFA has standard service definitions and requirements for case management staff, which have already been detailed in a previous section of this document.

SED SW (4) “Alternative Pathways:”

“(Conclusion 2) Policymakers may want to consider incentives to encourage the program and agencies to work with unlicensed staff to apply for licensure and meet all requirements by a date certain. It may be appropriate to provide a temporary license for such applicants, to allow them to continue to practice in the setting, while submitting the application and documentation to become licensed as an LMSW or LCSW. An on – going commitment to licensure within public programs and employer support for applicants could achieve the goal of licensure for individuals who seek to provider services that are restricted under law. “

NYSOFA Response: This issue highlights a key concern that all personnel engaged in any of the scope protect activities to be licensed. NYSOFA may be supportive of the development of alternative pathways for individuals to be credentialed depending on how it were to be structured. While licensure provides an entry level snapshot of potential skills necessary to independently serve clients and to enter the field with a license, passing a licensing examination does not guarantee that years later the State can assure their current competence – other than their work history in providing services. If an individual is effectively serving clients, NYSOFA would support that their work history be considered as a pathway to licensure.

SED SW (5) “Extension of broad-based exemptions from licensure:”

“(Conclusion) It is important to ensure that fragile members of the public uniformly receive adequate preferred services, regardless of where they receive those services. The Department is ready to collaborate with the Legislature, Executive and other stakeholders, to discuss the timeline for implementing changes in the licensing laws to minimize any disruptions in services and displacement of individuals or programs.”

NYSOFA Response: This statement is very broad and does not reflect the feedback regarding NYSOFA specifically. NYSOFA would recommend the continuation of the broad based exemptions. Specifically, there has been expressed in a prior survey overwhelming support for NYSOFA’s recommendation for a permanent exemption to allow programs that are part of the aging network to utilize non-licensed professionals to provide services that are funded by the Older Americans Act (OAA). In the Report, SED dismisses the broad support for this recommendation. NYSOFA would counter that a majority of its programs have service components that are supported either in part or completely funded by the OAA and must meet the federal standards for providing services – therefore an exemption should be applied to all aging network services.

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SED SW (6) “Civil Service Titles:”

“(Conclusion) Titles should be created and duties set forth by the Department of Civil Services to conform to Title VII of the Education Law where they do not currently exist, or where there is confusion or lack of specificity with in titles. This would include supervision of an individual who is only authorized to practice under supervision, (e.g. LMSW providing clinical services), as well as providing promotional opportunities (e.g., LMSW to LCSW to LCSW Supervisor).”

NYSOFA Response: NYSOFA does not provide direct services – but would support the Department of Civil Services in engaging in this process once all clarifications are finalized regarding the activities that are restricted by the scopes of the professions, as it would eventually impact the operations of local governments and not-for profits.

COST CONSIDERATIONS

Changes that were made by Chapter 57 of 2013 helped provide clarity regarding functions that are scope of practice protected and will prevent the disruption of the role of case manager with in the aging network. These changes negate the fiscal impact of enforcing the scopes of the seven new mental health professions. Case managers will be able to continue to operate independently and approve assessments for the authorization of services or in the formulation and implementation of a plan of action based on the client’s needs and strengths. Presently, NYSOFA has requirements for case management, both in terms of a generic definition that applies to all funding streams, and also for programs that specifically fund case management. Case managers may also be functioning in the role of support coordinator or consultant. In this role, the case manager may be acting as a teacher, functioning in the role of support coordinator and counselor. There are additional requirements for case management funded under the Expanded In-Home Services for the Elderly Program (EISEP) and the Community Services for the Elderly Program (CSE).

The following are the major programs funded and administered by NYSOFA, which would have been impacted if not for the enactment of Chapter 57 of 2013.

Each program listed below requires the provision of case management services and a comprehensive non-clinical assessment to determine eligibility for services and the development of a plan of care. Presently, approximately less than 5 percent of case management staff providing these services is a licensed professional. NYSOFA estimates that there are approximately 450 case managers/care coordinators working in the following programs:

- Expanded In-home Services for the Elderly Program (EISEP) – 51,000 clients served
- Community Services for the Elderly Program (CSE) – 78,516 clients served
- Home Delivered Meals – 64,600 clients served
- Social Adult Day Care – 4,530 clients served
- Respite – 6,100 clients served.

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Assuming that there are enough licensed professionals currently available statewide to perform these functions, the estimated costs associated with hiring licensed professionals to provide these services would exceed \$6.75 million (the difference between the average case manager salaries versus the salaries of the average licensed professional).

SUMMARY AND CONCLUSIONS

It has become apparent, based on the review by NYSOFA of the conclusions in the SED Report, that the interpretations offered by SED, which are continuing to evolve, will define what activities fall within the restricted scope of practice of some of the mental health professions. The State's health care system remains in the midst of an enormous process of change that has the potential to dramatically improve outcomes for our citizens, decrease costs and insure the improvement in quality care for all our citizens. As these transformational changes are implemented, it will require flexibility in the parameters used to govern our professions that serve as the foundation for our health and human services workforce.

NYSOFA and the other State agencies and SED are partners in the overall regulatory scheme to insure public protection and accountability. SED insures entry level competence and in particular regulates the private practice of the professions. Agencies share responsibility for the delivery of competent care post licensure by creating review processes to insure competently delivered care in the states system of care directly, as well as by regulation and contract, especially for those professional services that are provided by government directly or indirectly through license, certification, regulation or contract.

In this time of tremendous change in the health and human service system fiscal austerity, oversight of these services must be provided through the most effective vehicle. NYSOFA's experiences have demonstrated that the current systems overseeing the delivery of care through the aging services delivery network is as effective as the system that requires only licensed practitioners to provide all care to all individuals.

Recommendations

Based on these findings, NYOSFA would recommend the following two options:

- (1) Continue the exemption on a permanent basis (preferred): NYSOFA would recommend that the present exemption be made permanent, since the mechanisms for overseeing the delivery of care have long ensured the safe and effective provision of services to older New Yorkers. Indeed the quality of care provided by programs operating under the jurisdiction NYSOFA have been high and replacement of thousands of current workers with licensed professionals will not ensure an increase of the quality of care offered in these programs but will increase cost and limit access. In addition, oversight standards, required by the State to advance the transition to the provision of care coordination models by the Governor and the Medicaid Redesign Team (MRT) and the implementation

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of DSRIP that will further ensure high quality care and enhance the sustainability of such efforts.

- (2) Extend the exemption through July 1, 2020: NYSOFA would support and recommend to the Legislature as a second option providing a continuation of the exemption for five years to July 1, 2020. Given the review and explanation of the issues by NYSOFA and the affected State agencies, as well as protecting the significant investment over five years in New York thru DSRIP of \$6.45 billion, extending the exemption for this period would ensure that the transformational changes underway would not be disrupted by enforcing the scopes of practice of the seven mental health professions. .

Standards for Options Counseling

Administration for Community Living National Options Counseling Standards June 2012

Introduction

Background

Goals of the Standards

Standards for Options Counseling

Standard 1: Service Definition, Population, and Outreach

Standard 2: Getting to Options Counseling

Standard 3: Components of Options Counseling

Standard 4: Staffing

Standard 5: Partnerships

Standard 6: Continuous Quality Improvement, Evaluation and Outcomes

Introduction

In 2010, the Administration on Aging (AoA), now the Administration for Community Living (ACL), funded Aging and Disability Resource Center (ADRC) programs in 20 states to work with AoA and each other in a collaborative process to develop national minimum standards. These standards guide how Options Counseling (OC) is delivered, who delivers it, under what circumstances, and how outcomes are tracked across the ADRC network. Through the grant, states will also design, implement and test draft standards for Options Counseling.

Beginning in November 2010, ACL has met monthly with Options Counseling grantee states via conference call to discuss elements of minimum national standards and lay out a vision for options counseling. ACL has also sought input from federal partners, technical assistance providers and representatives from aging and disability services networks to ensure the standards are relevant to and applicable across all populations. These conversations have produced the following draft standards for Options Counseling based on the definition of Options Counseling proposed by the National Association of States United for Aging and Disabilities in 2007.¹

This is the third version of the draft standards and incorporates feedback from grantee draft standards and ACL's calls with grantee states to discuss their standards. Please

¹ Long-Term Support Options Counseling: Decision Support in Aging and Disability Resource Centers, NASUAD, 2007 online at: www.adrc-tae.org/tiki-download_file.php?fileId=29256

Standards for Options Counseling

note that this language is a **draft**; the standards will continue to evolve as ACL continues discussions with stakeholders at the federal, state and local levels.

ACL Vision for Options Counseling

The primary goals of Options Counseling (OC) are to facilitate informed decision-making about Long-Term Services and Supports (LTSS) and serve a key role in the streamlined access to supports. It represents a critical service of Aging and Disability Resource Centers (ADRCs) as they help provide a clear pathway for individuals to access LTSS. It supports the broader system goals of rebalancing Long-Term Services and Supports (LTSS) and helps to prevent or delay premature institutionalization by offering options to help individuals spend resources wisely in the community. Developing a formal Options Counseling program will facilitate some of the structural changes necessary to receive the enhanced Federal Matching Assistance Percentage (FMAP) available through CMS initiatives such as the the Balancing Incentive Program (BIP).²

Some individuals may only need information about LTSS, but many need options counseling for the following reasons:

- A tremendous amount of information about LTSS is available on-line, but it can be complex, contradictory, and confusing;
- Individuals and families may want or need additional support interpreting information and weighing the pros and cons of their different decisions about LTSS;
- Few people plan ahead for long-term supports; and
- Institutional placements often occur without consideration of available community-based options.
- Accessing public supports can become a complex process where navigation assistance is needed

ACL views Options Counseling as both a philosophy underpinning how ADRCs interact with individuals, as well as a process that ADRC staff will follow to support individuals and families to consider their options and access the right services and supports at the right time. Options Counseling should:

- Be available to anyone contacting the ADRC network;
- Be person-centered and directed by the individual;
- Support people of all income levels to make informed decisions;
- Be delivered in a timely and/or expedited manner when the need for a short-time frame is presented;
- Serve as comprehensive and streamlined process by which people learn about and are connected to immediate and on-going support as needed or requested;
- Be the service that brings the larger aging and disability networks closer together; and
- Be valued by a large set of potential funders and stakeholders.

² <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Balancing-Incentive-Program.html> get correct link here

Standards for Options Counseling

Options Counseling plays a pivotal role in supporting many federal initiatives and programs that encourage community living such as Veterans-Directed Home and Community-Based Services (VD-HCBS), participant-directed programs, care transitions interventions, and Medicaid waiver and other programs such as Money Follows the Person. Some of these programs represent potential future funding sources to sustain OC within ADRC networks.

Goals of the Standards

The main goal of these standards is to provide a clear definition of Options Counseling (OC) and a framework for which the aging and disability organizations involved in ADRC networks can build OC capacity. The specific goals of these standards include:

- Improving the consistency and quality of OC provided by ADRC networks including capacity to work with individuals who have private resources to spend on LTSS as well as those who may qualify for publically funded programs;
- Providing a basis to determine the impact of OC on the LTSS system;
- Developing the groundwork for training and continuing education materials and programs related to OC; and
- Preparing the aging and disability networks to meet the demands of the next several decades as a growing aging and disability population base seeks assistance in navigating LTSS.

Definitions

Individual - Organizations may have different terms for individuals served such as client, consumer, or participant. The individual is the person seeking Options Counseling. The individual may choose to include a representative, another person, or more than one person, to participate in the process.

Caregiver - A family member, partner, friend, or neighbor who supports an individual. Caregivers may also be the individuals seeking Options Counseling for their own supports. They do not make decisions for the individuals they are supporting.

Representative - A family member, friend or other person who is chosen by the individual seeking options counseling, to assist with decisions or to serve as the primary decision maker. This person may also be a guardian or an otherwise legally authorized to represent the individual.

Long-Term Services and Supports (LTSS) -Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs) provided to older people and other adults with disabilities who cannot perform these activities on their own due to a physical, cognitive, or chronic health condition that is expected to continue for an extended period of time, typically 90 days or more.³ These are sometimes referred to as Long Term Resources or simply Long Term Supports.

³

Adapted from LTSS Scorecard Definition http://www.longtermscorecard.org/-/media/Files/Scorecard%20site/Report/AARP_Reinhard_Realizing_Exp_LTSS_Scorecard_REPORT_WEB_v4.pdf

Standards for Options Counseling

Decision Support - A process of examining pros and cons of various options. It may include information and education, but goes beyond both of these to support an individual as he or she weighs options. It includes exploration of an individual's perceptions about the pros and cons and dialogue about how those perceptions influence potential decisions. The use of planning tools is a common method to assist the individual in the decision making process.

Person-Centered Planning Approach (PCP) - A process that is driven by the person with long-term support needs, and may also include a representative whom the person has freely chosen or is legally authorized. The PCP approach identifies the strengths, preferences, needs (clinical and support), and desired outcomes of the individual. Agency workers' (options counselors, support brokers, and others) role in the PCP process is to enable and assist the person to identify and access a personalized mix of paid and non-paid services. The individual's personally-defined outcomes, preferred methods for achieving them, training supports, therapies, treatments, and other services needed to achieve those outcomes become part of a written LTSS plan.⁴

Action Plan - A plan outlining goals, action steps, timelines, resources needed, responsible parties, and referrals made in the Options Counseling process that are needed by the individual and/or counselor to attain supports that meet the goals and preferences of the individual. This plan is time-limited and is directed and developed by the individual with support from the Options Counselor as needed. A copy of the action steps plan may be kept by both the Options Counselor and the individual as both may have action items to complete, and it may serve as a guide for the Options Counselor in following up with the individual as well. The action steps plan is the deliverable after OC process is complete. It outlines the steps individual will take to address the presenting goal or intention. It is driven by the individual and for the individual.

Long-Term Services and Supports (LTSS) plan -After a person is enrolled in publically funded long-term services and supports program (for example, Medicaid waiver), the LTSS is the plan that outlines the frequency and type of services and supports (both formal and informal) to meet personal goals. It is used as referral channel and to activate service and also as quality assurance plan to ensure goals and preferences are met. Options counselors can assist the individual in developing this plan but not all states have OCs serving in this role.

Participant-Directed Services - Publically funded LTSS that are planned, budgeted and directly controlled by an individual (with help of representatives, if desired) based on the individual's preferences, strengths, and needs. Participant-directed services maximize independence and the ability to live in the setting of the individual's choice.

⁴ Adapted from 2402a interagency HHS work group

Standards for Options Counseling

I. Service Definition, Population, and

Outreach *Standard 1.1: Definition of*

Options Counseling

ADRC Options Counseling is an interactive process where individuals receive guidance in their deliberations to make informed choices about long-term supports. The process is directed by the individual and may include others that the person chooses or those that are legally authorized to represent the individual. Options Counseling includes the following steps: 1) A personal interview to discover strengths, values, and preferences of the individual and the utilization of screenings for public programs, 2) a facilitated decision support process which explores resources and service options and supports the individual in weighing pros and cons, 3) developing action steps toward a goal or a long term support plan and assistance in applying for and accessing support options when requested, and 4) quality assurance and follow-up to ensure supports and decisions are working for the individual. Options Counseling is for persons of all income levels but is targeted for persons with the most immediate concerns, such as those at greatest risk for institutionalization.

National Interpretive Guidance

- i. **A personal interview**, which includes a "one-on-one" conversation with the individual, his or her representative- and their family members as appropriate - that would facilitate an initial screen to determine if the person needs LTSS. If so, then a comprehensive person-centered planning process starts to occur to identify in the individual's strengths, values, and preferences. This process will include the identification of all current supports, both formal and informal, and incorporate as appropriate the use of screening and assessment tools that may be required by various programs.
- ii. **A facilitated decision-support process** that helps individuals and their families weigh the pros/cons of various options, including exploration of self-directed options where individuals are empowered to hire, fire, and pay for services and supports through an individual budgeting process, and leads to:
 - A. Identification of desired and available options (including informal supports, emergency supports, funding sources, etc.).
 - B. Assisting individuals and families in determining how best to pay for and

Standards for Options Counseling

arrange the delivery of services, including helping individuals to assess sufficiency of their own resources, and their eligibility for public programs, including, if appropriate, Medicaid, Medicare, and Veterans' benefits;

iii. **Development of a LTSS service plan and connecting people to the services and supports they need:**

A. For those not participating in public programs, the ADRC counselor helps the individual develop a person centered plan that describes 1) the immediate next steps to be taken in the decision-making process, and 2) the mix of informal supports, community resources, and privately funded services the consumer elects to use based on his or her individual preferences and needs; B. For those using a public option such as Medicaid, Medicare and/or Veterans programs, the process includes:

- Facilitating eligibility and enrollment
- Assistance in developing a person centered service plan
- Facilitating support/service activation including choice of traditional of self-directed options
- Arranging for fiscal intermediary service when an individual chooses self-direction, and assisting with choice of support broker/agent

iv. **Quality Assurance & Follow-up to:**

- A. Assure the supports meet the individual's preferences
- B. Gather and act on consumer feedback on services and the delivery systems
- C. Serve as a navigator to ensure that the needed services are activated, providing on-going follow-up to monitor quality, and assist with changes in the services plan as necessary
- D. Input data into reporting systems that monitors program performance, customer satisfaction, customer trends, and customer preferences
- E. Use CQI process to ensure program success and resolution of issues and is part of a larger long term support system quality assurance process
 - If the Options Counseling program does not include assistance with applications for services, employment assistance, benefits counseling, futures planning, mobility assistance, and or support accessing participant-directed services, when available, there should be a mechanism in place to ensure the individual is connected to someone who can provide support in these areas.

Standards for Options Counseling

- The length of the Options Counseling process will vary based on a variety of factors, including: the pace the individual wants to take, the resources allocated by funding source, the program design of the particular ADRC/NWD/SEP process, as examples. The intention of the process is that the individual can return to the Options Counselor at various times for guidance and/or assistance obtaining long term supports. The person may obtain immediate assistance in a crisis situation or may be able to take the process more slowly based on the individual's current situation.

Standard 1.2: Target Populations: Who Should Receive Options Counseling?

Options Counseling is available to all persons with a disability, older adults or caregivers who request or require long term support services for a current need and/or persons of all incomes and assets who are planning for their future long term support service needs.

National Interpretive Guidance

- While the broad service population is the ideal, if ADRCs have limited funds, it is suggested that ADRCs consider targeting this service to the following categories of individuals due to the more immediate nature of their need for Options Counseling:
 - o individuals transitioning from hospitals,
 - o individual transitioning from skilled nursing facilities or extended care facilities, and
 - o individuals at high risk for institutionalization.
- ADRCs should strive to use the latest research and data available to identify the populations that might benefit the most from Options Counseling. States should assure that the targeting criteria is consistent with its existing plans for long-term support reforms which may include coordination with the States' Olmstead committee and plans developed by the Statewide Independent Living Council, State Unit on Aging, State Medicaid Agency, State Department of Veterans Affairs and other state agencies or statewide organizations that support individuals with disabilities.
- In some cases, caregivers may be the individuals seeking assistance with decision-making. Options Counseling should be offered to caregivers to assist in determining their desire for caregiver support which might include: communication strategies, ways to reduce caregiver stress, and the importance of individual self-determination. A core tenant of an ADRC is a commitment to break down barriers to assistance and support. It is essential to support caregivers while also protecting the rights of individuals to self-determine. Ideally, the ADRC network is tapping funding for supporting caregivers, providing options counseling, getting individuals connected to the supports and services they desire in a seamless and unified way so that the caregiver or individual being supported does not have to fit strict or particular

Standards for Options Counseling

program eligibility guidelines to obtain assistance. In the best processes, State leadership is working collaboratively with local ADRC sites to provide Options Counseling in an integrated and holistic way.

Standard 1.3: Marketing/Outreach

Each ADRC will have in place a written plan to promote awareness of Options Counseling to individuals and community providers. The Options Counseling marketing/outreach plan may be incorporated into the overall ADRC marketing/outreach plan.⁵

II. Getting to Options Counseling

Standard 2.1: Initiation/Referral Protocols for Options Counseling

Options Counseling is an essential piece of the No Wrong Door/Single Entry Point Process. Each ADRC will have in place a mechanism for receiving initial inquiries/referrals regarding or contacts that may lead to the initiation of the Options Counseling process. Each ADRC will have in place a uniform process regarding the initial contact/intake and determination of need or trigger for options counseling that is utilized at all locations and with all partners.

National Interpretive Guidance

- To facilitate a uniform initiation process, it is recommended that a formal protocol and training be established for staff and referral partners (e.g., I and R/A specialists, 211 specialists, SHIP counselors, benefits counselors, others as identified). Training would include recognizing when someone might benefit from Options Counseling (for examples see list below), informing the person that participation in Options Counseling is voluntary, and the procedures for connecting the individual with an options counselor, when referral is necessary.
- Some situations or scenarios that **may** indicate a need for Options Counseling include when an individual:
 - o requests or indicates an interest in receiving information or advice concerning long-term support options;
 - o is referred to the ADRC by a hospital, nursing home, assisted living home (or other long-term residential setting), home and community based waiver services provider, or other agency (including MDS 3.0 Section Q referrals);
 - o has had recent change in life situation and desires deeper discussion about their options;
 - o has LTSS needs but unsure about the process of accessing services or what services will best meet their preferences and needs;
 - o is requesting assistance in transitioning from one living situation to another;
 - o might be eligible for new benefits and supports and is unsure of

⁵ For more information about what should be included in an ADRC Marketing and Outreach plan see ACL ADRC Fully Functioning ADRC document. http://www.adrc-tae.org/tiki-download_file.php?fileId=29619

Standards for Options Counseling

what is best for them or what they might be eligible for; o is interested in a participant-directed program ; o is admitted to the hospital and needs to know what they should be

planning for once discharged; o was denied eligibility for Medicaid or another public program and

needs decision support about other options; o lacks awareness of existing community resources and supports

and could benefit from decision support and education around their options;

o has cognitive impairment and could benefit from support about early intervention, caregiver support, or LTSS related to dementia; o has behavioral health needs and would like support on options

related to their specific needs or situation; or o has multiple needs or a chronic illness and has a need or desire for

support on a broad array of options to meet their needs across many services and systems.

Standard 2.2: Delivery Setting/Mode

Every attempt should be made to deliver Options Counseling in the setting and by the method desired by the individual.

National Interpretive Guidance

Settings may include the individual's place of residence, an agency, a nursing home, hospital, rehabilitation center, medical practice, or even non-traditional settings of the individual's choosing. Modes of service delivery may include in person, by phone, by e-mail, by video conferencing technology, or other electronic method. Whenever possible an in-person meeting with the individual is preferred. In-home visits are a particularly useful method to help identify the values and preferences of the individual as well as actions needed to maintain independence. The ADRC may wish to establish guidance for staff on when to offer an in-person meeting or home visit.

III. Components of Options Counseling

Standard 3.1 Personal Interview

A key component of effective options counseling is setting a welcoming tone through a person-centered dialogue to learn about the individual's values, strengths, preferences, and concerns. This discussion is a process of discovering factors important to him or her to assist the person in exploring options and developing an action plan or long term support plan. It is important that the individual has to "tell their story" only once. Pertinent information obtained through the interview and required assessments need to be recorded by the person performing Options Counseling and shared as necessary with the individual's consent. The

Standards for Options Counseling

individual may choose to have a family member, caregiver, support person, or advocate participate with them in the process.

National Interpretive Guidance

- This conversation may occur once or over a series of interactions.
- The conversation should touch on key areas that would influence available options relevant to the individual's situation including strengths, physical, emotional, social, financial, and functional aspects. Based on the state and local ADRC mechanism for service delivery and the overall model of options counseling, the Options Counselor will need to obtain specific, pertinent information to assist in the application for publically funded services and supports.
- The conversation should occur in a timely manner and meet the schedule and needs of the individual.
- Options Counseling is person-centered and the individual controls the planning process, which includes: selection of goals; when and where meetings are held; who is a part of the planning meetings; the topics to be/not to be discussed; and personal decisions about supports and services.

Standard 3.2: Exploring Options/Planning

Options Counseling includes the exploration of resources so individuals can choose what is right for them to assist with current or future long term services and supports. Resources may include informal support, privately funded services, publically funded services and benefits, among others. A tailored list of resources that the individual identifies as helpful for him or her to live independently in their community should be offered in a timeframe that gets the information to them when they need it to make decisions.

National Interpretive Guidance

- OC should include discussion of available options without the personal bias of the Options Counselor.
- Organizations providing OC should have policies and procedures in place to remain free of conflicts of interest. As part of the OC process, the options counselor will encourage the individual to explore informal supports that might be available such as support from community groups, places of worship, neighbors, and friends.
- The OC process will include discussion of publically funded LTSS as well as private LTSS including the approximate cost of services.
- Options Counselors also should facilitate futures planning by talking with individuals about options for services and supports should they be needed in the future.
- To assist in the exploration of available options, it is recommended that Options Counselors assist individuals, when necessary, in making appropriate connections to persons that have specific training in available benefits and expertise related to the persons options (such as SHIP counselors, financial, employment, mobility assistance, etc..

Standard 3.3: Decision Support

Standards for Options Counseling

In addition to discussing and sharing information about available resources, Options Counseling assists the person in evaluating various pathways, including the pros/cons of specific options.

National Interpretive Guidance

Decision support is best performed by utilizing specific decision support tools, decision support processes, and decision support techniques, such as motivational interviewing and person-centered planning, and person-centered tools such as preferences maps, places maps, mind maps, evaluating options tools, and shaping outcomes tools. *(Insert references to these tools)*

Standard 3.4: Collaboration with Individual to Develop Action Steps or Long Term Support Plan

Another component of the options counseling process is offering to assist the person in developing his or her personal written plan of action. The written plan serves as a guide for the individual for future work and/or steps necessary to achieve goals or obtain LTSS that are important to the person in maintaining independence.

National Interpretive Guidance

While the ultimate pace of the process is determined by the individual, funding sources may mandate certain time frames for completion of the plan. It is recommended that ADRCs position Options Counseling within a framework that will flexibly meet the needs of the individual while taking advantage of possible funding sources. The best written plans are developed to the greatest extent possible by the individual with assistance as necessary. It is important for the plan to be shared by the individual with others as desired, as well as retained in a file or electronically by the Options Counselor to use in following up

Standard 3.5: Access to Community Supports

In addition decision support, Options Counselors will also provide assistance as requested by the individual to access or coordinate chosen services and supports. This support could be short or long process depending on the direction from the individual, degree of urgency expressed by the individual in meeting his or her goals, or availability of funding to provide such support. If this function is not performed directly by the Options Counselor, the ADRC should have appropriate referral protocols in place to support individuals in accessing this support from other sources. Options Counseling is part of a uniform process across the state that streamlines eligibility and access to public programs.

Related to eligibility for public programs, Options Counselors may be involved in independent evaluation, independent assessment, the support plan, and care coordination. To assure conflict free delivery, an Options Counseling program should

Standards for Options Counseling

ensure that the decision support and eligibility determination functions are separate from the provision of services and supports selected by the individual.⁶

National Interpretive Guidance

- Connection to community supports may include the following components:
 - providing or coordinating eligibility determination;
 - assisting as services and supports are arranged/scheduled (e.g. serving as a support broker in a participant directed program); and/or
 - accessing resources in order to return to the community from an institution or hospital (e.g. transition coaching).
- The ADRC network's capacity to provide on-going support to individuals may vary depending on availability of funding to support OC. ADRCs may want to develop this capacity to take advantage of a broad range of funding sources that support independent living in the community.

Standard 3.6: Follow-up

Follow-up is an essential component of Options Counseling to be offered to each individual. At this point the Options Counselor learns from the individual what progress towards goals and steps in the action plan has occurred. Any barriers to implementing the action plan can be discussed and the Options Counselor and individual can strategize about alternatives. Organizations offering Options Counseling should have standards for follow-up including time-frames and procedures.

National Interpretive Guidance

- Follow-up may be conducted in person, by phone, or electronically as resources allow and the individual prefers.
- The individual's action steps plan should guide the time-frame for follow-up, but following up one month after OC process is a general guideline.
- Follow-up allows:
 - the individual to clarify questions concerning his or her plan,
 - the individual to receive assistance from the Options Counselor regarding the application and eligibility processes, if requested,
 - the individual the opportunity to request assistance regarding the implementation of LTSS, and
 - the individual and the ADRC to evaluate the usefulness of the service, such as barriers encountered in achieving his or her goal or whether the goals were met.

IV. Staffing

Standard 4.1: Staffing Structure

⁶ Insert link for additional information.

Standards for Options Counseling

States and local ADRCs will determine a staffing structure for Options Counseling.

National Interpretive Guidance

- Options Counseling is preferably provided by one Options Counselor who supports the individual through the entire decision making process and follows up with the individual to see what decisions are working.
- Rapport-building is a critical component of Options Counseling.
- Options Counselors may be hired as new staff to perform Options Counseling, or ADRCs may choose to train existing staff from various

Standards for Options Counseling

departments and programs such as I & R/A, peer counselors, service coordinators, independent living skills trainers, case managers, front-line staff, transition coaches, or support brokers for participant-directed programs, as examples.

- ADRCs may choose to have Options Counselors provide Options Counseling as their only job responsibility, or ADRCs may organize their staffing structure that optimizes existing staff who serve in "blended roles" within the ADRC. It is at the discretion of the ADRC to determine what staffing structure will work best based upon their agency and organizational capacity and target population.
- The role of the Options Counselor and specialized skill set they bring in facilitating decision support may be valuable to other LTSS programs and initiatives such as care transitions, MFP, and VDHCBS. ADRCs may choose to organize their staffing structure in a way that builds the core competencies of their Options Counselors to support these other initiatives, or to hire specialized staff who are trained in the Options Counseling skill set but work only in their role as a care transition coach, or a MFP transition coordinator. It is up to the ADRC to determine what capacity they have to meet the needs of their consumers and the programs they have responsibility for administering.

Standard 4.2: Staff Education Work Experience

State and local ADRCs will set minimum qualifications for education and/or work experience to perform Options Counseling consistent with state and local requirements. Options Counselor specific requirements include competencies in the domains of decision support, person-centered planning, cultural competency, communication, participant direction, and quality.⁷

National Interpretive Guidance

Given the complexity of the work and the level of skill needed it should be noted that Options Counseling is not considered an entry level position. Experience with the competency domains listed above should be strongly considered. Generally, a bachelor's degree in a human services related field would be minimum qualifications but states and localities may consider the replacement of experience and training for the degree requirement. States and local ADRCs may also include certifications - such as Certified Information and Referral Specialist (CIRS).

Standard 4.3: Staff Training (*This section will be enhanced as AoA Core Competency work evolves along the domains of decision support, person-centered planning, cultural competency, communication, participant direction, and quality.*)

⁷ Reference detailed OC Competencies when complete and public

Standards for Options Counseling

All persons performing Options Counseling shall receive initial training. Each ADRC will have a staff development program in place. All persons performing Options Counseling should receive initial and ongoing training in the following areas:

- Physical and emotional aspects of aging and disability including
- Working with individuals with cognitive impairments and their caregivers,
- Vision for Aging and Disability Resource Centers and Options Counseling,
- Decision support strategies (e.g. person centered planning , motivational interviewing, relationship centered practice),
- Communication techniques for working with individuals and groups including use of adaptive and interpretive communication devices,
- Cultural competence,
- Information on available programs and resources (both public and private) including options to self-direct services and supports in publically funded programs,
- Documentation and follow-up protocols and requirements as established by the State and local ADRC.

For a comprehensive list of trainings for options counselors see ***PLACEHOLDER (insert link to NRCPDS Options Counselor and training and assessment guide when available)***

Training plans are required to best work with many individuals, including:

- People with Alzheimer's Disease or other types of dementia
- People with cognitive impairments, including traumatic brain injury
- People with visual impairments
- People who are hard of hearing or who are deaf
- People with intellectual and developmental disabilities
- People with physical disabilities
- People with mental health diagnoses
- People with cultural and ethnic backgrounds different from the Options Counselor
- Any person likely to use Options Counseling

Standard 4.4: Supervisor/Manager Training, Skills, Policy Maintenance

State and local ADRCs will set minimum qualifications for Options Counseling supervisors consistent with State and local requirements. Options Counseling supervisors shall receive initial training in the topic areas identified in Standard 4.3. An on-going development program specifically for Options Counseling supervisors shall also be in place.

National Interpretive Guidance

Standards for Options Counseling

Supervisors should possess the experience or educational training to oversee staff development, program management, program planning, policy/procedural

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maintenance, and program evaluation. Generally, a bachelor's degree in a human services related field would be minimum qualifications plus 3 - 5 years of direct service and/or management experience. A master's degree may be preferred. States and localities may consider the replacement of experience and training for the degree requirement.

V. Partnerships

Standard 5.1: Key Partners

Partnerships are the foundation of successful Aging and Disability Resource Centers. Since Options Counseling is at the center of streamlining eligibility and access to federal, state, and local services, it is important to include key partners in the process. Key partners include but are not limited to:

- state and local representatives of the aging network including those managing Title VI grants under the Older Americans Act;
- state and local representatives of the disability network, including the intellectual and developmental disability network
- state and local representatives of the Medicaid agency,
- state and local representative of the State Health Insurance Assistance Programs,
- representatives of Benefits Outreach and Enrollment Centers, if present,
- state and local providers of Information and Referral; and/or (if applicable), and
- state and local providers for other long term services and support counseling programs.

The list is not exhaustive and state and local ADRC planners are encouraged to include other partners as identified.

Standard 5.2: Partnership Roles

In addition to the identification of key partners, the ADRC will establish an overall strategy for the implementation of Options Counseling with key partners.

National Interpretive Guidance

For ADRCs in general and Options Counseling in particular to operate in a seamless manner, it is necessary that an overarching strategy be implemented with key partners. A process for including all partners and coming to agreements regarding roles is essential. Best practice indicates that leadership must be demonstrated at the highest levels to develop protocols (and written policies and procedures, MOUs, etc.) for a seamless and efficient system for the individual utilizing services.

Standards for Options Counseling

VI. Continuous Quality Improvement, Evaluation and Outcomes **Standard 6.1: Documentation**

Each ADRC will maintain a system to document unduplicated individuals receiving Options Counseling. Documentation should at a minimum include: name of individual(s) receiving OC, statement of needs, values and preferences, options discussed, plan of action for options counselor as well as individual, and the amount of time spent with/ or on behalf of the person.

National Interpretive Guidance

While ideally the individual who wishes to receive Options Counseling will provide demographic information, Options Counseling may still be provided if the person wishes to remain anonymous. In such circumstances, the only data required to be documented is the count of the options counseling process, and the amount of time spent with the individual. Documentation is preferably in an electronic format.

Standard 6.2: IT System Capacity for Tracking OC Outcomes

ADRCs will utilize secure information systems sufficient to track the outcomes of options counseling as established by the local ADRC. Local ADRCs should make reasonable effort to also track state and national outcomes.⁸

Standard 6.3: Quality Improvement plan linked to specific outcome measures.

Each state will develop a quality improvement plan for Options Counseling that involves making improvements to operations based on evaluation and survey information. At a minimum, the plan will monitor individual satisfaction with options counseling such as assistance with informed decision making, effectiveness in linking people to home and community based services when requested by the individual, as well as tracking transition and diversion activities. Options Counseling also plays a role in the larger Quality Improvement process by providing information about gaps in the system as identified by the individual.

⁸ For additional information on IT system capacity for ADRCs, please consult the ACL ADRC Fully Functioning Criteria http://www.adrc-tae.org/tiki-download_file.php?fileId=29619

**New York State Office of Alcoholism and Substance Abuse Services
Appendix to Unified Statement
Response to SED Report – Office of the Professions as required
pursuant to Chapter 57 of the Laws of 2013**

The following are the Office of Alcoholism and Substance Abuse Services' (OASAS') comments that have been developed in response to the Report developed by the State Education Department (SED) Office of the Professions pursuant to Chapter 57 of the Laws of 2013.

This document has been designed to provide an overview of how OASAS' programs are regulated and administered and offers comments in response to some of the findings contained in the NYSED report.

EXECUTIVE SUMMARY

The federal Substance Abuse and Mental Health Services Administration (SAMHSA) estimates that 8 percent, or 1.4 million, New York State residents age 12 and over (including 85,000 adolescents ages 12-17) experience a Substance Use Disorder (substance dependence or abuse) annually. Under its authorization in Section 19.07 of the New York State Mental Hygiene Law, the NYS Office of Alcoholism and Substance Services (OASAS) plans, develops, and regulates the state's system of Substance Use Disorder and Gambling treatment agencies. This includes the direct operation of 12 Addiction Treatment Centers, which provide inpatient rehabilitation services to about 7,400 persons per year. In addition, the Office certifies, funds, and supervises about 950 local, community-based treatment programs, which serve nearly 97,000 persons per day in a wide range of comprehensive services. The agency, in collaboration with local governmental units, also routinely inspects and monitors these programs to guarantee quality care and ensure compliance with state and national standards.

In addition to its program monitoring role, the Office also provides education and training for the staff of all OASAS providers; and administers a professional credentialing process for more than 13,000 addiction professionals including Credentialed Alcoholism and Substance Abuse Counselors (CASACs) and Trainees, Credentialed Prevention Professionals (CPP) and Prevention Specialists (CPS) and Credentialed Problem Gambling Counselors (CPGC).

DATA COLLECTION FINDINGS

In both 2013 and 2014 NYSED states that the majority of programs **do not use** unlicensed staff to perform restricted functions, however, in the cases where there is a majority, it is a slim majority. The other restricted functions, highlighted below, were reported **by the majority of providers to be performed by unlicensed staff**. This data is far clearer when reviewed in terms of the percentage of unlicensed staff still performing restricted activities as stated below.

- o 2014 percentages of Programs reporting the use of **Unlicensed Staff** to perform restricted functions, which is currently allowed under the exemption for identified state agencies:

APPENDIX C - New York State Office of Alcoholism and Substance Abuse Services

- 44% use unlicensed staff to perform Diagnosis; increase from 20% in 2013
- 49% use unlicensed staff to perform Assessment and Evaluation; consistent with 50.3% in 2013
- 44% use unlicensed staff to perform Psychotherapy; decrease from 47.6% in 2013
- 51.4% use unlicensed staff to perform Treatment Services other than Psychotherapy; consistent at 51% in 2013
- 52.8% use unlicensed staff to perform Assessment Based Treatment Planning; increase from 49.8% in 2013

These percentages have changed very little since the 2013 survey indicating that the provision of Chapter 57 of the Laws of 2013 which detail the activities that do not require licensure had little or no impact on the number of individuals that would be affected should the exemption lapse. NYSED continues to misrepresent that the majority of programs report no unlicensed staff performing restricted functions. They also purport that the provisions of Chapter 57 of the Laws of 2013 had an impact on the number of staff that would be affected should the exemption lapse. However, the similarity in the percentages stated above negate such claims by NYSED and indicate that the provisions did not allow a wide enough range of services to be performed by unlicensed staff to positively impact the percentages of programs and individuals affected by the exemption. Therefore, the reduction of staff percentages performing restricted activities as a result of the changes in Chapter 57 of the Laws of 2013 are negligible at best.

QUALITY OF CARE ASSURANCE:

In the 2014 report NYSED negates the need for a permanent exemption and negates the rationale that the current regulatory structure provides public protection in the exempt agencies. They compared affected agencies to Article 28 hospitals and noted that there have been no suggestions that unlicensed individuals could substitute for physicians, registered professional nurses, or other licensed healthcare professionals. OASAS is not suggesting that unlicensed individuals working in multidisciplinary teams “substitute” for licensed individuals but rather serve as “extenders” to the licensed professionals similar to “physician extenders” such as HIV Specialists and Diabetes Educators who perform certain specialty care roles in hospitals and Primary Care Practices. Such staff would work as part of a **multi-disciplinary team** composed of a range of staff, including psychiatrists and physicians, nurse practitioners and nurses, licensed and experienced clinicians, credentialed staff, certified trainees and unlicensed staff. In the OASAS system, treatment team meetings are held on a regular basis to review all patient records and make determinations on diagnosis, admissions, treatment plans and discharges. All decisions are made in collaboration with licensed health and behavioral health professionals who have final sign off on clinical decisions. Professional staff on the team have the overall responsibility for treatment plan implementation. Although one of the amendments made to Chapter 57 did allow unlicensed individuals to perform as part of a multidisciplinary team it nullified the benefit of this by also stipulating that restricted functions could only be performed by licensed individuals. This amendment would be more effective if restricted functions

APPENDIX C - New York State Office of Alcoholism and Substance Abuse Services

could be performed by unlicensed individuals within the confines of direct supervision and sign off by a duly licensed or exempt practitioner. In fact, OASAS has developed a Substance Use Disorder Counselor Scopes of Practice which identifies the educational and training criteria for each level of counselor as well as the functions which can be performed at each level and the corresponding supervisory requirements. This further ensures adequate oversight for each level of counselor within a multi-disciplinary team.

Furthermore, oversight by OASAS is performed in several ways, including by regulation, prior approval and review, inspection and certification, background checks, enforcement, and other state and federal oversight. Agencies are also required to have quality assurance mechanisms, which, by design operate independently of programs and the provision of services. OASAS performs certification reviews and ongoing surveys of State and voluntary provider facilities and programs to monitor compliance with applicable federal and State regulations and related policies. These certification and oversight requirements support high quality care that in many respects exceeds those services provided by private licensed practitioners. In addition to direct oversight, many programs operated or certified by OASAS receive additional oversight from:

- New York State Department of Health;
- Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services (audits and inspections);
- New York State Office of Medicaid Inspector General;
- New York State Office of State Comptroller (program audits);
- The New York State Justice Center for the Protection of People with Special Needs (effective June 30, 2013); and
- Private certification agencies including The Joint Commission and the Commission on Accreditation of Rehabilitation Facilities.

OASAS also implements Standards of Care which are essential for access to and quality of care for persons served by licensed clinics that provide services. These standards are based on regulatory requirements and must be incorporated into the policies of these licensed clinics and be applied consistently throughout the state. They highlight expectations for, among other areas, staffing, case loads, training, and best practices. Incident management regulations require the development, implementation, and ongoing monitoring of incident management programs by individual providers, and offer additional protections for the health and safety of clients and enhance their quality of care.

INNOVATIONS

OASAS providers are currently experiencing a myriad of changes and are in the midst of major transformations related to transitioning from a fee for service to a managed care reimbursement system. This will require all providers to contract and work with managed care companies in order to continue to provide SUD services in this changing environment. Providers are also participating in their regional Delivery System Reform Incentive Payment (DSRIP) networks, a \$6 billion state initiative to transform provider systems and strengthen relationships between acute, primary, and specialty care

providers as a means to increase the quality of care and reduce costs. Providers also continue to implement new systems to maintain compliance with the multi-phase requirements of the Affordable Care Act. Therefore, the timing of the expiration of the exemption could not occur at a more inopportune juncture. Should the exemption sunset, the stress caused by requiring providers to replace all unlicensed staff who currently perform restricted activities with licensed staff, would not only be fiscally compromising to providers but also risk the success of the other mandated quality improvement and cost saving initiatives currently being implemented by the state.

RESPONSES TO SED CONCLUSIONS - TOPICS FOR DISCUSSIONS - BY PROFESSION

OASAS concurs that “diagnosis” could be provided and should be included in the Scope of Practice for individuals licensed under Article 163. Additionally, OASAS would support the establishment of standards for education and experience as part of a time-limited, alternative pathway to licensure. We would also purport that experience gained under the “exemption” in a program overseen by OASAS would be eligible to satisfy the experience requirements for licensure since the exemption allowed unlicensed individuals to perform the restricted functions in exempt settings. However, throughout the report NYSED indicates they will not entertain such experience due to the fact that non-licensed individuals were restricted from performing these activities thereby completely negating experience gained under the exemption. OASAS also supports the newly implemented continuing education requirements for Social Workers and the planned requirement for all those licensed under Article 163, however we would strongly suggest that the requirement be amended to allow appropriate coursework certified by OASAS to be eligible to satisfy those continuing education requirements without the need for a duplicative review and approval by NYSED. OASAS is the overseer of addiction services in NYS and as such is the appropriate NYS entity to be reviewing and approving addiction coursework for social work and mental health practitioner continuing education through a collaborative and reciprocal relationship with NYSED.

COST CONSIDERATIONS

Chapter 57 of the Laws of 2013 was an attempt to identify additional activities that could be performed by unlicensed individuals as an alternative to a proposed permanent exemption. In OASAS’ case the only function that was identified which impacted the unlicensed staff performing restricted activities was that of case management. Of the previously identified 2,451 State and Non-Profit FTEs impacted in the OASAS provider system, 540 or 22% were performing case management functions and would now be allowed to perform these activities should the exemption sunset. The remaining 78% perform restricted activities within the confines of a multi-disciplinary team and the 2013 modifications related to multi-disciplinary teams unfortunately, did not allow for this to occur. The estimated individuals and fiscal impact to OASAS and its provider system should the exemption sunset is 1,911 individuals and \$ 51,196,032 in additional costs to OASAS and its provider system. Please also note, contrary to what the NYSED report indicates, OASAS only identified staff currently not holding a license of any kind (including mental health practitioner licenses) and also did not include anyone who holds an exempt credential such as a CASAC. NYSED also identified in their report the

current civil service titles and their salaries which may be affected by the exemption sunset. However, they did not take into consideration the substantially lower salaries paid by OASAS providers, as estimated in the fiscal impact portion of this document, and therefore the civil service chart should be removed from the report as it does not accurately represent the salaries of affected individuals in the Non-Profit provider system.

SUMMARY AND CONCLUSIONS

Considerable time and effort has been exerted over the past five years to find a reasonable way to incorporate the appropriate use of trained and unlicensed staff within the confines of the Social Work, Psychology, and Mental Health Practitioner Scopes of Practice legislation. These efforts have resulted in less than satisfactory results for the majority of individuals who would be impacted should the exemption lapse. Therefore, it is reasonable to conclude that continued efforts in this vein would result in similarly minor impacts in the number of individuals affected or costs incurred by the sunset of the exemption. Since the inception of this legislation it has been recognized that the providers who were operating and overseen by state agencies were significantly different than private practitioners and therefore, were granted an exemption. The ensuing efforts to proceed without the need for an exemption have been very limited in its effectiveness. Therefore, it is time to cease expending time and energy in this direction and make permanent the exemption that currently exists for state agencies.

Recommendations

Exemption made permanent:

**Office of Children and Family Services (OCFS)
Appendix to Unified Statement
Response to SED Report – Office of the Professions as required
pursuant to Chapter 57 of the Laws of 2013**

EXECUTIVE SUMMARY

The Office of Children and Family Services (OCFS) is responsible for regulating and providing funding to programs and services involving foster care, adoption and adoption assistance, child protective services including the operation of the Statewide Central Register of Child Abuse and Maltreatment, preventive services for children and families, and protective programs for adults and victims of domestic violence. OCFS is also responsible for the functions performed by the State Commission for the Blind, and coordinates the state government response to the needs of Native Americans on reservations and in communities.

OCFS also provides oversight and monitoring of regulated child care (family day care, group family day care, school-age child care and day care centers outside of New York City), legally exempt child care, child care subsidies, child care resource and referral programs, and the Advantage After-School Program, which provide services and programs for infants, toddlers, pre-school and school-aged children and their families.

OCFS is also responsible for all elements of the State's juvenile justice programs, and operates residential facilities, community-based group homes, day-placement centers and reception center programs for juvenile delinquents and juvenile offenders placed in OCFS custody. OCFS regulates and monitors the private residential programs (voluntary agencies) that serve adjudicated Persons in Need of Supervision and juvenile delinquents, as well as children in foster care.

OCFS works with the local departments of social services (LDSS) and county and municipal youth bureaus to offer local youth development programs and programs for runaway and homeless youth.

Social services in New York State are locally provided and State supervised. As such, OCFS partners with the LDSS in each county and in the City of New York, as well as numerous not-for-profit organizations statewide to make available the above-listed services. Not-for-profit organizations often contract with the State and with the LDSS to provide these services. The OCFS workforce, LDSS staff and employees of not-for-profit organizations perform diverse tasks and activities in order to meet the varied needs of the children and families of New York

As reflected in the attached multi-agency response and reiterated below, discontinuing the current social worker licensure exemption would have serious adverse consequences for children in need of social work services, as it would have the practical effect of making those services less available to those in need. Requiring licensure of all social workers would have a significant adverse fiscal impact on the agencies that are regulated, funded

and/or approved by OCFS. In turn the fiscal impact would negatively affect the vulnerable populations served by these agencies as agencies would be unable to fully afford the increased cost of licensed social workers to provide the necessary services. Moreover, there are existing regulatory, quality assurance and enforcement measures surrounding the services provided to children and families in programs under OCFS' auspices, and such protections mitigate the need to hire licensed professional in these areas. Furthermore, the data upon which SED based its recommendations is unreliable for a number of reasons.

DATA COLLECTION FINDINGS

OCFS believes that the data relied upon by SED to form conclusions about the workforce effected by the 2013 changes in the Education Law is unreliable, for the following reasons: 1) the survey did not require responders to identify their organization or program type; 2) the overall survey results show that a large proportion of surveys were completed by programs that do not appear to provide any of the major functions in question (social work, psychology and therapy); 3) it is unclear whether the responders fully understood the survey definitions; 4) among the responders who indicated that they did provide some of the major functions, were programs that are not under the purview of OCFS, but who nevertheless received an OCFS survey; and 5) the survey used numerous similar occupational titles to classify staff from various organizations, thus introducing a significant level of ambiguity. Therefore, SED's interpretation of this data is also unreliable since the data upon which the interpretation is based is inherently flawed.

The impact of the provisions of Chapter 57 of the Laws of 2013 which detail the activities that do not require licensure

Chapter 57 of the Laws of 2013 amended the Education Law to clarify that certain task fall outside of the scope of practice of social work and therefore do not require licensure. Some of these enumerated tasks included functions overseen by OCFS that are performed by voluntary agencies or local social services districts, including, but not limited to, investigations conducted or assessments made by adult or child protective services, adoption home studies and assessments, family service plans, transition plans and permanency planning activities. In its report, SED asserts in general terms, that these changes to the Education Law have created confusion and that further amendments to the Education Law may be needed "to ensure the practice of the profession is consistent with education and examination requirements to protect the public." However, OCFS never considered these tasks to be within the scope of practice in the first instance. Furthermore, OCFS, local social services districts and voluntary agencies have found such statutory language to be helpful.

QUALITY OF CARE ASSURANCE

Extensive regulatory, licensure and oversight processes instituted and maintained by OCFS provide ample safeguards and is more than sufficient to avoid any potential harm to the public from the provision of social work services by unlicensed individuals:

APPENDIX D – Office of Children and Family Services

a. Program Certification, Monitoring and Oversight Process

Programs licensed, regulated or funded by OCFS are subject to oversight, monitoring and regulation. Oversight of programs licensed, regulated or funded by OCFS is performed in several ways, which include regulatory oversight, prior approval and review of new programs, inspection and certification of residential facilities, background checks of staff, enforcement of statutory and regulatory requirements, and other State and federal oversight.

Regulatory Oversight: OCFS establishes regulations and guidance for all of its licensed programs. These include but are not limited to: voluntary agencies operating residential facilities for children, juvenile detention facilities, runaway and homeless youth programs and residential programs for victims of domestic violence.

Voluntary Agencies Operating Residential Facilities for Children

OCFS regulates residential programs for children, which include group emergency foster care, agency boarding homes, group homes, supervised independent living programs and institutions. Based on information reported to OCFS by the agencies that operate these programs, OCFS estimates that there are nearly 2,200 full time equivalent positions in titles categorized as social worker 1 and over 680 full time equivalent positions in titles categorized as social worker II. In addition, 97 voluntary agencies reported having a director or supervisor of social services position. OCFS uses the social worker 1 and social worker II categories for voluntary agency staff employed in all levels of residential care including group homes, emergency group homes and institutions.

Pursuant to OCFS regulations, each child care agency and facility operated by such agency must maintain, and keep current and available, a manual or manuals which clearly state the policies of such agency with respect to its programs including policies on admission criteria and procedures, psychiatric and medical care, social services, child care, education, religious observance, religious instruction and training, discharge criteria and procedures, discipline and restraint, appropriate custodial conduct, children's rights, room isolation, shelter, clothing, diet, work and recreation, plant maintenance, fire, sanitation and safety (18 NYCRR § 441.4).

In addition, OCFS regulations require each child care agency to maintain a separate manual on personnel policies and practices, including a clear delineation of areas of responsibility and delegations of authority. All policies are to be reviewed periodically by agencies and modified as appropriate.

Additionally, OCFS regulations require each agency authorized by OCFS to establish an intake policy, including admission criteria and procedures, and specifying the services and programs offered by such agency and the children served. A copy of the policy shall be submitted to OCFS in accordance with requirements upon completion of the annual review, reflecting any change in policy affected by such review.

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The OCFS regulations include several specific requirements that relate to social workers, as follows:

1. **Group Emergency Foster Care Programs.** Pursuant to regulation, these programs must have the ability to assess each child and family's service needs and make recommendations regarding the most appropriate service plan for the child and family. These programs also provide case planning (18NYCRR Part 451).
2. **Group Homes and Agency Boarding Homes.** Pursuant to regulation, group homes and agency boarding homes must employ a person to supervise the group home program who is a professionally trained social worker, a person with experience in child welfare, or a person holding a master's degree in a related field who is in the employ of the agency (18 NYCRR Parts 447 and 448).
3. **Institutions.** Pursuant to regulation, institutions must provide staff and services necessary for the health and safety and proper care and treatment of children in care (18 NYCRR Part 442). Institutional personnel may include:
 - ❖ **Director of Social Work Services.** A director of social work services is required to have a master's degree in social work or graduation from an accredited school of social work and a minimum of two years of social work experience in a supervisory capacity;
 - ❖ **Supervisor of Social Work Services.** A supervisor of social work services must have a master's degree in social work or graduation from an accredited school of social work and a minimum of three years of experience, at least one of which is under qualified supervision in the field of child welfare.
 - ❖ **Social Worker I.** A social worker I must be a college graduate, who is pursuing or intends to pursue within a reasonable time, graduate study in social work. A social worker I may carry casework or group work responsibilities with children and families and may be responsible for the planning and coordination of all services and resources affecting children and their families, but always functions under the direct supervision of a person who has completed two years of graduate study from an accredited school of social work.
 - ❖ **Social Worker II.** A social worker II must be a college graduate with at least one year of graduate study in social work. He or she performs casework or group work with children and families and may be responsible for planning and coordination of all services and resources affecting children and their families, but always functions under the direct supervision of a person who has completed two years of graduate study from an accredited school of social work.

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- ❖ **Social worker III.** A social worker III must have completed two years of graduate study from an accredited school of social work, is responsible for the planning and coordination of services to child and families, and may supervise individuals in social worker II and I titles.

Local Departments of Social Services (LDSS)

OCFS does not need to address the use of unlicensed caseworkers by LDSS. In May of 2010, SED provided a letter to the New York Public Welfare Association (NYPWA), which is an organization representing New York's 58 LDSS. In this letter, SED interpreted whether caseworker duties, as described in sample job descriptions provided by LDSS, were restricted to licensed persons under Articles 154 and 163 of the Education Law. SED determined that LDSS caseworkers would not have to be licensed or otherwise authorized to provide the services in these job descriptions. Permanent exemptions that were enacted pursuant to Chapter 57 of the Laws of 2013 also clarified that those functions performed by child protective services and adult protective services caseworkers do not require licensure.

Juvenile Detention Services

Juvenile detention is temporary care and maintenance away from home for children held pending a proceeding under Article 3 or 7 of the Family Court Act or a juvenile offender proceeding in criminal court. Juvenile detention programs may be operated by a county government or a not-for-profit agency on behalf of a county government, provided that the program is certified by OCFS. OCFS regulations require detention facilities to provide child care and treatment for youth in such facilities. Institutional detention settings are required to have one social work staff per 15 children. Social work staff must be graduates of accredited colleges with two years of experience working with children.

OCFS-Operated Juvenile Justice Facilities

OCFS does not need to address the use of Youth Counselors (YC's) in facilities operated by OCFS. Chapter 57 of the Laws of 2013 did not propose to eliminate the exemption for government-employed psychologists, and SED has reviewed the job description for Youth Counselors (YC's) and found that these individuals are not subject to licensure. Most of the staff in OCFS facilities are in Youth Division Aide, Teacher, Cook, and Clerical positions, and do not engage in activities requiring an exemption. For those positions which involve the provision of services for which licenses are required, OCFS hires licensed LMSW, Psychologists, and Psychiatrists to provide services involving those activities requiring licensure. Accordingly, OCFS does not require an exemption for these OCFS staff members.

Prior Approval and Review: Part of OCFS' oversight and quality assurance measures for the residential facilities certified by OCFS require that licensed or approved programs go through a review and approval process prior to

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establishing or substantially changing their programs. Operating Certificates are issued to residential programs that are subject to visitation, inspection and supervision by OCFS. These programs include residential facilities for children operated by voluntary agencies, which are not-for-profit corporations, membership corporations or charitable organizations with the authority to operate such facilities. The types of facilities include institutions, group residences, (group homes, agency boarding homes, and supervised independent living programs.) The programs receiving operating certificates from OCFS also include residential facilities for the care of victims of domestic violence; and facilities for runaway and homeless youth, which include approved runaway shelters and transitional independent living programs. OCFS does not issue Operating Certificates to programs licensed or certified to operate by another State department or agency.

Inspection and Certification: OCFS provides ongoing oversight through on-site visits (announced and unannounced). Re-certification visits include a review of program practices, staffing credentials, supervision, service utilization, and quality improvement initiatives. The inspection and certification process reviews agency staffing and supervision plans to ensure staff are properly credentialed and trained.

Background Checks: OCFS' oversight and quality assurance measures also require that OCFS conducts background checks for criminal history, child abuse and maltreatment, and abuse and neglect of vulnerable persons prior to hiring staff, or using volunteers, contractors or consultants. Voluntary agencies are also required to conduct checks for child abuse and maltreatment, criminal history checks and abuse and neglect of vulnerable persons prior to hiring staff, or using volunteers, contractors or consultants.

Enforcement: Where violations of law occur, OCFS can enforce compliance with the law for programs certified by OCFS. The enforcement mechanisms available to OCFS include: issuance of plans of corrective action; suspension or limitation of operating certificates; and revocation of operating certificates. OCFS may also withhold reimbursement to voluntary childcare agencies and/or funding for an agency's repeated non-compliance.

Other State, Federal and Certification Oversight: In addition to direct oversight, programs operated or certified by OCFS receive additional oversight from:

1. New York State Justice Center for the Protection of People with Special Needs;
2. New York State Family Court;
3. New York State Comptroller's Office; and/or
4. United States Department of Justice.

b. Quality Control

OCFS is focused on quality in addition to regulation, compliance and oversight. This is done through a variety of methods, including requirements for casework contacts, maintenance of uniform case records, family court monitoring, and incident reporting. These measures help to provide additional assurance that social work services are being properly provided and supervised even where unlicensed social workers provide the services.

1. **Casework contacts:** pursuant to regulation, the local social services district, or the voluntary agency or purchase of service agency, if required by contract with the district, must provide casework contact services to each child in its care, the child's caretakers and to the child's parents or relatives in a manner prescribed by OCFS regulations. These contacts must be documented in the uniform case record, which is electronically maintained in the Statewide CONNECTIONS system.
2. **Uniform case records:** pursuant to regulation, case records must be maintained by local social services districts or by the voluntary agency or purchase of service agency, if required by contract with the district, for each child in its care, in accordance with the requirements of sections 372, 409-e and 409-f of the Social Services Law (SSL). The uniform case records follow a prescribed format and are maintained electronically in the Statewide CONNECTIONS system.
3. **Family Court:** pursuant to statute, family courts must review the permanency goals of each child who is in foster care every six months.
4. **Incident reporting:** pursuant to statute and regulation, any abuse or maltreatment of a child, either as an incident of discipline or otherwise, is absolutely prohibited. In accordance with the provisions of section 413 of the SSL, volunteers and employees of all child care agencies and facilities who have child-caring responsibilities are required to report any suspected incidents of familial child abuse or maltreatment to the Statewide Central Register of Child Abuse and Maltreatment. They are required to report any suspected abuse or neglect of a child receiving residential care by staff of a residential program, as well as any significant incidents involving a child in residential care, to the Vulnerable Persons Central Register, which is maintained by the Justice Center for the Protection of People with Special Needs. The legal standard for reporting is that a report must be made when there is reasonable cause to suspect that a child coming before the residential staff member in his or her official or professional capacity is an abused, maltreated or neglected child.

INNOVATIONS

In analyzing the potential impact of allowing the present exemptions to expire, up-coming improvements to the delivery of medical and behavioral health services for foster children should be considered. Presently, in accordance with recommendations of the Medicaid Redesign Team, the State is preparing to transition the health and behavioral health delivery system for foster children to a model where care is coordinated by health homes.

This change in service model may increase the fiscal impact associated with requiring licensure in programs under OCFS' auspices in outer years. Additionally, as the licensed workforce continues to decrease in size, additional flexibility may be needed to meet the staffing needs associated with this new service delivery model.

RESPONSES TO SED CONCLUSIONS - SOCIAL WORK

a. Clarification of practice/conclusions

OCFS has some concerns about the SED conclusions as reflected in the report. While SED acknowledges a need for additional clarification in the law, the report does not provide a plan, time frames or a clear description of the steps that SED might contemplate to achieve the necessary clarifications. SED is unclear as to the circumstances under which SED might seek amendments to clarify the law or when it might seek such amendments. OCFS believes that more information concerning how SED believes the law should be further clarified and how they intend to accomplish this should be included in the report.

Further, the report infers that SED is not inclined to more narrowly define those activities that would be performed by licensed professionals, but instead seems to prefer defining those activities rather broadly. OCFS respectfully disagrees with SED's inclusion of broad definitions of activities permitted to be performed only by licensed professionals. Since any limitation on activities to licensed professionals carries serious adverse consequences for persons who engage in the activities without a license, it is essential that persons involved in social work activities be clearly apprised of those activities that are permitted to be performed by unlicensed persons and those prohibited to unlicensed persons. This can only be achieved by being specific as to those activities that are permitted and those that are not.

b. Delegation of professional services/conclusions

Delegation of duties is a proven cost-effective method of providing quality services to the public and is absolutely necessary if social work services are to be provided to all of those in need. Simply put, there are too few licensees available to carry out the duties that programs described above must perform to meet the service needs of children and families throughout the State. Delegation enables the safe and effective provision of services in a manner that keeps the costs of services at a reasonable level, thus serving the interests of as many members of the public as possible.

c. Occupational exemptions/conclusions

SED proposes in the report to work with the exempt agencies to clarify activities that may be performed by unlicensed individuals who hold certain credentials. OCFS welcomes this suggestion but notes that greater specificity in regard to permitted and prohibited activities is necessary. As noted previously, OCFS believes it is essential that persons involved in social work activities be clearly apprised of those activities that are permitted to be performed by unlicensed persons and those prohibited to unlicensed persons.

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d. Alternative pathway/conclusions

The report suggests that SED may be open to alternative pathways to attaining licensure, although SED defers to the Legislature to establish “time-limited alternatives” for only “long-standing practitioners” who meet “certain requirements.” While OCFS agrees that alternative pathways to licensure would be helpful, it is unclear what those alternative would be, or how such alternatives would be developed or implemented. OCFS would like more specifics on SED’s thoughts in this regard before offering additional comments.

e. Extension of broad-based exemptions from licensure/conclusions

It appears from the report that SED intends to move forward with discontinuing the current exemptions without fully considering the legitimate concerns about the utility of the information gathered in the surveys or the serious practical, financial and workforce issues such discontinuance would raise. SED appears to be basing its decisions solely on the licensed professionals who responded to its surveys. In doing so, SED seems to be disregarding the economic realities and service needs of the public. OCFS believes that it is vital that any decision on the current exemptions consider the very real service needs of the public and the economic realities of providing necessary services to the public. Those needs and realities militate strongly in favor of continuing and extending the current exemptions.

f. Civil service titles/conclusions

As discussed above, as SED now agrees that our Youth Counsel positions do not require licensure, previous concerns that were raised by OCFS have been addressed.

COST CONSIDERATIONS

OCFS has determined that the fiscal impact of allowing the social worker licensure exemption to expire is now approximately \$72 million dollars. This number is substantially higher than the fiscal impact of non-renewal of the social worker licensure exemption from previous years because OCFS is now estimating that this proposal would impact approximately 300 additional voluntary agency staff, if the exemption to licensure is not extended or made permanent under the law. The increase in staffing requirements is largely due to statutory initiatives implemented by OCFS that have required voluntary agencies to hire more staff or to open new programs, such as the Close to Home Initiative.

Presently, the approximate number of individuals who provide services at agencies regulated, funded or approved by OCFS and would be impacted if the exemption lapsed is as follows:

- 35 Social Services Assistant Directors
- 337 Social Services Case Aides
- 136 Social Services Directors
- 10 Social Services Education Coordinators
- 15 Social Services Psychologists (non-licensed)
- 1910 Social Services Social Workers
- 187 Social Services Specialists

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- 251 Social Services Social Work Supervisors
- Applied Behavior Analysts – No information available

These figures are based on mandated reports to OCFS from agencies that operate residential facilities for children. OCFS does not receive information from agencies that do not operate residential programs but provide preventive services, so these figures are actually under reporting the number of positions affected.

Additionally, the number of staff needed by voluntary agencies to provide social work services has steadily increased, and OCFS predicts that this increase will likely continue as the Close to Home initiative continues to expand. Consequently, the fiscal impact of ending the exemption has grown, and will continue to do so.

SUMMARY AND CONCLUSIONS

OCFS recommends that the current exemptions be made permanent or extended as continuation of the exemption is both necessary to the provision of vitally important services and appropriate in regards to the protection of the public. Additionally, allowing the exemptions to expire would be costly and would result in a dramatic reduction in the availability of critical services to children and families in need throughout the State.

**New York State Department of Corrections and Community
Supervision (DOCCS) Appendix to Unified Statement
Response to SED Report – Office of the Professions as required
pursuant to Chapter 57 of the Laws of 2013**

The following are The New York State Department of Corrections and Community Supervision's (DOCCS) comments that have been developed in response to the Report developed by the State Education Department (SED) Office of the Professions pursuant to Chapter 57 of the Laws of 2013.

This document has been designed to provide an overview of how The New York State Department of Corrections and Community Supervision programs are regulated and administered, and offers comments in response to some of the findings contained in the report.

EXECUTIVE SUMMARY

The New York State Department of Corrections and Community Supervision is a large state governmental agency that is responsible for the confinement and habilitation of approximately 54,700 offenders held at 54 state facilities, including the 915 bed Willard Drug Treatment Campus, and 36,500 parolees supervised throughout seven regional offices. Our mission is to improve public safety by providing a continuity of appropriate treatment services in safe and secure facilities where offenders' needs are addressed and they are prepared for release, followed by supportive services under community supervision to facilitate a successful completion of their sentence.

We currently have an extensive array of programs for offenders, one that offers services that fall within the parameters of the 2002 State Law and Article 163. We have conducted a thorough investigation of the duties performed by the personnel responsible for instituting these programs in regards to the current issue and request for exemption status.

DATA COLLECTION FINDINGS

SED drew extensively upon the language from the 2011 survey for the 2014 survey. This does provide consistency but it also can perpetuate a mistake or missed data. We believe that the survey was too broad and missed some very key factors. We are in agreement that self-selected respondents may not be representative of the entire population of agencies that provide services within the scope of psychology, social work and mental health practice, as defined in the Education Law. DOCCS is in agreement with SED's report that the definition of diagnosis within the various practices must be clarified. It is very difficult to assess the duties and responsibilities of positions that may or may not require licensure when there still needs to be clarification within the licensed professions.

QUALITY OF CARE ASSURANCE:

ALCOHOL AND SUBSTANCE ABUSE TREATMENT (ASAT) DOCCS is accredited by The American Correctional Association and is required to meet training needs for all employees. Employees in the mental health, psychology, social work and alcohol and substance abuse treatment services professions are mandated to meet even more stringent requirements.

As outlined in our survey responses, the Department works hand in hand with other New York State agencies, such as OMH and OASAS, regarding services provided to the offender population. Important to note is that OASAS has oversight and monitors DOCCS' programs, which provide care and treatment to inmates in our custody who have a history of alcohol and substance abuse disorders. Currently DOCCS has over 9,000 inmates in treatment services within our correctional facilities, with an additional 17,302 inmates with an identified substance abuse need on required program lists throughout the state.

DOCCS operates substance abuse disorder treatment services in various correctional facilities with the mission for treatment services to provide the inmate with the foundation for positive change and to help him/her prepare for a successful return to the community by providing assessment, education, counseling, relapse prevention, and discharge planning. Supervising Offender Rehabilitation Coordinators Alcohol and Substance Abuse Treatment (ASAT), and line staff Offender Rehabilitation Coordinators (ASAT) and ASAT Program Assistants (both identified as "primary counselor") develop an individualized substance abuse treatment plan for each participant. This is based on their Axis I diagnostic impression rendered from the admission and comprehensive evaluation process. Treatment planning identifies an integrated program of therapies and interventions, to include individual and group therapy, which ASAT staff provides. Continuous treatment plan reviews, updates, and evaluation of inmate progress toward treatment plan goals aid in continuing recovery discharge planning. The successful program participant is responsible for demonstrating progress toward established treatment plan goals in applicable life areas, which should be reflected in changes in behavior and attitudes resulting in maintaining a crime and drug-free lifestyle. The above services are provided directly by NYS Department of Corrections and Community Supervision staff.

SAFEGUARDS IN PLACE

Quality Improvement Plan

A facility-specific Quality Improvement Plan (QIP) is developed for all substance abuse treatment services. The Quality Improvement Plan will identify clinically relevant quality indicators that are based upon professionally recognized standards of care. This process will include, but not be limited to an annual self-evaluation. The review will focus on the treatment services offered at the facility.

Record review documentation must be incorporated into the facility's QIP, and may be addressed through identified sections of the treatment record. In the absence of an appropriate supervisory Qualified Health Professional (QHP) for review and signoff of

applicable non-QHP recording, quarterly review of minimally (3) non-QHP records by a multidisciplinary review team, to include assigned staff, must be identified in the QIP.

Substance Abuse Treatment Annual Report

All treatment services prepare an annual report and submit it to the facility Superintendent and Deputy Superintendent of Program Services, with a copy to the facility's Central Office Substance Abuse Treatment Services liaison and designated support staff person. This report documents the effectiveness and efficiency of the service in relation to its goals and indicates any recommendation for improvement in its services to inmates, as well as recommended changes in its policies and procedures. The annual report must be completed and submitted by close of business on the last business day in October of each year in order to ensure timely compilation and submission to the Department's Executive Team by Central Office Substance Abuse Treatment Services.

INNOVATIONS

DOCCS, by law, cannot receive reimbursement from Medicare or Medicaid for any services provided within our correctional facilities, contrary to the New York State Education Department's (SED) report. Inmates under custody that are enrolled in Medicaid are placed in suspended status and reimbursement can be made only in instances of inpatient hospital stays. Any treatment while in DOCCS custody performed inside of an institution are precluded from Medicaid coverage.

RESPONSES TO SED CONCLUSIONS - TOPICS FOR DISCUSSIONS - BY PROFESSION

At this juncture, DOCCS is most concerned with the Social Worker (SW) topics of discussion. We are in agreement with the conclusion of SW1 (clarification of practice), SW3 (occupational exemptions), SW4 (alternative pathway) and SW5 (extension of broad based exemptions from licensure). All of these would have a large impact on this agency. As stated above, clarification of practice within the professions would be extremely beneficial. We continue to support occupational exemptions for our employees holding CASAC certification. Alternative pathways are also of value, but of most value to DOCCS would be the extension or permanent adoption of broad based exemptions from licensure. As previously stated, this agency already has a tremendous amount of oversight and regulation and we work hand in hand with OASAS on our alcohol and substance abuse treatment programs.

The modifications made by the changes outlined in Chapter 57/2013 provided clarification when dealing with specific activities performed by a large cohort of DOCCS staff, specifically the clarification regarding de-escalation techniques, as this is an important aspect of the work of our 20,000 security staff who utilize such techniques to avoid situations to require the use of physical force and prior to referral to a licensed mental health provider. Additionally, the ability for non-licensed staff to be assigned to a treatment team has also been useful as we find that a team approach to working with an offender has a positive impact on an offender's behavior and rehabilitation.

COST CONSIDERATIONS

DOCCS has 298.5 positions in our Alcohol and Substance Abuse Treatment Services Program that would be affected if the exemption is not made permanent. The cost of hiring licensed professionals for these positions would be \$6,074,497 and would bring our total costs up to \$22,066,582 (see chart). The additional costs primarily result from replacing current non-licensed staff with more expensive licensed staff and re-classifying existing titles to higher grade levels.

Because only certain tasks of groups of employees fall under the Scope of Practice, we would be forced to attempt to hire licensed individuals to perform those restricted activities while at the same time be unable to layoff the equivalent number of our current employees who are performing the restricted duties. There is no Civil Service mechanism to separate these employees because their duties have changed.

The cost of advanced education can be challenging and/or prohibitive as shown with CASAC certification or LMSW licensure. Credentialed Alcohol and Substance Abuse Counseling Certification is another path, but it is equally as challenging, costly and time consuming. In order to obtain a CASAC certification, an individual must document a minimum of 6,000 hours (approximately 3 years) of supervised, full-time equivalent experience in an approved work setting (2,000 hours must be paid; Bachelor's degree in an approved Human Service field may be substituted for 2,000 hours; Master's degree in an approved Human Service field may be substituted for 4,000 hours) and a minimum of 350 clock hours, which address the full range of knowledge, skills and professional techniques related to chemical dependence counseling. The approximate cost to participate in an OASAS education program is \$4,000. The initial non-refundable CASAC application fee is \$100; exam fee \$200; re-test fee \$200; CASAC-T extension fee \$100.

A CASAC term is 3 years. CASACs are required to document 60 clock hours of relevant experience and training each 3 year period (40 hours specific to addictions). A renewal application fee is \$150. If the 3 year term expires and a renewal application is submitted within 1 year of the expiration, renewal fees include the \$150 plus an additional \$50 for each 6 month period or part thereof, maximum \$50. If the 3 year term expires and a renewal application is submitted more than 1 year of the expiration date, renewal fees include the \$150 plus an additional \$100 for each one year period or part thereof, maximum \$200. For our staff that would need to have advanced degrees, it would require them to go back to school. The cost of additional education for licensure requirements also presents challenges. Degree programs required to qualify for licensure, such as a Master's Degree in Social Work or Counseling, typically require 2 years of full-time attendance. Admission to these programs is highly competitive, the number of programs in the public schools (SUNY system) at the master's level is very limited, and the costs are currently estimated at \$25,000 per year. DOCCS has large numbers of employees that are not necessarily living close enough to one of the SUNY campuses, with a master level program in social work or counseling, to commute. If admission to appropriate educational programs was granted, it is estimated that the cost

for two years of attendance at graduate programs for the unlicensed individuals would be in the millions.

Of great concern is the fact that there will be individuals who can not or will not want to return to college. Besides the cost factor there are personal, social, health and/or family factors that may preclude them from returning to school to receive an advanced degree.

In addition, we are very concerned that there would **not** be enough certified and/or licensed individuals available to address our needs.

Lastly, if there are further modifications made to the previous changes outlined in Chapter 57/2013, the fiscal impact on DOCCS would increase by approximately \$30.6 million. This figure does not take into account any impact on custodial staff (Correction Officer, Correction Sergeant, Correction Lieutenant), who utilize de-escalation techniques as an important aspect of their work in the avoidance of situations to require the use of physical force and prior to referral to a licensed mental health provider.

SUMMARY AND CONCLUSIONS

This agency directly addresses the needs of a very limited and distinct population, those offenders who have been incarcerated in its facilities. The Department's Mission statement includes a commitment to provide "a continuity of appropriate treatment services," making it the responsibility of all agency employees.

With the passage of Correction Law 622, mandating the implementation of a sex offender program for incarcerated sex offenders, the Department recruited and hired Psychologists and LMSWs. Ongoing recruitment of Psychologist and LMSW titles has been unsuccessful. We have not been able to fill all these vacant positions due to a lack of interest of prospective candidates. Mandating the need to hire more LMSW for the ASAT program would make an already difficult situation much worse.

We believe that DOCCS ASAT services would be unable to comply with professional licensure laws applicable to substance abuse treatment services provided in the State-operated and in State funded, approved, and regulated programs by July 1, 2016, due to the approximately two thirds of ASAT staff who would need to pursue and obtain minimally a Credentialed Alcoholism and Substance Abuse Counselor title. It is noted that approximately 33% of DOCCS treatment staff statewide are designated as a Qualified Health Professional (OASAS requirement is 25% at each site).

Recommendations on alternative pathways to licensure would be to receive SED's acceptance of the established Civil Service education and experience requirements for the ASAT titles. As well as, possible modification to the Civil Service requirements to include a (QHP), of which a CASAC is, could be explored with the allowance for "grandfathering" in current employees in such titles.

Recommendations for amendments to laws, rules and regulations necessary to fully implement the requirements for licensure by July 1, 2016 would be to develop established waivers in regards to percentages of QHP staff necessary at each site to maintain the provision of substance abuse treatment services. As well as action plans for those sites without QHP staff. The collaboration between DOCCS and OASAS has developed waivers (Memorandum of Understanding) to address such staffing considerations when specified DOCCS sites are identified for OASAS certification.

DOCCS has revised the ASAT services operation and procedural manuals to meet or exceed the OASAS Operating Guidelines established for the Department. The collaboration resulted in the implementation of diagnosis determinations, QHP reviews, and development of QIPs to support a team approach to treatment services, and outline procedures required in the absence of a QHP. The DOCCS/OASAS collaboration has provided an opportunity to create a seamless re-entry experience for the offender, whose participation in DOCCS ASAT services will be viewed favorably by OASAS community-based agencies, thus reducing costs at the community level.

If SED is unable to make an exemption for the provision of substance abuse treatment services within the Department, it would necessitate a huge step backwards in the strategic planning and implementation of such services. Offenders with identified substance abuse treatment needs would be unable to access treatment services for potentially years pending their release, or never for those with life sentences. It is imperative that exemptions be made in order to meet the needs of the population served.

Recommendations

We firmly believe that we have appropriate safe guards currently in place. The huge cost and availability of geographically dispersed LMSW candidates is prohibitive. This department strongly recommends a permanent exemption, as the cost of implementing the laws in question and the disruption to the workforce, programs, and services provided would be catastrophic.

Office for People With Developmental Disabilities (OPWDD)
Appendix to Unified Statement
Response to SED Report – Office of the Professions as required
pursuant to Chapter 57 of the Laws of 2013

Following are OPWDD's comments that have been developed in response to the Report developed by the State Education Department (SED) Office of the Professions pursuant to Chapter 57 of the Laws of 2013.

EXECUTIVE SUMMARY

The New York State Office for People With Developmental Disabilities (OPWDD) provides and coordinates services for people with developmental disabilities and their families and conducts research into the causes and prevention of developmental disabilities. OPWDD provides access to services through a regional system dividing the state into geographic sections that are overseen by Developmental Disabilities Regional Offices (DDROs) and Developmental Disabilities State Operations Offices (DDSOOs). OPWDD directly provides residential and day program services to thousands of individuals with developmental disabilities and operates the research component of OPWDD, the Institute for Basic Research in Developmental Disabilities (IBR). It also partners with a network of over 600 OPWDD voluntary not-for-profit agencies to offer approximately 40 different types of individualized and person-centered services to more than 120,000 people with developmental disabilities and their families.

OPWDD directly operates, and approves, certifies and regulates voluntary not-for-profit agencies that operate programs in which individuals perform one or more of the restricted activities of assessment/evaluation, diagnosis, assessment-based treatment planning, psychotherapy and treatment other than psychotherapy identified in the survey. Both OPWDD state-operated programs and OPWDD approved, funded or regulated voluntary programs are currently covered by the extended exemption from licensure provided in Chapter 57 of the Laws of 2013.

The types of programs that employ individuals who perform restricted activities and are currently operated by OPWDD and/or its voluntary not-for-profit partners may include:

1. Clinic treatment facilities (Article 16 Clinics) that provide outpatient clinical services, including long term therapies such as occupational and physical therapy and speech and language pathology; behavioral and mental health services such as psychology and social work services and/or pharmacologic management by appropriate medical practitioners; and health care services such as dietetics/nutrition and nursing services.
2. Clinically enhanced day and/or residential habilitation services that focus on behavioral interventions and stabilization and/or long term habilitative therapy needs.
3. Family support services that may offer family and/or individual counseling, group therapy, diagnostic and evaluation services and/or crisis intervention.

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4. Intensive Behavior (IB) services, a service available under the Home and Community Based Services (HCBS) waiver that address behavioral needs before more expensive crisis services are necessary (e.g., psychiatric emergency services, hospitals and/or centers).
5. Day treatment services, which are a planned combination of diagnostic and treatment services provided to persons with developmental disabilities in need of a broad range of clinically supported and structured habilitation services.
6. Intermediate Care Facilities (ICFs) that provide services based on necessary clinical areas and treatment plans that ensure persons receive active treatment to address their identified needs.

In addition to the above types of community-based programs, OPWDD directly operates institutional programs that serve people who are remanded on an involuntary status through the courts or through a clinical determination of need and require specific treatment and/or supervision. The campus-based programs include Developmental Centers (DCs), Multiply Disabled Units (MDUs), Autism Units, Special Behavior Units, and Local and Regional Intensive Treatment Units (LITs and RITs), and Centers for Intensive Treatment (CITs) and provide treatment for fewer than 600 people. These inpatient treatment services include behavioral and mental health services and the performance of restricted activities to meet the needs associated with significant risk management issues, mental health services for individuals with dual diagnoses (developmental disability and mental illness) or severe emotional dysfunction; and transitional treatment for persons with autism and severe behavioral challenges.

Other programs operated directly by OPWDD and indirectly through OPWDD approved, funded or regulated voluntary programs provide coordination and/or concrete services, and do not typically involve the performance of restricted activities that require the services of licensed individuals. The following are examples of some of these programs:

1. Service coordination (case management services), which provides observation and information gathering about the person's living situation, health and available support systems to clarify the person's needs; describes and reports a person's behavior to professional team members to identify possible problems and areas of need; and provides access or referral to appropriate services and supports. Service coordination may be part of the residential services provided by Intermediate Care Facilities (ICFs) or through Medicaid Service Coordination (MSC), Plan of Care Support Services (PCSS) or one of the Care at Home (CAH) waivers for children.
2. Certified community residential settings such as individualized residential alternatives (IRAs), family care, and supervised and supportive community residences provide room and board, personal assistance, community integration and inclusion and/or training in activities of daily living.
3. Day, residential and community habilitation services that focus on ability building related to social skills, activities of daily living, and achieving person-centered valued outcomes or providing necessary direct personal assistance.
4. Family support programs that provide respite, recreation, parent to parent networking, information and referral and after school programs.

DATA COLLECTION FINDINGS

OPWDD has reviewed the State Education Department's (SED) draft report to the Legislature and the Executive pursuant to Chapter 57 2013. While there are several interpretations throughout the report that are supported by the data in terms of percentages of respondents expressing agreement versus disagreement with specific proposals, the conclusions drawn based on the data did not necessarily correspond in each instance. The conclusions appeared to draw at least in part from information that was not included in the survey tool and were still clearly focused on supporting the requirement for licensure of the various professions.

It is notable that the 2014 SED survey responses comprise less than 5 percent of the impacted programs and services under OPWDDs jurisdiction and therefore do not accurately reflect the services that unlicensed individuals provide. While OPWDD operates, regulates, approves, or funds over 7,700 programs, only 247 programs who responded to the SED survey identified being under the oversight of OPWDD. Regardless, if the survey results are extrapolated for the purposes of meaningful analysis, the continued need for the exemption is necessary since almost 50 percent of the restricted functions, excluding diagnosis, are identified as being provided by unlicensed practitioners.

If the "scope of practice" exemption were to lapse, not only would there be inadequate numbers of licensed professionals to provide needed services, but the increased cost to the State to replace unlicensed staff with licensed individuals in not-for profit programs would be approximately \$99 million annually. If state-operated programs are included, the total cost of the elimination of the "scope of practice" exemption for OPWDD is estimated to be approximately \$106 million annually. The overwhelming reimbursement mechanisms for these services are funded by taxpayer dollars, including Medicaid, Medicare, and State deficit financing.

It is not believed, nor does the evidence demonstrate, that ending the exemption would result in better client outcomes. OPWDD has strong regulatory, licensing, and monitoring processes to ensure that providers furnish high quality and cost effective behavioral health services.

Due to concerns about professional workforce shortages, financial constraints and dramatic changes to the behavioral healthcare delivery system, OPWDD, consistent with OMH, recommends a permanent extension with a review in five years to address the new needs arising from the effects of the above constraints in conjunction with the upcoming changes.

QUALITY OF CARE ASSURANCE

Pursuant to federal and state law and regulation, OPWDD provides individuals with developmental disabilities served within the OPWDD service delivery system with significant protections from the risk of inappropriate or poor quality services. Services provided to individuals with developmental disabilities that are licensed, certified, funded or otherwise approved by OPWDD must comply with detailed requirements established in

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OPWDD regulations, and, if funded by Medicaid, must also comply with the standards established under OPWDD's Home and Community Based Services Waiver with the federal Center for Medicare and Medicaid Services and applicable Medicaid regulations. OPWDD's Division of Quality Improvement (DQI) which, by design, operates independently of OPWDD programs and the provision of services, performs certification reviews and ongoing surveys of OPWDD and voluntary provider facilities and programs to assure compliance with applicable federal and state regulations and related policies. These certification and oversight requirements provide assurances of quality of care that go well beyond the protections afforded by professional licensure alone to members of the general public who privately engage the services of licensed practitioners. The certifications and reviews include, but are not limited to:

- Residential Programs: All residential facilities must meet rigorous standards for initial certification pursuant to OPWDD regulations. After initial certification has been obtained, Article 16 of the Mental Hygiene Law requires that all site-based programs certified by OPWDD be recertified at least every three (3) years; intermediate care facilities must be recertified annually. OPWDD currently reviews and certifies more than 7000 residential programs.
- Home and Community Based Waiver Services and Medicaid Service Coordination: OPWDD's Home and Community Based Service (HCBS) Waiver, approved by the federal government on October 1, 2009, requires an annual review of a sample of all Waiver-funded and Medicaid service coordination authorized by OPWDD for compliance with regulatory and other program requirements. OPWDD's sample review includes approximately 9,500 Waiver reviews and 3,000 MSC reviews.
- Abuse reporting: OPWDD regulations provide detailed requirements for the reporting of incidents which may endanger the well-being of individuals residing in residences operated or certified by OPWDD. Reportable incidents include situations involving insufficient, inconsistent or inappropriate services, treatment or care to meet the individuals' needs (14 NYCRR Part 624). OPWDD conducts at least an annual review of each agency's incident management practices.
- In addition to OPWDD's own rigorous oversight, there are also external oversight bodies which provide additional layers of protection for individuals served in the OPWDD system. Section 13.33 of the Mental Hygiene Law provides for the establishment of a Board of Visitors, appointed by the Governor with the advice and consent of the Senate, for each Developmental Disabilities Services Office of OPWDD. Members of the boards are vested with broad powers to visit and inspect state facilities, and have access to all books, records and data of the facility.
- In December 2012, legislation was signed creating the Justice Center for the Protection of People with Special Needs Act (PPSNA), an initiative that has transformed how the state protects over one million New Yorkers in state operated, certified or licensed facilities and programs. This law established a set of uniform standards to be implemented by the Justice Center for the protection of people receiving services from facilities and programs that are certified and/or operated by a number of state agencies, including OPWDD. The Justice Center established and reformed policies and procedures concerning incident management effective

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June 30, 2013. The Justice Center possesses broad powers of investigation of complaints of abuse or mistreatment in mental hygiene facilities.

OPWDD amended 14 NYCRR 624 to add conforming definitions of abuse, neglect and other incident categories. Part 624 regulations are designed to protect people receiving OPWDD services. Part 624 specifies that all Reportable Incidents and Notable Occurrences must be thoroughly investigated and non-reportable events must be addressed according to agency policy. In addition to complying with Part 624, Intermediate Care Facilities for Individuals with Developmental Disabilities (ICFs/IID) must also comply with federal regulations in 42 CFR Part 483. In some instances, the federal regulations and guidelines related to the protection of people receiving services are more stringent than the requirements in Part 624.

INNOVATIONS

Over the past several years OPWDD has initiated the development of a new services waiver called the People First Waiver. OPWDD plans to create major programmatic and financial advances in its service delivery system through the implementation of the People First Waiver. These system changes will allow OPWDD to more accurately determine a person's needs for services through a care management model and provide individualized services to best meet those needs.

The new waiver will also allow OPWDD to review how well the current services, including behavioral and mental health services, meet the needs of people with developmental disabilities, and to find ways to promote better personal outcomes for persons who receive these services. OPWDD will continue to meet the same needs for service, and will better coordinate cross system services with OPWDD services while exploring means to better access services, new service options, and innovative ways of organizing care and treatment. Many of these improvements in service access involve supporting individuals in more autonomous living environments and work settings, and integrating clinical services into those settings. The ability to pilot and implement the health and medical home models, and the flexibility of the behavioral health workforce, are critical considerations to developing services that are cost effective, high quality and accessible.

Based on analyses conducted by OPWDD, people with developmental disabilities are living longer and have a lifespan that is nearly comparable to that of the general population. The data shows that in the past twenty years the percentage of people with a psychiatric diagnosis who are served by OPWDD has almost doubled (16 percent in 1989 to more than 30 percent in 2010). In addition, consistent with the national trends, the growth rates of autism diagnoses has reportedly grown five-fold from 3% in 1989 to more than 17% in 2010.

The growing proportion of persons who receive services from OPWDD and who have a mental illness strongly suggests the need for cross system services to provide support to persons currently residing in the community as well as the subpopulation of persons living in institutions who will transition to the community. Through the People First Waiver,

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OPWDD will update and improve how a person's needs are assessed so that a person with greater needs will receive appropriately greater levels of service.

Specifically to address the support needs of persons who are dually diagnosed with an intellectual/developmental disability and mental illness, OPWDD has been working with leaders at the Center for START Services from the Institute on Disability at the University of New Hampshire to design and implement NY START services. Systemic Therapeutic Assessment, Resources and Treatment (START) is a nationally recognized model for the prevention and response to behavioral health crises which often impacts on a person's capacity to benefit from community based supports and services and which may create risk for the person or other community members. The START model is focused on effective treatment strategies for individuals with developmental disabilities who have dual behavioral health needs which supports their opportunities for active participation in community based supports. The START model will create a consistent, evidence based model for NYS through the following practices:

- Cooperative agreements between cross systems providers;
- Available response by trained START team members to support providers and or first responders at the time of a crisis event;
- Available therapeutic center based (respite) services in a specialized setting for the purpose of stabilization;
- A community based clinical team to augment the existing services available to the person with the focus on treatment and prevention of crisis; and
- A consistent data collection system to ensure measurement of the model's impact on an individual and a system level.

NY START Services are being designed to utilize a cost-effective, best-practices approach to allow for maximum use of waiver eligible services and to improve the system for crisis response and prevention services. In the future, the START program will be incorporated into the DISCO managed care model.

In terms of how OPWDD is updating and improving how a person's needs are assessed to ensure that appropriate supports and services are available to them, a great deal of work has gone into the development of what is known as the Coordinated Assessment System (CAS). Working in consultation with the developers of the interRAI Intellectual/Developmental Disability (ID/DD), this assessment tool was selected as the core instrument of the CAS after input from stakeholders across New York State and extensive research. The CAS is a comprehensive tool aimed at gathering information on an individual's needs, strengths and interests to inform a person-centered care plan and for inclusion in resources allocation. The CAS is:

- Comprehensive
- Standardized
- Person-centered
- Focused on identifying individual strengths, needs and interests
- Comprised of a core tool with supplements tailored to a person's individualized needs (Child and Adolescent Supplement; Mental Health Supplement; Forensic Supplement; Medical Management Supplement; Substance Use Supplement)

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The goals of a CAS are to provide a comprehensive, person-centered assessment of an individual that can be used to identify the supports and services needed to maximize his/her quality of life. The second goal is to inform resource allocation in order to provide for equity of services based on a person's needs. Another important goal of the CAS, in conjunction with the DOH and the OMH assessment tools for individuals in need of long-term supports and services, was to meet the Core Standardized Assessment requirements under the Balancing Incentives Program (BIP). The CAS, as well as the OMH assessment tool, will be integrated into the DOH Information Technology (IT) assessment system in 2015. Utilizing one IT solution for these assessment tools will create efficiencies and savings for the residents of New York State.

The significant increase in the growth rate of autism and autism spectrum disorders (ASD) challenges OPWDD to develop community-based services that support the range of needs associated with these diagnoses. The People First Waiver will encourage a more efficient service system designed to focus funding support on individualized services that provide opportunity for people with developmental disabilities and severe behavioral issues to make changes that lead to personal growth, development and an improved overall quality of life.

Behavioral and mental health services are an important part of the framework of supports that allow many people with developmental disabilities and mental illness and/or behavior disturbances to constructively engage in work and other meaningful activities, live in a home of their choice, and develop positive relationships. Reliable and timely access to these essential services is necessary to realize the OPWDD vision of a comprehensive and integrated care management environment for all people with developmental disabilities. Central to the success of all of the initiatives above is access to clinicians from various disciplines that have the knowledge, familiarity, training and interest in working with individuals who have intellectual/developmental disabilities.

As OMH has pointed out, the delivery of behavioral health services is also undergoing a significant redesign in response to the Affordable Care Act (ACA) and the Delivery System Reform Incentive Payment (DSRIP) program. With the passage of the ACA, and the imminent transition to Medicaid managed care, the broader service delivery system is now in the process of extraordinary change to address quality of care and contain costs. The primary goal of DSRIP is to reduce unnecessary hospitalizations, which requires expanding the capacity and quality of community based providers with a major focus on the integration of healthcare services.

These changes will result in a much greater demand for licensed professionals as behavioral and physical healthcare providers coordinate quality care. In addition, it is expected that there will be an increase in the need to access specialty care, including mental health services and services for persons with intellectual/developmental disabilities, in order to achieve the goal of reduced hospitalizations in accordance with the objectives of DSRIP. These changes are likely to result in an increase in the number of

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individuals who need to be served, while the licensed workforce continues to reduce in size.

TOPICS FOR DISCUSSION:

SOCIAL WORK

Clarification of practice/ conclusions:

- OPWDD agrees with the conclusion regarding the need to clarify the practice of licensed master social work and licensed clinical social work.

Delegation of professional services/ conclusions:

- OPWDD agrees with the conclusion regarding the need to conduct further detailed review of the activities that are restricted under the Education Law and those tasks that can be delegated to unlicensed persons as part of an inter-disciplinary model of assessment, diagnosis and treatment.

Occupational exemptions/ conclusions:

- OPWDD agrees with the recommendation from OMH and OASAS to allow unlicensed persons to provide services that the law restricts to individuals licensed or authorized when those services are delivered under the oversight of OMH, OASAS and OPWDD given the obligations for quality oversight provided for by mental hygiene law and independent oversight entities such as the Justice Center. Given the well-documented shortage of licensed professionals available to meet the needs of individuals served by the mental hygiene agencies, statute and agency-specific regulations provide for quality assurance and oversight mechanisms in the current settings where these services are delivered. This recommendation continues to be valid. OPWDD continues to support this proposal.

Alternative pathway/ conclusions:

- OPWDD agrees with the conclusion regarding developing an alternative pathway to licensure, as well as with the recommendation to determine why individuals with MSW degrees, who should qualify for licensure as an LMSW, are not already appropriately licensed. There is a need to identify any barriers to licensure and based on what is identified to develop and implement policies to ensure compliance as SED suggests.

Extension of broad-based exemptions from licensure/ conclusions:

- OPWDD agrees with the need to minimize any disruptions in services or displacement of individuals or programs that may result with ending the permanent

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exemptions. The past repeated sunsets in 2009 and 2012 have not benefitted the system or the individuals served.

Civil Service titles/ conclusions:

- OPWDD agrees with the conclusions drawn regarding civil service title changes that are needed to clarify roles and practice in state-operated programs.

MENTAL HEALTH PRACTITIONERS

Clarification of Practice / conclusions:

- OPWDD agrees with the conclusion regarding the need to clarify the practice of the mental health practitioners.

Delegation of professional services/ conclusions:

- No comment

Occupational exemptions/ conclusions:

- No comment.

Alternative pathways:

- OPWDD agrees with the conclusion:

Extension of broad-based exemptions from licensure/ conclusions:

- No Comment.

Civil Service titles/ conclusions:

- OPWDD agrees with the conclusion.

PSYCHOLOGY

Clarification of Practice / conclusions:

- OPWDD agrees with the conclusion by SED that any changes in law or regulation pertaining to the practice of Psychology should minimize disruptions in service and protect the health, safety and welfare of the public.

Delegation of professional services/ conclusions:

- OPWDD agrees with the conclusion regarding the need to conduct a detailed review of the activities that are restricted under the Education Law and those tasks that can be delegated to unlicensed persons as part of an inter-disciplinary model

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of assessment, diagnosis and treatment. There is clearly a need to reach agreement with SED on activities that do not require licensure in order to reduce the number of individuals who would require licensure under Title III.

Occupational exemptions/ conclusions:

- OPWDD agrees with the conclusion by SED that the long-standing exemption pertaining to the practice of Psychology on the part of a person holding a minimum of a master's degree in psychology who is in the employ of a federal, state, county or municipal agency, etc., should remain in place as long as the activities and services they provide are part of their salaried position for that civil service or governmental entity. According to SED's conclusion this exemption has existed since 1956 without evidence of harm and OPWDD would concur with this statement. OPWDD employs a large number of clinicians meeting the requirements to be in a Psychologist 1 or Psychologist 2 civil service title, and continues to propose that the permanent exemption enjoyed by clinicians in civil service or governmental entities be applied to programs in the voluntary sector. Despite the assertion by SED that the current exemption applied to those clinicians with a master's degree in psychology working for state government has not resulted in harm to the public, they continue to conclude that a similar exemption applied to clinicians with the same educational requirements of at least a master's degree in psychology working in the employ of the voluntary sector for agencies who are certified and funded by OPWDD is not in the public interest as it could result in individuals receiving varying levels of care depending on the setting where those services are provided. OPWDD disagrees with this conclusion, particularly given that the educational qualifications are essentially the same, and the agency has a strong regulatory framework and oversight practices to ensure that not-for-profit providers deliver high quality, person-centered and cost effective behavioral health services. OPWDD promulgated regulations in January of 2013 defining the educational, experiential, and supervision and oversight requirements necessary to allow clinicians with a master's degree in psychology to provide services under the supervision of a licensed psychologist or licensed clinical social worker, similar to what has been in place under the civil service structure. This has afforded the necessary oversight and protections in civil service and governmental settings for clinicians with a master's degree in psychology to provide services without undue risk to the public. OPWDD continues to advocate that a similar solution be considered for its voluntary providers, even if only applied as an interim step to the development of a new licensed title for clinicians with a master's degree in psychology that would enable them to be licensed in their own right.

Alternative pathways/ conclusions:

- OPWDD agrees with the conclusion by SED that the law should provide an alternative pathway to licensure for long time practitioners.

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Extension of broad-based exemptions from licensure/ conclusions:

- OPWDD found the conclusion by SED about the need for all individuals providing services to be licensed in order to protect the health, safety and welfare of the public to be too generalized as there was no recognition for the quality assurance and oversight role that the mental hygiene agencies are obligated to provide. SED did not offer real solutions for these concerns, despite the fact that data from the Office of the Professions website regarding “County of location” reflects severe shortages of Licensed Psychologists, as well as other licensed mental health professionals, in many counties throughout the state.

Civil Service titles/ conclusions:

- OPWDD agrees with the conclusion.

New Professions:

- OPWDD supports adding a new behavioral health practitioner license, with a requirement for a master’s degree in psychology, or having successfully completed at least 60 graduate hours in a program leading to a doctoral degree in psychology; having two years of supervised full-time experience in the delivery of professional behavioral health or psychological services; and passing an examination. This would benefit OPWDD’s vast network of not-for-profit agencies as a long term solution to the expiration of the exemption. This would require considerable time to develop, however.

Applied Behavior Analysis:

- OPWDD agrees with the conclusion.

Continuing Education:

- No comment.

Workforce Planning:

- No comment.

Privileged Communication:

- OPWDD agrees with the suggestion.

Limited Permits:

- OPWDD agrees with the suggestion.

COST CONSIDERATIONS

OPWDD disagrees with the conclusion by SED that the costs of licensure could be offset by the revenue generated through provision of services by licensed professionals. Given that there is a real shortage of appropriately qualified and licensed clinicians in New York State to meet the current demands for services, and given that the numbers diminish further in terms of those licensed clinicians who are knowledgeable and skilled in working with individuals with developmental disabilities, there simply will not be sufficient supply to meet the demand resulting in further loss of needed services along with revenue.

OPWDD has projected a total cost of \$106 million dollars to its delivery system to replace not-licensed individuals who perform restricted activities with licensed practitioners. The projection included estimates of both the costs related to recruiting and replacing individuals in OPWDD operated programs that may provide services under the scope of practice of a LMSW and perform restricted activities associated with clinical social work, and Applied Behavior Specialist and Behavior Intervention Specialist staff who perform restricted activities under the scope of practice of psychology in OPWDD approved, funded or regulated voluntary agencies. This projection does not include any loss of Medicaid revenue to New York State due to the inability to provide services to persons pending recruitment of appropriately licensed or authorized individuals.

SUMMARY AND CONCLUSIONS

As New York State undergoes radical changes to implement managed care, parity and DSRIP over the next several years, the movement of services into the community will create increased demand for services. There are already challenges with meeting the needs of individuals currently receiving services in the system due to the shortages of appropriately qualified and licensed clinicians in New York State, and given that the numbers diminish further in terms of those licensed clinicians who are knowledgeable and skilled in working with individuals with developmental disabilities, there simply will not be sufficient supply to meet the demand. The licensure law was designed to create a means of ensuring the provision of high quality behavioral healthcare services by preventing unqualified individuals from independently providing services. OPWDD has a robust program for licensing, monitoring, and oversight that continues to ensure high quality care in all its services, including behavioral health services.

OPWDD, consistent with OMH, recommends extending the exemption without termination but require periodic reports to the Executive and the Legislature (every 5 years or less after DSRIP) on state agencies efforts to continue to professionalize the delivery system workforce while maintaining high quality, cost effective behavioral health services.

**New York State Department of Health Appendix to Unified Statement
Response to SED Report – Office of the Professions as required
pursuant to Chapter 57 of the Laws of 2013**

The following are Department of Health comments that have been developed in response to the Report developed by the State Education Department (SED) Office of the Professions pursuant to Chapter 57 of the Laws of 2013.

This document has been designed to provide an overview of how Department of Health programs are regulated and administered and offers comments in response to some of the findings contained in the report.

EXECUTIVE SUMMARY

The Department of Health (the Department) is responsible for the protection and promotion of the health of the inhabitants of the state (NYS Constitution Article XVII §3). Among other responsibilities, the Department provides services directly through several state-run institutions and indirectly through reimbursement for service, approval of private providers, and the issuance of operating certificates and licenses.

In particular, the Department directs and oversees patient care, research, capital construction, and the fiscal management of the five Department of Health state-owned and operated health care facilities: Helen Hayes Hospital and the New York State Veterans Homes at Batavia, Montrose, Oxford and St. Albans.

Further, the Department acts as the single state agency for medical assistance, with responsibility to supervise the plan for medical assistance as required by title XIX of the federal Social Security Act (42 USC 1396, et seq.: grants to states for Medicaid and Children’s Health Insurance Program), or its successor, and to adopt regulations as may be necessary to implement this plan.

The Department’s Office of Primary Care and Health Systems Management has oversight over the operating certificates and licenses to providers that fall under the purview of the Department. This oversight focuses on ensuring facilities are meeting legislative and regulatory standards before being certified, subsequent inspections, and responding to complaints against the facilities.

DATA COLLECTION FINDINGS

As noted herein, the Department does not anticipate a direct impact to its own state-operated programs or to the providers under its jurisdiction, but defers to other impacted state agencies.

QUALITY OF CARE ASSURANCE

As noted above, providers with operating certificates or licenses issued by the Department are required to meet statutory and regulatory standards and are subject to survey and, where appropriate, enforcement action.

INNOVATIONS

The Delivery System Reform Incentive Payment (DSRIP) Program, a component of the \$8 billion Medicaid Waiver Amendment, will reinvest \$6.42 billion over the next five years, beginning April 1, 2015, for the purpose of transforming the State's health care safety net system, reducing avoidable hospital use and achieving other improvements in health and public health, and promoting the sustainability of delivery system transformation by leveraging managed care payment reform. Pursuant to terms and conditions agreed to with the federal Centers for Medicare and Medicaid Services (CMS), DSRIP providers will collaborate as part of "Performing Provider Systems" (PPSs) in the design and implementation of a range of projects, including projects to create integrated delivery systems that incorporate the full continuum of care and eliminate service fragmentation.

PPSs include both major public hospitals and safety net providers, with a designated lead provider for the group. Safety net partners can include an array of providers, including hospitals, health homes, nursing homes, clinics, federally qualified health centers (FQHCs), behavioral health providers, community based organizations and others. Many of these providers are licensed, certified, operated, regulated, funded or approved by other exempt state agencies, including but not limited to, the Office of Mental Health and the Office of Alcoholism and Substance Abuse Services, and would be directly affected by the expiration of the exemption.

The expiration of the exemption during the five-year DSRIP period could impact the ability of these providers to effectively work with their PPS partners in carrying out the DSRIP Project Plans. Furthermore, there could be unintended consequences to the State as efforts are made to transform the delivery system, as well as on the delivery of behavioral health (mental health and substance use disorder) and social services. Given the rapid and transformative changes in the health care delivery system to be achieved through DSRIP, in order for it to be successful, a steady workforce is needed to help navigate and sustain the change.

RESPONSES TO SED CONCLUSIONS - TOPICS FOR DISCUSSIONS - BY PROFESSION

As noted herein, the Department does not anticipate a direct impact to its own state-operated programs or to the providers under its jurisdiction, but defers to other state agencies that oversee providers engaged in DSRIP.

COST CONSIDERATIONS

As previously noted by the Department in connection with earlier reports regarding the exemption at issue, the Department does not expect that it will bear any additional expenses associated with the expiration of the exemption as applied to staff of the

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Department-operated facilities. Similarly, the Department does not expect that the expiration of the exemption would impact the health provider workforce that falls primarily under the Department's authority. However, as noted above, the expiration of the exemption would impact other providers who are PPS partners and thus will be engaged in DSRIP projects.

SUMMARY AND CONCLUSIONS

The Department recommends that the existing exemption be continued at least until July 1, 2020, in order to avoid unnecessary disruption to the implementation of DSRIP. Although the current exemption is in place until July 1, 2016, the Department recommends that such extension be sought during the current legislative session, rather than the next, to eliminate the uncertainty faced by impacted providers who are involved in DSRIP activities. In addition, the transformative nature of DSRIP is likely to have such an impact on health and behavioral health care services, as well as community-based programs that complement such services, that further consideration should be given to a permanent exemption.

Recommendations

The exemption should be extended until at least July 1, 2020, and further consideration should be given to making the exemption permanent.

**Office of Mental Health Appendix to Unified Statement
Response to SED Report – Office of the Professions as required
pursuant to Chapter 57 of the Laws of 2013**

The following are the Office of Mental Health (OMH) comments that have been developed in response to the Report developed by the State Education Department (SED) Office of the Professions pursuant to Chapter 57 of the Laws of 2013.

This document has been designed to provide an overview of how OMH programs are regulated and administered and offers comments in response to some of the findings contained in the report.

EXECUTIVE SUMMARY

OMH recommends the existing “scope of practice” exemption be made permanent. The delivery of behavioral health services is undergoing a significant redesign in response to the Affordable Care Act (ACA) and the Delivery System Incentive Payment (DSRIP) program. With the passage of the ACA, and the imminent transition to Medicaid managed care, the service delivery system is now in the process of extraordinary change to address quality of care and contain costs. Under DSRIP, the primary goal is to reduce unnecessary hospitalizations with a major focus on expanding the capacity and quality of community based providers with a significant focus on the integration of healthcare.

This will result in a greater demand for licensed professionals as behavioral and physical healthcare providers coordinate quality care. In addition, it is expected that there will be an increase in the need to access specialty care, including mental health, in order to achieve the goal of reduced hospitalizations in accordance with the objectives of DSRIP. These changes are likely to result in an increase in the number of individuals to be served, while the licensed workforce continues to reduce in size.

Currently, the State is in the process of approving Health and Recovery Plans (HARPs), which will manage care for adults with significant behavioral health needs. In addition to the State Plan Medicaid services offered by mainstream Managed Care Organizations (MCOs), qualified HARPS will offer access to an enhanced benefit package comprised of Home and Community Based Services (HCBS) designed to provide the individual with a specialized scope of support services not currently covered under the State Plan. Organizational change and restructuring of this magnitude imposes a substantial challenge on both the State and providers’ limited resources and workforce capacity.

In addition, if the “scope of practice” exemption were to lapse, not only would there be inadequate numbers of licensed professionals to provide needed services, but the increased cost to the State to replace unlicensed staff with licensed individuals in community-based programs would be approximately \$61.9 million annually. If state-operated programs are included, the total cost of the elimination of the “scope of practice” exemption for OMH alone is estimated to be approximately \$74.6 million

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annually. (These estimated costs do not include any potential increase in fringe benefits, lost revenue to programs as new employees are hired and phasing in a new client caseload, costs for training or annualized costs.) The overwhelming reimbursement mechanisms for these services are funded from public sources, including Medicaid, Medicare, and State deficit financing.

It is notable that the 2013 SED survey responses comprise less than 10 percent of the impacted programs and services under the agency's jurisdiction and therefore do not accurately reflect the services that unlicensed individuals provide. While OMH operates, regulates, approves, or funds approximately 4,500 programs, only 392 programs responded to the SED survey. Regardless, if the survey results are extrapolated for the purposes of meaningful analysis, the continued need for the exemption is necessary since nearly 50 percent of the restricted functions, excluding diagnosis, are provided by unlicensed practitioners.

It is not believed, nor does the evidence demonstrate, that ending the exemption would result in better client outcomes. OMH has a sophisticated regulatory, licensing, and monitoring apparatus to ensure that providers furnish high quality and cost effective behavioral health services.

Finally, as we conclude the current evaluation period:

- Very little has changed concerning the lack of availability of licensed practitioners
- Dramatic changes occurring in behavioral healthcare delivery will have a major impact on increasing demand
- The significant shortfall in both fiscal resources and licensed practitioners to deliver the needed services will undermine the State's efforts to effectively redesign the Medicaid system of care
- The education and licensing system require further time to train and license sufficient practitioners to replace and/or retrain and credential currently unlicensed individuals in exempt settings

Due to concerns about professional workforce shortages, financial constraints and dramatic changes to the behavioral healthcare delivery system, OMH recommends a permanent extension with a review in five years to address the new needs arising from the effects of the above constraints in conjunction with the upcoming changes.

OMH's mission is to promote the mental health of all New Yorkers, with a particular focus on providing hope and recovery for adults diagnosed with serious mental illness and children diagnosed with serious emotional disturbance. To achieve this, OMH has a dual role as the lead authority for the public mental health system to (1) set policy and provide funding for community services and (2) operate inpatient and outpatient services. Consistent with the practice of mental health evaluation, diagnosis and treatment, the OMH vision has evolved over time to one that today is more community-oriented and recovery-focused. OMH has the responsibility for the development,

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regulation, and funding of an organized community-based system of treatment, rehabilitation, and support services for individuals with serious mental illness and for children with serious emotional disturbances. This system serves more than 700,000 individuals annually in approximately 4,500 programs operated, regulated, funded, and approved by OMH (Attachment A). The emphasis on recovery-oriented services is central to achieving quality outcomes and to advancing New York State's behavioral health mission and vision.

Over the past 30 years, OMH has been transforming the delivery of mental health services through deinstitutionalization to reinvestment in increased community based services. During this time, Medicaid, the major funder of behavioral health services, had continued payments on a fee-for-service basis. As the behavioral health system focused on reinvestment and expanding community services, the importance of fully integrating individuals with serious mental illness into the community became paramount. At the same time, there has been an increasing recognition of the importance of coordination and integration of physical and behavioral healthcare, both for the purpose of addressing the whole individual, and for maximizing healthcare resources. Thus the State has been moving definitively towards incorporating behavioral health services into comprehensive Medicaid managed care plans, which will be responsible for individuals' physical and behavioral health services.

Background

In 2002, in response to concerns about the delivery of poor quality behavioral health services by some unqualified individuals in the private sector, New York State implemented legislation to strengthen the licensure requirements for mental health professionals. The Education Law had previously authorized the licensure of psychologists and certified social workers and protected those titles. The legislation:

- provided a defined scope of practice for psychologists;
- replaced a single certified social worker licensure with two new licensed titles; and
- created four new licensed titles but limited scope of practice professions.

The legislation provided for exemption to the licensure requirements for staff who were performing any of the restricted activities while employed in programs that were operated, regulated, funded or approved by delineated state agencies or local governments. The legislative exemption also recognized the regulatory and quality oversight role of OMH. The initial exemption to OMH scheduled to expire in 2010 was found to be valuable, viable and necessary and was extended twice, first to 2013 and later to 2016.

When the licensure law for behavioral health practitioners was passed in 2002, no one envisioned the changes that were coming and its impact on services. Universal health

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insurance coverage under the ACA and the implementation of mental health parity are having a revolutionary impact on the availability and delivery of health and behavioral healthcare services. One consequence is that the population being served today represents only a fraction of the population expected to be served in the near future. According to data from the Department of Health (DOH), 768,800 previously uninsured individuals enrolled in a health plan through the NYS Health Exchange (Attachment B). In addition to the increasing number of individuals who will have insurance coverage, the Mental Health Parity and Addictions Equity Act (MHPAEA) is expected to also increase the need for behavioral healthcare services.

Substantial treatment of behavioral health disorders have gone underdiagnosed due to such factors as a shortage of mental health professionals and the stigma of mental illness. As recognition in the connection between health and behavioral health advances, increasingly new techniques of integrated and collaborative care will create an unprecedented workforce demand in healthcare as well as an increased market for social workers. In addition, the Federal government has changed the definition of home and community-based services that have resulted in an expansion of services provided in local communities. With changes under the ACA and parity law, individuals are now being assessed earlier and receiving treatment for behavioral health issues. As a result of these significant changes in the behavioral healthcare system, there will be a substantial increase in the need for services, while the licensed workforce continues to reduce in size.

DATA COLLECTION FINDINGS

In 2013, the SED developed the Online Survey of Programs and Agencies Exempt from Licensure Laws mandated by Chapter 57 of the Laws of 2013 to collect information from programs and agencies that provide one or more of the five restricted services identified in law. The survey was disseminated statewide to programs that are operated, regulated, approved and funded by the exempt State agencies. OMH partnered with the various provider organizations that encouraged providers to participate and complete the 2013 Survey.

A total of 850 programs from the agencies exempt from licensure laws responded statewide. Specifically for OMH, there were 392 program responders to the survey out of approximately 4,500 OMH programs; this represents a response rate of less than 10 percent. Based on the limited sample of responders, OMH has significant concerns that this does not accurately reflect the vital role unlicensed professionals have in delivering necessary services in the behavioral health care system. In order to best inform policy makers and the decision-making process, additional information is necessary with a more extensive sampling of program responders. Given the small proportion of survey respondents, confusion in data results, and the substantial changes in the service delivery system which will result in an increased demand for services, while simultaneously addressing a decrease in the supply of practitioners, OMH strongly supports a permanent exemption.

Five Survey Services

The survey attempted to capture a snapshot of services that the SED Office of Professions considers to be restricted to licensed individuals. Operating under the current extension of the exemption in the social work law, OMH and its affiliated agencies report they are providing the following services:

- **Diagnosis** – In OMH-licensed programs, physicians are to provide both the diagnosis and authorize treatment. According to SED survey results, 19.4 percent of the respondents reported that unlicensed employees in their program provide diagnosis. The reported prevalence of this practice does not correspond to OMH’s findings in its extensive monitoring and oversight of community providers. The disparity in the findings of this report may be explained by the small sample size, as well as ambiguity about what constitutes “diagnosis”. In many cases, providers may have unlicensed individuals reporting on symptoms identification and not actually diagnosing an individual, but reporting the practice as “diagnosis”.
- **Assessment/Evaluation** – Approximately 50 percent of respondents stated that unlicensed employees provide assessment and evaluation as referenced in the 2013 Survey Response provided by SED. Assessment/Evaluation is provided by a mix of paraprofessional, professional, and licensed staff. Some type of assessment generally occurs in most OMH funded services including: psychological evaluation; psychiatric evaluation; psycho-social assessment; or rehabilitation assessment.
- **Psychotherapeutic Treatment** - Of the 358 respondents, 47.6 percent indicated that unlicensed staff provides psychotherapeutic treatment. The survey did not ask the amount of time the unlicensed individual engaged in psychotherapy or about their supervision. Again it appears that because of the vague definition of psychotherapy, many staff could assume to be providing psychotherapy while being engaged in crisis de-escalation techniques, counseling or behavior modification on a limited basis. In OMH licensed programs, no unlicensed individual performs psychotherapy without the supervision of a licensed professional. OMH’s licensed programs have been competently providing psychotherapy using a multi-disciplinary team model successfully prior to and after the enactment of the “scope of practice” exemption. It should be noted that a significant portion of the licensed professional workforce receives their training in OMH programs.
- **Provision of Treatment Other Than Psychotherapeutic Treatment** – 51 percent of the respondents reported that unlicensed staff do provide treatment other than psychotherapeutic treatment. The OMH service delivery system

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typically provides a wide range of services to individuals living with serious mental illness. Since services are provided in program settings, rather than an individual private practice setting, individuals can receive more comprehensive care, addressing impairments in key life domains.

- **Development of Assessment-Based Treatment Plans** - Almost 50 percent of the respondents indicated that unlicensed staff develop assessment-based treatment plans. Assessment based treatment planning is primarily performed in licensed treatment programs and “service planning” is done predominantly in the case management, residential and rehabilitation programs. While many services provided under the jurisdiction of OMH include similar activities such as screening for co-occurring disorders and gathering health information, such functions are not “assessment based treatment planning.” In the performance of such activities OMH programs use a multi-disciplinary team structure that requires physician sign-off for treatment/service plans.

The statewide survey findings showed that the five restricted activities: assessment/evaluation; diagnosis; assessment-based treatment planning psychotherapy; and treatment, other than psychotherapy, are performed by those in a broad array of titles. There are many titles because they have been integrated into the delivery system bringing a richness of education, experience and diversity to treatment (Attachment C).

In summary, except for diagnosis activity, the percentages of programs reporting unlicensed individuals not performing the other four restrictive activities was virtually equal to those percentage of those programs with licensed individuals performing the four activities. The percentages of those not performing the activities ranged from 49 percent to 52.4 percent. However, a response rate of less than 10 percent does not allow for a valid analysis of the data.

Furthermore, OMH has the authority to make determinations as to the qualifications of the behavioral healthcare workforce in delivering quality services to the needs of the 700,000 individuals served in our system. While the State is undergoing significant efforts to integrate the behavioral and physical healthcare systems, the OMH and DOH service delivery models are not comparable. The types of health care overseen and delivered by these agencies are distinctively different and OMH has a highly developed infrastructure to regulate, monitor, and oversee the delivery of quality services. In fact, SED deemed in 2004 it appropriate for unlicensed individuals who were employees of federal, state, county or municipal government or in any other legal settings to perform restricted services.

QUALITY OF CARE ASSURANCE:

Current Public Protection and Quality Standards in OMH

The articulated purpose of the NYS licensing law that created four new mental health practitioners professions was “to protect the public from unprofessional, improper, unauthorized and unqualified” practices (Legislative Intent of Chapter 676 of the Laws of 2002).

Programs operated, funded, and licensed by OMH have long been recognized for accomplishing this important purpose. Moreover, public behavioral health programs provide high quality services which are provided cost effectively and in underserved areas of the State. The current 2014 fiscal climate calls into question the imposition of additional restrictions on the operations of these programs.

Further, public protection by OMH is enhanced by multiple federal, state and county oversight including:

- Federal audits and reviews
- State control agency audits and inspections
- County oversight of mental health programs

OMH employs complex oversight mechanisms to ensure that safe and effective quality services are provided within the various programs that the agency operates, regulates, funds, or approves. This oversight ensures that safe and effective services are provided to the population served whether licensed or non-licensed direct care personnel are providing such services.

Program Certification, Monitoring and Oversight Process

OMH’s Bureau of Inspection and Certification reports that there are 4,500 programs licensed, regulated, or funded by OMH. This includes State and county operated, not-for-profit, and for profit programs. Programs licensed and funded by OMH are subject to oversight, monitoring, and regulation from numerous entities.

Oversight is performed in several ways:

- **Regulation:** OMH has regulatory authority and has established regulations and/or guidance for all licensed programs (e.g., Clinics, CDT, Day Treatment, PROS, IPRT, Partial Hospital, and Residential) and many unlicensed programs (such as case management and supported housing).

OMH regulations require OMH licensed providers to:

- Perform comprehensive assessment;
- Maintain individualized treatment plans;

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- Conduct periodic treatment team meetings and treatment plan reviews;
 - Provide supervisory professional oversight (as contrasted with private independent practitioners where no oversight is required); and
 - Maintain operating policies and procedures, including a staffing plan
- **Prior Approval and Review (PAR) process:** Operators need PAR approval before establishing new programs or substantially changing existing programs. The PAR process includes a review of such areas as operator character and competence, fiscal viability, public need, and charities registration.
 - **Inspection and Certification:** OMH provides ongoing licensure oversight through on-site visits (announced and unannounced). Re-certification visits include a review of clinical practices, staffing credentials, supervision, service utilization, and quality improvement initiatives. The inspection and certification process reviews agency staffing and supervision plans to ensure staff are properly credentialed and trained. OMH policy precludes non-licensed clinical staff performing duties unsupervised.
 - **Balanced Scorecard:** The public sector has the regulatory apparatus that improves the quality and competence of services. The OMH Balanced Scorecard measures and reports on outcomes experienced by individuals served in our public mental health system, results of public mental health efforts undertaken by OMH, and critical indicators of organizational performance. The Scorecard is designed to improve accountability and transparency in New York State government by allowing anyone to use OMH data and to inform decision making and assess the service needs of the community.
 - **Background Checks:** In 2004, legislation was enacted requiring licensed community providers of mental health services to request OMH to conduct criminal background checks of potential staff and volunteers in positions that would involve regular and substantial contact with program clients. This function was transferred to the Justice Center for the Protection of People with Special Needs via the passage of Chapter 501 of the Laws of 2012. In addition, this law further requires providers licensed by OMH to check the Justice Center-maintained Staff Exclusion List prior to hiring an individual in a position involving client contact, and must also screen such candidates through the Statewide Central Register of Child Abuse and Maltreatment.
 - **Enforcement:** OMH Enforcement mechanisms include issuance of Monitoring Outcome Reports, Plans of Corrective Action, fines, license suspensions, and revocation of licenses. OMH may also withhold payments for an agency's repeated non-compliance.

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- **Fiscal Oversight:**
 - **Reimbursement** – OMH establishes Medicaid reimbursement rates for licensed programs and administers State Aid funding to local government. In return, OMH gathers data on services provided by mental health providers.
 - **Contract Oversight** – In addition to Medicaid reimbursement for licensed programs, OMH provides direct contracting and program oversight for many programs.
 - **Accountability** – OMH promotes fiscal viability and accountability in the service delivery system through (a) fiscal reviews and audits and (b) OMH Field Office reviews of fiscal viability through the certification process.

- **County Oversight:** Section 41.13 of the Mental Hygiene Law establishes the powers and duties of local government units in administering local mental hygiene services through planning, oversight, quality assurance, and contracting with voluntary organizations. Examples of oversight of voluntary programs by a local governmental unit per a contract may include the following:
 - Establishing and monitoring program process and outcome objectives;
 - Requiring participation in local Community Service Board meetings to educate and encourage programs' service to specific community needs;
 - Establishing standards and procedure for addressing misconduct and disciplinary measures;
 - Requiring appropriate non-profit corporate compliance plans; and
 - OMH Field Office staff work with county/city government in order to assure adherence to the program model, documentation and meeting contract deliverables.

- **Other State, Federal and Certification Oversight:** In addition to OMH direct oversight, most programs operated or licensed by OMH receive additional oversight from one or more of the following:
 - NYS Department of Health
 - Federal Centers for Medicare and Medicaid Services (audits and inspections)
 - Federal Department of Justice
 - New York State Office of Medicaid Inspector General
 - New York State Office of State Comptroller (program audits)
 - New York State Justice Center for the Protection of People with Special Needs

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- Private Certification Agencies including The Joint Commission, The Commission on Accreditation of Rehabilitation Facilities, and others

Quality Control

OMH is focused on quality in addition to regulation, compliance and oversight. This is done through the use of multidisciplinary teams and standards of care.

- **Multi-disciplinary Teams** – Many OMH licensed and funded programs are structured to build in quality control through the use of multi-disciplinary teams. These teams are composed of a range of staff from psychiatrists to licensed and experienced therapists to trained peers. The strength of the teams is enhanced by strong supervision and sign off by experienced and appropriately licensed team members. Teams use a multi-disciplinary approach to set the direction with the recipient for treatment. Professional staff on the team have overall responsibility for treatment plan implementation.
- **Standards of Care** – OMH has developed clinical standards of care which are essential for access to and quality of care for persons served by licensed clinics that provide mental health services. These represent Interpretive Guidelines that are based on existing OMH regulatory requirements. Such standards of care must be incorporated into the policies of these licensed clinics and be applied consistently throughout the State. The Standards of Care highlight expectations for:
 - Staffing
 - Caseloads
 - Training
 - Tracer Methodology
 - Screening
 - Assessment Domains
 - Best Practices

Complaint Investigation: OMH receives complaints from a variety of sources. It operates a Customer Relations Toll Free Line, which receives approximately ten-thousand calls each year. Complaints frequently arrive at the Customer Relations Line by referral from other agencies and organizations such as police departments, the Justice Center, the Department of Health, and the Office for Persons with Developmental Disabilities. The majority of the complaints come directly by phone. Complaints are also received at each OMH Field Office, at the Office of the Commissioner, and through the Office of Consumer Affairs. Many complaints come to OMH as letters, faxes, email, or from walk-ins.

Complaints are routed and resolved commensurate with the consumer's needs. Simpler complaints are handled by staff of the Customer Relations Line. Complaints

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related to regional service provision are tasked to the Field Offices. All allegations of abuse or neglect are pursued by Clinical Risk Managers and in coordination with the Justice Center. Depending on need, complaints are also routed to other Agencies and Organizations, such as the Department of Health, Child Protective Services, or Community Mobile Crisis Teams, to name just a few.

Incident Reporting: Social Services Law Article 11, Mental Hygiene Law Section 29.29, NCR 14 Part 524: Incident management statutes and regulations are intended to ensure the development, implementation and ongoing monitoring of incident management programs, by individual providers, including robust incident reporting and investigation provisions, with enhanced oversight by the Justice Center. These laws and regulations are designed to ensure the health and safety of clients are protected and to enhance their quality of care.

Mental Hygiene Legal Service (MHLS): The Office of Court Administration funds MHLS to represent, protect and advocate for the rights of people who reside in, or are alleged to be in need of care and treatment in, facilities which provide services for persons with mental disabilities.

INNOVATIONS

Redesign of the Behavioral Healthcare System

The delivery of behavioral health services is undergoing multifaceted and unprecedented change at this time, in part due to the ramifications of the ACA. The implementation of the ACA is being effected by the State's Medicaid Redesign Team (MRT), which has been tasked with changing the paradigm for healthcare delivery. Two major components of the redesign are the movement of the Medicaid behavioral health benefit into managed care and the DSRIP program, both of which are focused on improving quality while decreasing costs. Key to the success of both initiatives will be the increased availability of outpatient behavioral and physical healthcare services, in order to improve individuals' behavioral and general health status, and reduce the need for hospital care.

The vision for Behavioral Health Managed Care is one that provides New Yorkers with fully integrated behavioral health and physical healthcare services offered within a comprehensive, accessible and recovery oriented system. The benefit for people on Medicaid will be dramatically changing, particularly for individuals with high needs.

Medicaid recipients will receive behavioral healthcare through one of two behavioral health managed care models:

- 1) **Qualified Mainstream Managed Care Organizations (MCOs):** For all adults served in mainstream MCOs throughout the State, the qualified MCO will

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integrate all Medicaid State Plan covered services for mental illness, substance use disorders (SUDs), and physical health conditions.

- 2) **Health and Recovery Plans (HARPs)** will manage care for adults with significant behavioral health needs. They will facilitate the integration of physical health, mental health, and substance use services for individuals requiring specialized expertise, tools, and protocols which are not consistently found within most medical plans. In addition to the State Plan Medicaid services offered by mainstream MCOs, qualified HARPs will offer access to an enhanced benefit package comprised of HCBS, such as Community Psychiatric Support and Treatment and Crisis Intervention, designed to provide the individual with a specialized scope of support services not currently covered under the State Plan.

Guiding the reform in the behavioral health system, DSRIP will create sweeping changes in the delivery of services, improving the quality of care while reducing costs. The main objective of DSRIP is to reduce avoidable hospitalizations by 25 percent over 5 years and transform the healthcare system.

Furthermore, a key component of DSRIP is the integration of behavioral and physical healthcare in order to coordinate and deliver services. It is expected that behavioral healthcare recipients will have increased access to primary and specialty care in order to achieve the goal of reduced hospitalizations. Licensed practitioners in the behavioral healthcare system will be highly sought after by physical healthcare providers, thus expanding the demand for licensed professionals and placing additional strain on workforce capacity. In addition, there will be an increased need for behavioral health services and given the limited number of qualified professionals this will put additional vulnerabilities on the mental health system.

Both the movement to managed care and the implementation of DSRIP will result in an increase in the number of individuals in need of services in the community. The State's healthcare system is already stressed by a shortage of licensed professionals and implementation of managed behavioral healthcare and DSRIP provisions will place an additional burden on a vulnerable workforce. If the exemption is not continued the State will be facing a workforce shortage crisis which will inevitably impact the quality of care delivered to the behavioral health population, and the ability of the State to successfully implement these initiatives.

Workforce Shortages

Currently, the number of licensed mental health professionals in NYS is not sufficient to provide necessary services in the public mental health system. While the State embarks on a significant redesign of the behavioral healthcare system and many previously uninsured individuals secure health insurance coverage, additional skilled professionals will be needed to meet the surge in health services for both behavioral

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and physical healthcare. Identified below are a number of factors impacting the current workforce of behavioral health workers resulting in shortages, particularly in certain regions of the State:

- Forty of New York's 62 counties (65 percent) are designated federal and/or state mental health professional shortage areas. The equivalent of 3.1 million individuals, or 16 percent, of the state's population live in those areas (Attachment D).
- Twenty-two counties in NYS that have not been designated as federal mental health professional shortage areas have census tracts, special populations and/or facilities that have been designated as such shortage areas.
- In addition, the licensed mental health workforce in NYS is aging. Statewide, 28 percent are of retirement age (62 years and older), more than half (54.1 percent) of licensed mental health practitioners are over 50 years of age, and only 26.3 percent are under the age of 40. The differences in the size of the retirement populations compared to the population under the age of 40 in these professions poses a discouraging prospect for recruitment. By region, the most severe evidence of recruitment issues for psychologists is in the Hudson River Region and for both LCSWs and psychiatric nurse practitioners in Long Island.
- 67.8 percent of LCSWs are over 50 years old, 37.7 percent are of retirement age, and only 13.1 percent are under 40. This is of particular concern given LCSWs comprise 32.8 percent of all licensed mental health professionals.
- Among psychologists, 63.9 percent are over the age of 50, 38.1 percent are of retirement age, and only 16.8 percent are under 40 (Attachment E).

Both the movement to managed care and the implementation of DSRIP will result in an increase in the number of individuals in need of services in the community. As a result, there will be an inadequate number of licensed mental health staff to serve our behavioral health population. The State's healthcare system is already stressed by a shortage of licensed professionals. Implementation of managed behavioral healthcare and DSRIP provisions will place an additional burden on a vulnerable workforce. If the exemption isn't continued the State will be facing a workforce shortage crisis which will inevitably impact the quality of care delivered to the behavioral health population, and the ability of the State to successfully implement these initiatives.

RESPONSES TO SED CONCLUSIONS - TOPICS FOR DISCUSSIONS

The SED conclusions do not take into account the significant shortfall in providers that would occur as a result of the exemption's sunset in July 2016. In essence, the flat line of growth within the profession has been unaddressed by the occupational education and licensure system. The data reviewed by OMH shows no meaningful growth in the licensed workforce while there will be exponential demand for services.

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Rather than moving in the direction of increasing the workforce, the Professions have focused instead on well-intentioned compulsory continuing education of the current licensed workforce which has provided greater expense and cost to the provider system, without any marginal gains in expanding the licensed workforce (see Cost Considerations below).

The Legislature and Executive have embarked these past four years in a successful strategy of delivering services within the fiscal resources available to the State and without the record deficits of the past. The SED recommendation to increase insurance costs and increase the reimbursement of the limited workforce would damage the Medicaid system at a time when the State has shown success in containing the cost curve while providing effective, high quality services. New York State policy is to both improve outcomes and reduce expenditures. The SED recommendations would increase costs without any significant improvement in outcomes at a very important point in Medicaid and Insurance Reform, especially as the system moves into managed care.

The past repeated sunsets in 2009 and 2012 have not served the system well or more importantly, the patients who are served. The DSRIP proposal will insure quality care with the goal of reducing avoidable hospitalizations by 25 percent over five years while reducing costs. It would be prudent, given the high quality of care now delivered under the exemption at a markedly lower cost, to maintain the exemption without termination, while requiring the agencies responsible for cost effective, high quality care to periodically report on the status of the behavioral health workforce and the State's success in enhancing professionalism in the workforce while maintaining a cost effective program.

COST CONSIDERATIONS

If the exemption were allowed to expire, OMH estimates this would result in a significant fiscal impact to the State totaling approximately \$74.6 million. Currently, there are approximately 4,506 unlicensed professionals in full time titles, employed with community based mental health providers through NYS. It is estimated that the cost of replacing these unlicensed professionals with licensed professionals would total \$61.9 million (Attachment F).

Approximately 560 unlicensed professionals in full time titles are employed with New York State based providers. If OMH had to replace these 560 unlicensed professionals with licensed professionals, the fiscal cost would be an additional \$10 million (Attachment G).

The total fiscal cost to replace 5,066 unlicensed staff is approximately \$72 million. This amount includes fringe benefit rates and indirect costs, however, the total cost does not include costs associated with selecting and training licensed staff. If OMH were to undertake the task of selecting and training licensed staff, the fiscal costs would be staggering.

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Finally, if OMH were to lose its permanent Psychologist exemption in Article 153 of the Education Law, and had to replace all non-licensed psychologists with Licensed Psychologists, it would cost approximately \$2.8 million (Attachment H). This figure does not factor in the cost of having to keep non-licensed psychologists on the payroll and not assigning them protected activities to perform, while replacing each of them with Licensed Psychologists. The \$2.8 million in Psychologist costs would be in addition to the \$10 million identified, which brings the final total to approximately \$74.6 million. Summarized in the table below is the annual fiscal impact if OMH were required to replace unlicensed staff with licensed individuals:

Fiscal Impact of SED Licensure Requirements	
Community-based providers	\$61.9M
State-operated facilities	\$10.0M
Licensed Psychologists	\$2.8M
Total	\$74.6M

SUMMARY AND CONCLUSIONS

As New York State undergoes radical changes to implement managed care, parity and DSRIP over the next several years, the movement of services into the community will create increased demand for services. The aging of the licensed professionals will decrease the supply, aggravating what is already a shortage. The licensure law was designed to create a means of ensuring the provision of high quality behavioral healthcare by preventing unqualified individuals from independently providing services. The exemption was in recognition that there were already safeguards in place in the OMH-licensed provider sector. OMH has a robust program for licensing, monitoring, and oversight that continues to ensure high quality care. The report's findings that individuals have been exceeding their proper scope of practice even under the exemption are not consistent with OMH's findings in the field.

OMH recommends extending the exemption without termination but require periodic reports to the Executive and the Legislature (every 5 years or less after DSRIP) on state agencies efforts to continue to professionalize the delivery system workforce while maintaining high quality, cost effective behavioral health and human services. The ultimate goal is licensure when the ambiguities and contradictions in the current law, that do not now promote high quality, cost effective behavioral health and human services, have been effectively addressed.

ATTACHMENTS

Attachment A – Overview of the Community Based-System

Attachment B – Marketplace Enrollment by Program

Attachment C – Occupational Titles of Individuals Engaged in Each of the Five Functions

Attachment D - Licensed Mental Health Workforce in NYS: Size and Geographic Distribution – August 2014

Attachment E – Licensed Mental Health Professionals in NYS by Age Group as Percentage of Total Number in Specialty 2009 Compare to 2014

Attachment F – Mental Health Professional Licensing Fiscal Impact

Attachment G – State Impact of SED Licensure Requirements

Attachment H – Psychologist Job Rate

Overview of the OMH Community-Based System

OMH has the responsibility for the development, regulation, and funding of an organized community-based system of treatment, rehabilitation, and support services for individuals with serious mental illness and for children with serious emotional disturbances. This system serves more than 700,000 individuals annually.

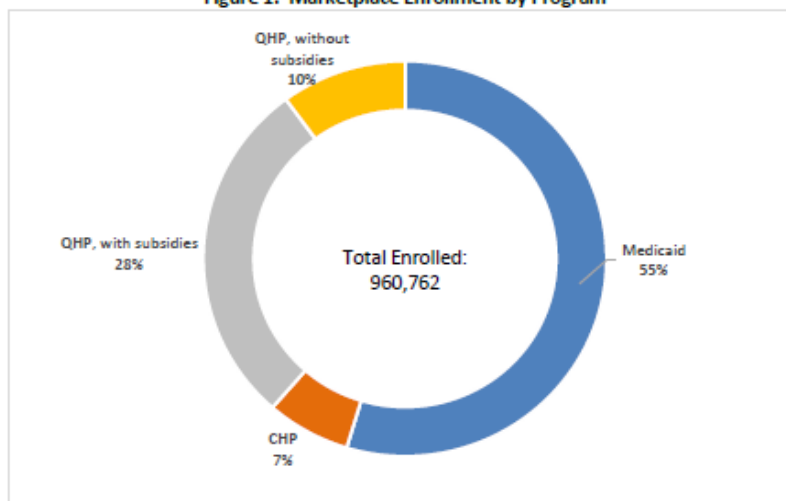
OMH classifies its programs into four major categories: Emergency; Inpatient; Outpatient; and Community Support. Programs may be operated by the State, county, municipality, or not-for-profit agencies.

- **Emergency** programs provide rapid psychiatric and/or medical stabilization while assuring the safety of the individuals who present risk to themselves or others. Programs include local emergency services and comprehensive psychiatric emergency programs (CPEPs).
- **Inpatient** programs are hospital-based psychiatric treatment programs providing 24-hour care in a controlled environment. These may be located in State operated or non-State Operated hospitals. Institutional programs often serve forensic or dually diagnosed populations.
- **Outpatient** programs include assessment, symptom reduction, treatment and rehabilitation in an ambulatory setting or in the community. Programs include Clinic, Partial Hospitalization; Continuing Day Treatment; Day Treatment; Intensive Psychiatric Rehabilitation Treatment (IPRT); Assertive Community Treatment (ACT); and Personalized Recovery Oriented Services (PROS).
- **Community Support Programs** help individuals with severe mental illness with developing the skills and supports to live as independently as possible in the community. Community support services include: ICM/SCM/Blended case management, care coordination, outreach, supported employment, peer support, family support, respite, residential and other services.

**Section 2:
Individual Marketplace**

As of April 15, 2014, 1,319,239 New Yorkers had completed applications and 960,762 people had enrolled in coverage through NY State of Health's Individual Marketplace. This includes 370,604 people who enrolled in QHPs with or without financial assistance, 525,283 who enrolled in Medicaid and 64,875 who enrolled in Child Health Plus. This report offers a snapshot of the nearly 1 million people who enrolled through April 15, 2014.

Figure 1: Marketplace Enrollment by Program



QHP Enrollees by Income

Eligibility for financial assistance available through the Marketplace is based on household income. The Marketplace collects income data only when consumers indicate that they would like to apply for financial assistance. As such, the income data shown below in Figure 2 is for the 273,888 enrollees in subsidized QHPs.

More than half (53 percent) of enrollees in subsidized QHPs have income at or below 200 percent of the Federal Poverty Level (FPL). Nearly one fourth (23 percent) of subsidized QHP enrollees have incomes between 200-250 percent FPL. The remaining 24 percent of QHP enrollees have incomes above 250 percent FPL.

Attachment C

Occupational Titles of Individuals Engaged in Each of the Five Functions:

- Psychologist (MA/MS)
- Psychologist (Ph.D./PsyD)
- Bachelors of Social Work (BSW)
- Masters of Social Work (MSW)
- Social Work Case Manager
- Masters in Mental Health Counseling (MHC)
- Masters in Marriage & Family Therapy (MFT)
- Masters in Creative Arts Therapy (CAT)
- Psychoanalysis
- Rehabilitation Counselor
- Vocational Counselor
- Care Coordinator
- Case Manager
- Case Worker
- Youth Counselor
- Applied Behavior Analyst (ABA)
- Applied Behavior Analyst Assistant (ABAA)
- Counselor or Residential Program Aide
- Mental Health Therapy Aide or Assistant
- Prevention Counselor
- Recreation Therapist
- Service Coordinator
- Correction Officer
- Correction Sergeant
- Correction Captain
- ASAT Program Assistant
- Supervising Correction Counselor (ASAT)
- Supervising Correction Counselor

Attachment D

The Licensed Mental Health Workforce in New York State: Size and Geographic Distribution – August 2014

1. Size of the Mental Health Workforce

In New York State, the licensed MH workforce includes a total of 76,385 psychiatrists, psychologists, clinical or master level social workers, nurse practitioners – psychiatry, marriage and family therapists, mental health counselors, psychoanalysts, and creative arts therapists (Table 1). Licensed master social workers (LMSWs) make up the largest proportion statewide (32.8%), followed closely by licensed clinical social workers (LCSWs, 32.4%), then by psychologists (14.0%), psychiatrists (8.6%), mental health counselors (6.7%), others (3.8%), and nurse practitioners – psychiatry (1.7%). In broad terms, nearly two thirds of the MH workforce in New York State is accounted for by social workers and slightly more than a fifth includes psychologists and psychiatrists.

There is a limitation in this report with regard to describing the MH- psychiatric nurse specialty in New York State. NYS licensing data show only “nurse practitioners-psychiatry” as a MH-psychiatric nurse specialty.

All other nursing specialties that contribute to the licensed MH workforce are combined in the general category of “nurse” in the NYS licensing data and are not counted within the licensed MH workforce described in this report.

Discipline	Number	% of Total
Licensed Master Social Worker (LMSW)	25,086	32.8%
Licensed Clinical Social Workers (LCSW)	24,727	32.4%
Psychologists	10,732	14.0%
Psychiatrists	6,578	8.6%
Mental Health Counseling	5,081	6.7%
Other*	2,889	3.8%
Nurse Practitioners (NP) – Psychiatry**	1,292	1.7%
Total	76,385	100%

*Because of their smaller numbers, marriage and family therapists, psychoanalysts, and creative arts therapists are combined in the "Other" category in this analysis.
**Excludes all MH nurses other than nurse practitioners.

This limitation also extends to other data sources such as professional nursing organizations, which also combine all nursing specialties in a general category of “nurse” in their data collection processes. Therefore at this time it is not possible to identify the statewide population of nurses specializing in psychiatric-MH care.³

¹ Data for psychiatrists is from 2014. Psychiatrist data source: American Board of Psychiatry and Neurology, Inc. (ABPN). Retrieved July 15, 2014 from <https://application.abpn.com/verifycert/verifycert.asp>

² Data for all professions other than psychiatrists is as of June 2, 2014 and was provided by the Office of the

Professions at the New York State Education Department. County of location reflects the licensee's primary mailing address on record with the State Education Department. This address may either be the licensee's home or practice address. Licensees must be registered in order to practice and use a professional title within New York State; being registered, however, does not necessarily mean the licensee is actively engaged in practice.

³ Hanrahan, N., Stuart, G.W., Brown, P., Johnson, M., Draucker, C.B., & Delaney, K. (2003). The psychiatric-mental health nursing workforce: Large numbers, little data. *Journal of the American Psychiatric Nurses Association*, 9(4), 111-114.

Table 2 summarizes the distribution of MH professionals in New York State by discipline and OMH region as a percentage of statewide totals.

OMH Region:	Central		Hudson River		Long Island		New York City		Western		State wide
	N	% Statewide Total	N	% Statewide Total	N	% Statewide Total	N	% Statewide Total	N	% Statewide Total	N Total
Discipline											
LMSW	1,649	6.6%	4,641	18.5%	4,508	18.0%	11,180	44.6%	3,108	12.4%	25,086
LCSW	1,523	6.2%	5,651	22.9%	4,899	19.8%	10,269	41.5%	2,385	9.6%	24,727
Psychologists	471	4.4%	2,336	21.8%	2,092	19.5%	4,979	46.4%	854	8.0%	10,732
Psychiatrists	277	4.2%	1,216	18.5%	912	13.9%	3,691	56.1%	482	7.3%	6,578
Mental Health Counseling	529	10.4%	1,114	21.9%	807	15.9%	1,608	31.6%	1,023	20.1%	5,081
NP – Psychiatry	146	11.3%	285	22.1%	364	28.2%	288	22.3%	209	16.2%	1,292
Other	169	5.8%	483	16.7%	429	14.8%	1,488	51.5%	320	11.1%	2,889
Total	4,764	6.2%	15,726	20.6%	14,011	18.3%	33,503	43.9%	8,381	11.0%	76,385

Except for Nurse Practitioners-Psychiatry, the largest percentages of all MH disciplines are located in New York City. Across regions, the smallest percentages of all MH disciplines are located in the Central region.

Mental Health Professional Shortage Areas in New York State

Maldistributions of mental health professionals in New York State are recognized by designated federal or state mental health professional shortage areas. Table 3 details New York State counties by region and shortage area designations. In the table, counties are designated a New York State Regents Psychiatric Shortage Area by the New York State Education Department as of January 1, 2014.⁴ Counties are designated a federal Mental Health Professional Shortage Area (MHPSA) as of September 1, 2011 by the Bureau of Health Professions at the United States Department of Health and Human Services.⁵ A geographic area will be federally designated as having a shortage of mental health professionals if certain criteria are met as provided by 42 Code of Federal Regulations (CFR), Chapter 1, Part 5, Appendix C (October 1, 1993, pp. 34-48).⁶ In addition, where there is no county wide federal designation, the table indicates whether counties have census tracts, special populations or health care facilities that have been designated federal MHPSAs.

⁴ See <http://www.highered.nysed.gov/kiap/precoll/documents/2013ShortageBulletin.pdf>

⁵ See <http://hpsafind.hrsa.gov/HPSASearch.aspx>

⁶ See <http://bhpr.hrsa.gov/shortage/hpsas/designationcriteria/designationcriteria.html>

**The Licensed Mental Health Workforce in New York State:
Size and Geographic Distribution – August 2014**

Table 3. Number of Licensed Mental Health Professionals by New York State Region and County^{7,8}

OMH Region	County	Federal Mental Health Professional Shortage Area (MHPSA)	Only census tract, populations or facilities with Federal MHPSA designation	NYS Regents Psychiatric Shortage Area	2012 US Census Est. Population	Psychiatrists	Psychologists	LCSWs	LMSWs	Mental Health Counseling	Nurse Practitioner - Psychiatry	Other ⁹	Total	MH Professionals per 10,000 population
Central	Broome	YES		YES	198,060	33	76	257	261	20	18	18	683	34
Central	Cayuga		YES	YES	79,552	4	4	40	51	20	7	5	131	16
Central	Chenango	YES		YES	49,933	0	4	43	33	3	1	3	87	17
Central	Clinton	YES		YES	81,654	13	8	43	32	51	6	4	157	19
Central	Cortland	YES		YES	49,474	3	10	30	41	10	1	1	96	19
Central	Delaware	YES		YES	47,276	0	7	35	23	5	3	5	78	16
Central	Essex	YES		YES	38,961	0	11	29	20	20	2	1	83	21
Central	Franklin	YES		YES	51,795	3	11	28	21	22	2	2	89	17
Central	Fulton	YES		YES	54,925	1	8	26	27	4	3	0	69	13
Central	Hamilton	YES		YES	4,778	0	2	4	4	2	1	0	13	27
Central	Herkimer	YES		YES	64,508	0	1	36	37	5	1	3	83	13
Central	Jefferson		YES	YES	120,262	8	23	50	72	40	6	5	204	17
Central	Lewis	YES		YES	27,224	2	2	7	13	10	1	0	35	13
Central	Madison	YES		YES	72,382	8	19	53	55	14	3	11	163	23
Central	Montgomery	YES		YES	49,941	6	6	19	21	11	3	1	67	13
Central	Oneida	YES		YES	233,556	33	41	199	205	31	24	9	542	23

⁷ Data for psychiatrists is from 2014. Psychiatrist data source: American Board of Psychiatry and Neurology, Inc. (ABPN). Retrieved July 15, 2014 from <https://application.abpn.com/verifycert/verifycert.asp>

⁸ Data for all professions other than psychiatrists is as of June 2, 2014 and was provided by the Office of the Professions at the New York State Education Department. County of location reflects the licensee's primary mailing address on record with the State Education Department. This address may either be the licensee's home or practice address. Licensees must be registered in order to practice and use a professional title within New York State; being registered, however, does not necessarily mean the licensee is actively engaged in practice.

⁹ "Other" category includes Creative Arts Therapists, Marriage and Family Therapists, and Psychoanalysts.

**The Licensed Mental Health Workforce in New York State:
Size and Geographic Distribution – August 2014**

Table 3. Number of Licensed Mental Health Professionals by New York State Region and County^{7,8}

OMH Region	County	Federal Mental Health Professional Shortage Area (MHPSA)	Only census tract, populations or facilities with Federal MHPSA designation	NYS Regents Psychiatric Shortage Area	2012 US Census Est. Population	Psychiatrists	Psychologists	LCSWs	LMSWs	Mental Health Counseling	Nurse Practitioner - Psychiatry	Other ⁹	Total	MH Professionals per 10,000 population
Central	Onondaga		YES		466,852	141	192	462	605	151	51	86	1,688	36
Central	Oswego	YES		YES	121,700	4	13	30	59	42	5	6	159	13
Central	Otsego	YES		YES	61,709	6	17	66	28	14	2	6	139	23
Central	St. Lawrence	YES		YES	112,232	12	16	66	41	54	6	3	198	18
Central	<i>Total Region</i>	13	2	14	1,986,774	277	471	1,523	1,649	529	146	169	4,764	24
Hudson River	Albany				305,455	101	226	468	442	127	41	25	1,430	47
Hudson River	Columbia			YES	62,499	4	32	69	65	9	10	7	196	31
Hudson River	Dutchess		YES		297,322	68	166	513	383	91	33	36	1,290	43
Hudson River	Greene	YES		YES	48,673	3	11	48	40	12	1	3	118	24
Hudson River	Orange		YES		374,512	52	96	438	355	102	18	29	1,090	29
Hudson River	Putnam				99,607	15	53	181	130	37	10	27	453	45
Hudson River	Rensselaer			YES	159,835	7	34	157	183	56	17	8	462	29
Hudson River	Rockland		YES		317,757	135	204	566	495	91	18	48	1,557	49
Hudson River	Saratoga				222,133	35	94	269	224	101	22	16	761	34
Hudson River	Schenectady		YES		155,124	32	54	181	220	76	11	13	587	38
Hudson River	Schoharie	YES		YES	32,099	1	2	19	11	7	2	0	42	13
Hudson River	Sullivan	YES		YES	76,793	3	17	76	63	26	4	4	193	25
Hudson River	Ulster		YES		181,791	33	99	395	229	90	18	41	905	50
Hudson River	Warren		YES	YES	65,538	13	31	68	47	21	9	7	196	30
Hudson River	Washington		YES	YES	62,934	0	6	34	29	9	1	0	79	13
Hudson River	Westchester		YES		961,670	714	1,211	2,169	1,725	259	70	219	6,367	66
Hudson River	<i>Total Region</i>	3	8	6	3,423,742	1,216	2,336	5,651	4,641	1,114	285	483	15,726	46

**The Licensed Mental Health Workforce in New York State:
Size and Geographic Distribution – August 2014**

Table 3. Number of Licensed Mental Health Professionals by New York State Region and County^{1,4}

OMH Region	County	Federal Mental Health Professional Shortage Area (MHPSA)	Only census tract, populations or facilities with Federal MHPSA designation	NYS Regents Psychiatric Shortage Area	2012 US Census Est. Population	Psychiatrists	Psychologists	LCSWs	LMSWs	Mental Health Counseling	Nurse Practitioner - Psychiatry	Other ³	Total	MH Professionals per 10,000 population
Long Island	Nassau		YES		1,349,233	579	1,226	2,551	2,356	455	129	249	7,545	56
Long Island	Suffolk		YES		1,499,273	333	866	2,348	2,152	352	235	180	6,466	43
Long Island	<i>Total Region</i>	0	2	0	2,848,506	912	2,092	4,899	4,508	807	364	429	14,011	49
NYC	Bronx		YES		1,408,473	200	205	810	1,417	130	30	44	2,836	20
NYC	Kings		YES		2,565,635	398	872	2,396	3,404	442	73	367	7,952	31
NYC	New York		YES		1,619,090	2,650	3,254	4,970	3,564	548	108	865	15,959	99
NYC	Queens		YES		2,272,771	362	528	1,624	2,328	398	57	188	5,485	24
NYC	Richmond		YES		470,728	81	120	469	467	90	20	24	1,271	27
NYC	<i>Total Region</i>	0	5	0	8,336,697	3,691	4,979	10,269	11,180	1,608	288	1,488	33,503	40
Western	Allegany	YES		YES	48,357	0	15	14	18	28	3	2	80	17
Western	Cattaraugus	YES		YES	79,458	3	8	33	46	32	2	1	125	16
Western	Chautauqua		YES	YES	133,539	4	8	60	111	55	3	5	246	18
Western	Chemung	YES		YES	88,911	16	12	75	89	24	3	4	223	25
Western	Erie		YES		919,086	179	308	809	953	369	52	50	2,720	30
Western	Genesee		YES	YES	59,977	1	5	35	52	13	4	3	113	19
Western	Livingston		YES	YES	64,810	0	10	45	45	16	2	4	122	19
Western	Monroe		YES		747,813	213	330	668	1,091	295	98	176	2,871	38
Western	Niagara			YES	215,124	6	18	96	145	48	5	4	322	15
Western	Ontario		YES		108,519	15	30	100	108	33	13	20	319	29
Western	Orleans	YES		YES	42,836	0	4	13	24	5	0	3	49	11
Western	Schuyler	YES		YES	18,514	0	5	21	15	2	0	2	45	24
Western	Seneca	YES		YES	35,305	3	0	30	19	8	1	1	62	18

**The Licensed Mental Health Workforce in New York State:
Size and Geographic Distribution – August 2014**

Table 3. Number of Licensed Mental Health Professionals by New York State Region and County^{2,4}

OMH Region	County	Federal Mental Health Professional Shortage Area (MHPSA)	Only census tract, populations or facilities with Federal MHPSA designation	NYS Regents Psychiatric Shortage Area	2012 US Census Est. Population	Psychiatrists	Psychologists	LCSWs	LMSWs	Mental Health Counseling	Nurse Practitioner - Psychiatry	Other ⁵	Total	MH Professionals per 10,000 population
Western	Steuben	YES		YES	99,063	8	23	65	64	20	5	4	189	19
Western	Tioga				50,478	4	6	59	47	8	4	6	134	27
Western	Tompkins	YES		YES	102,554	21	62	189	151	22	8	24	477	47
Western	Wayne		YES	YES	92,962	5	6	39	82	35	3	9	179	19
Western	Wyoming	YES		YES	41,892	1	1	25	25	7	1	1	61	15
Western	Yates	YES		YES	25,344	3	3	9	23	3	2	1	44	17
Western	<i>Total Region</i>	10	7	14	2,974,542	482	854	2,385	3,108	1,023	209	320	8,381	28
Statewide		26	20	34	19,570,261	6,578	10,732	24,727	25,086	5,081	1,292	2,889	76,385	39

Table 4 summarizes New York State counties designated as mental health shortage areas by OMH region. As of January 2014, 40 of New York's 62 counties (65%) are designated as shortage areas and 16% of the State's population lives in those areas. Overall, an estimated 3,111,401 people in the State live in designated Federal and/or State mental health shortage areas.

OMH Region	Number of counties	Counties Designated federal and/or state MH shortage areas	Percent of total	2012 US Census Est. Population	Population in shortage designated counties	Percent of region total
Central	20	19	95%	1,986,774	1,519,922	77%
Hudson River	16	6	38%	3,423,742	442,833	13%
Long Island	2	0	0	2,848,506	0	
New York City	5	0	0	8,336,697	0	
Western	19	15	79%	2,974,542	1,148,646	39%
Total	62	40	65%	19,570,261	3,111,401	16%

Nearly a third of counties designated as mental health shortage areas are located in the Central and Western regions. More than three quarters (77%) of the population in the Central region lives in a designated mental health shortage area and more than one third of the population in the Western region lives in a shortage area. In the Hudson River region six counties are designated as mental health shortage areas and 13% of the region's population lives in those areas. No county in New York City or Long Island is designated as a shortage area.

These results should be looked at with caution. As described in Table 3, 22 counties in New York State that have not been designated as federal mental health professional shortage areas have census tracts, special populations and/or facilities that have been designated as such shortage areas. Eighteen of these 22 counties (including all of New York City and Long Island) also have no state mental health shortage designation. The total population in these additional census tracts, special populations or facilities is unknown.

To better understand mental health workforce capacity, it is essential to examine the geographic distribution of the workforce in addition to its size (i.e., number of practitioners). Historically, mental health practitioners have aggregated in areas with better mental health insurance benefits and a more educated population.¹⁰ Research has shown that practitioners tend to cluster in urban and suburban areas, leaving rural and inner-city areas understaffed.¹¹

Table 5. Distribution of Licensed Mental Health Workers Compared to New York State Population by Region

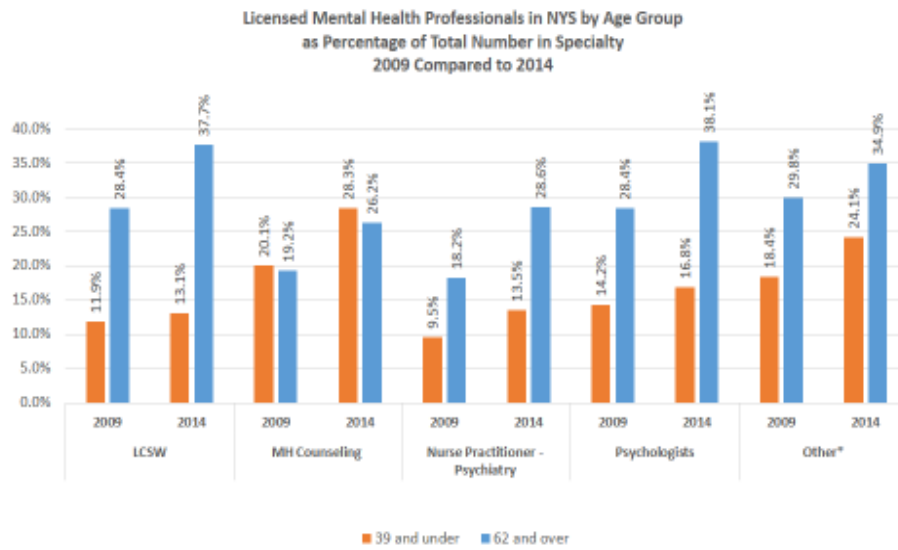
Region	2012 U.S. Census Estimated Population	Percent Total State Population	Percent of Profession, Statewide (N=76,385)							Total % Statewide Workforce
			Psychiatrist	Psychologists	LCSW	LMSW	Mental Health Counseling	Nurse Practitioners – Psychiatry	*Other	
Central	1,986,774	10%	4.2	4.4%	6.2%	6.6	10.4%	11.3%	5.8%	6.2%
Hudson River	3,423,742	17%	18.5	21.8%	22.9%	18.5	21.9%	22.1%	16.7%	20.6%
Long Island	2,848,506	15%	13.9	19.5%	19.8%	18.0	15.9%	28.2%	14.8%	18.3%
New York City	8,336,697	43%	56.1	46.4%	41.5%	44.6	31.6%	22.3%	51.5%	43.9%
Western	2,974,542	15%	7.3	8.0%	9.6%	12.4	20.1%	16.2%	11.1%	11.0%
Statewide Total	19,570,261	100%	100	100%	100%	100	100%	100%	100%	100%

* Others include Creative Arts Therapists, Marriage and Family Therapists, and Psychoanalysts.

As presented in Table 5, this is the case in New York. For example, 56.1% of psychiatrists and 46.4% of psychologists practice in New York City, where 43% of the State’s population resides. In contrast, 4.2% of psychiatrists and 4.4% of psychologists practice in the more rural Central region, where 10% of the State’s population resides. The Central region has the lowest percentage of mental health professionals statewide: overall, 6.2% of the mental health workforce in New York State practices there. The situation is similar in the Western region where 11.0% of the mental health workforce practices and 15% of the state’s population resides. In comparison, in the Hudson River and Long Island regions the percentage of the state’s mental health workforce is greater than the percentage of the state’s population living in those regions.

¹⁰ Knesper, D. J., Wheeler, J. R., & Pagnucco, D. J. (1984). Mental health services providers' distribution across counties in the United States. *American Psychologist*, 39, 1424–1434.

¹¹ Merwin, E., Hinton, I., Dembling, B., & Stern, S. (2003). Shortages of rural mental health professionals.



*Other includes Marriage and Family Therapists, Psychoanalysts and Creative Arts Therapists

Data Source: Office of the Professions, the New York State Education Department.
Prepared by Office of Performance Measurement and Evaluation, NYS Office of Mental Health, November 2014

Attachment G

State Impact of SED Licensure Requirements Office of Mental Health

Current Title / Grade	# of Field Positions	Job Rate	Total Cost for Current Staff	New Title / Grade	Job Rate	Total Cost for Proposed Staff		Job Rate Difference	Total Impact
						Proposed Staff	Job Rate Difference		
Security Hospital Senior Treatment Asst / G-16	77	64,980	5,003,460	Licensed Master Social Worker 2 / G-20	73,519	5,690,293	8,339	657,503	
Recreation Therapist / G-14	91	53,606	4,876,146	Creative Arts Therapist / G-20 *	73,519	6,690,229	19,913	1,812,083	
Senior Recreation Therapist / G-17	79	63,003	4,977,079	Creative Arts Therapist / G-20 *	73,519	5,808,001	10,518	830,922	
Rehabilitation Counselor 1 / G-17	23	63,003	1,449,023	Licensed Master Social Worker 2 / G-20	73,519	1,690,917	10,518	241,914	
Rehabilitation Counselor 2 / G-19	135	70,013	9,451,755	Licensed Master Social Worker 2 / G-20	73,519	9,925,065	3,506	473,310	
Residential Program Specialist / G-16	31	59,628	1,848,778	Licensed Master Social Worker 2 / G-20	73,519	2,279,089	13,881	430,311	
Social Work Assistant 1 / G-12	7	48,078	336,546	Licensed Master Social Worker 2 / G-20	73,519	514,633	25,441	178,087	
Social Work Assistant 2 / G-14	46	53,606	2,465,876	Licensed Master Social Worker 2 / G-20	73,519	3,381,874	19,913	915,998	
Social Work Assistant 3 / G-17	57	63,003	3,591,057	Licensed Master Social Worker 2 / G-20	73,519	4,190,583	10,518	599,526	
Social Worker 1 / G-18	14	66,494	930,916	Licensed Master Social Worker 2 / G-20	73,519	1,029,266	7,025	98,350	
Total	560		34,932,636			41,170,640		6,238,004	

Figure: 3,485,797
Indirect Costs: 317,822
Total Costs: 9,481,622

Assumptions/Notes:
 1. Assume job rates for current positions, at most, current employees have a salary above the minimum, and job rate by percent of salary. * agency has indicated that it is likely these candidates who would qualify for the licensed positions will have the education and experience to warrant a salary above the current job rate. Job rate for PEST G-20 (MSP 2) reflective of MW/2014 is \$73,519.
 2. The Commission Through this does not currently exist; however, we believe that this is would be allocated to G-20 once established.
 3. Total costs include fringe benefits (P/2014 rates \$5,696) and indirect costs (rate 2.8%).

Attachment H

State Impact of SED Licensure Requirements - Psychologists Office of Mental Health

Current Title / Grade	# of Filled Positions	Job Rate	Total Cost/for		New Title / Grade	Job Rate	Total Cost/for		Job Rate Difference	Total Impact
			Current Staff	Proposed Staff			Proposed Staff	Job Rate Difference		
Psychology Assistant 3 / G-16	13	\$9,638	\$775,294		Licensed Psychologist / G-25	\$94,834	\$1,232,842	\$35,196	\$457,548	
Psychologist I / G-21	9	\$77,376	\$696,384		Licensed Psychologist / G-25	\$94,834	\$853,506	\$17,458	\$157,122	
Psychologist 2 / G-23	62	\$85,635	\$5,309,370		Licensed Psychologist / G-25	\$94,834	\$5,879,708	\$9,199	\$570,338	
Associate Psychologist	66	\$85,635	\$5,651,910		Licensed Psychologist / G-25	\$94,834	\$6,259,044	\$9,199	\$607,134	
Total	150		\$12,432,968				\$14,225,100			\$1,792,132

Job Rate to Job Rate

Assumptions/Notes:
 1. Assumed job rate for current positions, as most current employees have a salary above the beginning rate and do not have any proposed staffing, as agency has indicated that it likely these candidates who would qualify for the proposed positions will have the education and experience to warrant a salary above the current job rate. See number 18A1C-251 Licensed Psychologist (effective 04/01/2014) at \$94,834.
 2. Total costs include fringe benefits (using 2014-15 rates 55.88%) and indirect costs (rate 2.58%).
 Existing positions would be replaced by new positions through RE-ALLOCATION, and possibly layoffs (if employment was NOT included).

Fringe: \$1,001,449
Indirect Costs: \$453,441
Total Costs: \$2,258,932

**New York State Office of Temporary and Disability Assistance
Appendix to Unified Statement
Response to SED Report – Office of the Professions as required
pursuant to Chapter 57 of the Laws of 2013**

The following are the NYS Office of Temporary and Disability Assistance's (OTDA's) comments that have been developed in response to the report developed by the New York State Education Department (SED) Office of the Professions pursuant to Chapter 57 of the Laws of 2013.

This document has been designed to provide an overview of how OTDA programs are regulated and administered, and offers comments in response to some of the findings contained in the SED report.

EXECUTIVE SUMMARY

OTDA is responsible for supervising programs that provide assistance and support to eligible low-income families and individuals. OTDA's functions include, but are not limited to, providing temporary cash assistance, assistance with paying for food, and heating assistance; overseeing New York State's child support enforcement program; determining certain aspects of eligibility for Social Security disability benefits and administering a state supplement to federal Supplemental Security Income benefits; supervising homeless housing and services programs; and providing assistance to certain immigrant populations. OTDA's homeless housing/services and immigrant assistance program providers, which are the subject of this statement, are comprised of not-for-profit organizations that contract with OTDA through the Center for Specialized Services (CSS).

CSS consists of four bureaus, all of which deliver services to low-income persons with special needs and/or circumstances. Three of the Center's program areas work with contract agencies that may employ staff performing work addressed by Chapter 57 of the Laws of 2013 and related laws. They are as follows:

Bureau of Housing and Support Services

The Bureau of Housing and Support Services (BHSS) administers an array of programs to address the problems of homelessness in the State. These range from programs to prevent homelessness to the actual construction of housing for homeless individuals and families. Other BHSS programs provide essential services to homeless persons to stabilize their housing situations and increase their levels of self-sufficiency.

BHSS administers the Homeless Housing and Assistance Program (HHAP), as well as a range of support services programs for homeless and at-risk families and individuals, including the Solutions to End Homelessness Program (STEHP), the New York State Supportive Housing Program (NYSSHP), the Operational Support for AIDS Housing Program (OSAH), and the Housing Opportunities for Persons with AIDS Program (HOPWA).

Bureau of Shelter Services

The Bureau of Shelter Services (BSS) is responsible for certification, oversight, and inspection of those emergency shelters in New York State that serve more than 19 single homeless individuals or more than 10 homeless families. BSS works closely with BHSS to coordinate an entire continuum of care for homeless individuals and families with the goal of assisting them in attaining and maintaining housing stability.

Bureau of Refugee and Immigrant Assistance

The Bureau of Refugee and Immigrant Assistance (BRIA) is New York State's single point of contact on policies and programs for the implementation of services to refugees and other eligible immigrant populations. BRIA directs resources to local agencies under contract with OTDA to provide refugees and their families with employment and support services, to assure foster care for unaccompanied refugee minors, to assist victims of human trafficking, and to help repatriated U.S. citizens arrive home safely from abroad. The bureau also promotes access for Limited English Proficient populations to benefits and services through translated materials.

Contract Providers and Job Titles

Unlike many of the agencies temporarily exempt from the requirements of Chapter 57 of the Laws of 2013 and related laws, OTDA's contract agencies have limited ability to bill the Medicaid program or insurance companies for the services they provide, and generally rely upon grants and fundraising to operate. Therefore, OTDA's contracted service providers typically do not follow a strict taxonomy of job titles with corresponding job duties to facilitate medical billing and coding, and employees with a number of different job titles may engage in the exact same activities. To illustrate this point, provided below is a small sampling of the job titles found in various OTDA contract providers' programs for employees who may engage in activities addressed by Chapter 57 and related laws:

1. Housing Case Manager
2. Day Program Coordinator
3. Case Manager
4. Life Skills Coach
5. Housing Advocate
6. Human Potential Advocate
7. Director of Housing
8. Director of Supportive Services
9. Family and Youth Advocate
10. Homelessness Prevention Coordinator
11. Family Service Provider

This list is provided to illustrate the difficulty OTDA's contract providers have in identifying additional titles needing exemption, as well as the difference between the way OTDA's providers deliver services as compared to other exempt agencies. Nevertheless, the providers OTDA contracts with are on the frontlines of the human services industry, working directly with the most marginalized members of our society, and Chapter 57 and

related laws have the potential to dramatically impact their operations, as discussed further below.

DATA COLLECTION FINDINGS

In November 2013, the first SED survey was made available online. Less than a year later, SED requested that a second survey be taken. In both instances, OTDA solicited participation from 365 contracted services providers. Approximately 29 percent of OTDA's providers participated in the first survey and approximately 19 percent of OTDA's providers participated in the second survey. The other State agencies exempt by Chapter 57 of the Laws of 2013 also appear to have had low participation rates by their providers. Consequently, OTDA has concerns about the reliability and validity of the survey responses upon which SED is basing its recommendations.

It is OTDA's position that it is not prudent to make recommendations for an entire category of providers based upon responses obtained from a relatively small number of them. Additionally, the survey permitted participants to skip questions, making the actual participation rate even lower than it appears, meaning very little can be extrapolated from the survey results. In its report to the Legislature, SED frequently uses words like "many" and "most" to describe answers to survey questions. OTDA disagrees with SED's stated conclusions because conclusions based upon responses received from a relatively small percentage of providers cannot be fairly said to accurately describe the current practices of "many" or "most" providers.

In addition, as stated in the above paragraphs, many of OTDA's providers' job titles are not reflected in SED's surveys. Due to the facts that a significant number of OTDA's contract providers are neither eligible for reimbursement from Medicaid nor licensed or certified by another entity, their job titles tend not to be as well-defined as some of the more clinical titles reflected in SED's surveys. OTDA's contract providers use varied names to describe similar jobs, making it difficult to suggest additional titles for exemption.

Chapter 57 of the Laws of 2013 includes clarification and newly identified activities that do not require licensure. Many of the services provided by OTDA's contracted agencies are included in this list, such as: service plans regarding job training and employability, housing, and general public assistance; and de-escalation techniques, peer services, and skill development. These are some of the most essential tasks performed by staff within OTDA's contracted agencies. However, it is clear that continuation of the exemptions, as well as additional clarification of the restricted activities, is needed.

The not-for-profit services providers who responded to the survey provide a wide array of services including the operation of homeless shelters, transitional and permanent supportive housing, homeless services, and refugee services. These services are designed to meet the most basic, and essential needs of clients, such as obtaining safe housing, food, and clothing – needs identified by Abraham Maslow as being lowest on the needs hierarchy. Many of the activities that OTDA's providers engage in can be described using vocabulary similar to that used by clinicians, especially activities related

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to “diagnosis” and “assessment,” but OTDA’s providers do not engage in clinical interventions that should require licensure. Despite SED’s attempts to define such activities, the differences between the meanings of the terms in various settings make it very difficult for providers to discern exactly what is being asked for in the surveys.

In its 2014 survey, SED provided the following description of “treatment other than psychotherapeutic treatment:” “Using psychological interventions to modify behavior for the purposed of preventing or eliminating symptomatic, maladaptive, or undesired behavior; to enhance interpersonal relationships, personal, group, or organizational effectiveness, or work and/or life adjustment; or to improve behavioral or mental health.” The work described above and purported by SED to require licensure, is essential to the functioning of emergency homeless shelters, and transitional housing programs everyday. Teaching and modeling “life skills” such as de-escalation of arguments, use of appropriate interpersonal skills, employment of effective communication strategies and elimination of undesired behaviors is done on a daily basis in those housing settings. OTDA asserts that licensure is not required to assist a consumer in developing these basic skills.

Another description of “treatment other than psychotherapeutic treatment” found in the 2014 Survey of Providers is as follows: “Providing professional clinical interventions or professional counseling services to change or improve a consumer’s behavioral health related to addictions, such as alcohol or substance abuse; compliance with treatment programs for physical illnesses, such as cardiac rehabilitation regimens, or recognizing and controlling behavior leading to spousal or child abuse.” The language used in the preceding description is confusing; although it uses the word “clinical,” it suggests that unlicensed individuals cannot provide informal counseling (e.g., encouraging a client to take his/her medication) and referrals to appropriate providers, services that are integral to OTDA’s contract providers’ work. As previously stated, the staff in OTDA’s contract agencies work hard to provide basic care services to clients. In order to attend to the myriad needs of a client, agency staff make referrals to a variety of services, some of them clinical in nature. Staff members are trained, as is the general public, to notice signs of substance abuse, human trafficking, child abuse, and domestic violence; therefore it is essential that staff members are empowered and trained on how to speak to clients about these issues and make appropriate referrals and linkages. In these situations, it is not treatment that is being provided to consumers, but rather, information about how and when to seek such treatment.

OTDA’s position regarding alternate pathways to licensure is that contract providers’ staffs do not require an alternate pathway to licensure, because they do not require licensure at all. Often times the most effective form of assistance is the peer-to-peer work done by paraprofessionals who were once clients and have successfully established themselves, returning as members of the staff at a facility, or type of facility, they once lived in. This type of work would not be enhanced if done by licensed professionals; in fact it could not be done, because licensed professionals would not have the cultural competence needed to relate the consumers in this manner.

QUALITY OF CARE ASSURANCE

OTDA has considerable regulatory authority over the programs it funds and the agencies with which it contracts. Although OTDA itself does not license its providers or its providers' staffs, it does have several mechanisms in place to ensure that quality services are provided to consumers across New York State. With many providers competing for limited funds, OTDA is able to fund only the best providers in their fields. Moreover, when contracts expire, providers are not guaranteed an "automatic" contract renewal – and if a particular contract provider does not demonstrate excellent performance outcomes, no contract renewal will be forthcoming.

An exhaustive application and contracting process ensures that the best providers across the state are awarded contracts and funding. Prospective providers submit lengthy applications detailing the processes by which their services will be delivered. OTDA carefully examines all proposed programs, and selects only those that employ evidence-based, proven practices to receive funding. Once the funding decision has been made, measurable outcomes are established and monitored for each selected program.

Throughout the life of a contract, OTDA staff and supervisors monitor the provider through direct visits to occur not less than once a year. At these visits, case files are examined, policies and procedures are discussed, and staff and clients are interviewed. In addition to annual monitoring visits, which are required as a term of the contract, OTDA staff often make additional visits to programs; receipt of a client complaint, a facility emergency, or a change to a term of the contract could also result in a visit by the contract manager or inspector. Following a monitoring visit, the contract manager makes the not-for-profit staff aware of any deficiencies found during the visit, and follows that conversation up with a letter, requesting any deficiencies be corrected within 90 days of the issuance of the letter. The contract manager follows up with the agency until the deficiency has been corrected.

As required by New York Codes, Rules and Regulations (NYCRR), OTDA provides oversight and certification for certain types of homeless shelters. Each certified emergency shelter is inspected on an annual basis, as well as in response to complaints. Shelter inspections take place over the course of several days and are performed by highly trained inspectors who are experts in both the programmatic and physical standards that emergency shelters are held to. Following the annual shelter inspection, a report of findings is sent out and a response to the report is required. This response details how a facility plans to correct any cited violations; after any necessary corrective action plan is put into place, OTDA re-inspects the facility to ensure its compliance with this plan.

OTDA provides trainings to emergency shelter staff across the state, and often contracts with experts in the field to ensure the relevance of the trainings it provides. In addition to offering trainings to its emergency shelter providers on a regular basis, OTDA partners with its sister agencies to ensure the dissemination of the most up-to-date and effective information to all its contract providers. Furthermore, OTDA is a member of several interagency task forces, allowing it to provide the best possible oversight and support of

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its contract providers. As noted under Data Collection Findings, above, OTDA's contract service providers do not provide services that should require a license. Therefore, OTDA considers the aforementioned quality assurance measures adequate to protect its consumers and recommends additional clarification of the restricted services identified by SED.

INNOVATIONS

The impact of allowing the expiration of the exemption should be analyzed against the backdrop of efforts currently being undertaken to transform how services are being provided by the health and human services networks of New York State. The behavioral health and health care systems are engaged in several initiatives to promote high quality care, including the ongoing transition to care coordination by health homes and behavioral health organizations as approved by the Medicaid Redesign Team (MRT). OTDA has been a part of many MRT sub-committees and administers several million dollars of MRT funding.

In addition, systemic changes to New York's State's health care system are going to be driven by the Delivery System Reform Incentive Payment (DSRIP) Program. The federal government has awarded New York \$6.42 billion to support projects that will seek to fundamentally restructure the health care delivery system by reinvesting in the Medicaid program, with the primary goal of reducing avoidable hospital use by 25 percent over five years. Services to the homeless and other vulnerable populations are being integrated into many of the local projects commencing across New York. Current trends and improvements to the State's service delivery framework may require flexibility in the parameters used to govern the professions serving as the foundation of our health and human services workforce, in order to ensure that the contemplated changes remain sustainable.

RESPONSES TO SED CONCLUSIONS

In SED's report, under "Topics for Discussion -- Social Work," item "SW1: Clarification of practice," SED concludes that "[the] Board of Regents and Education Department, with the assistance of the State Board for Social Work, will continue to provide further clarification of terms and functions within the law." SED further states that, under some circumstances, "it may be appropriate for the Department to seek amendments to the Education Law to ensure the practice of the professions is consistent with education and examination requirements to protect the public." OTDA strongly supports such clarifications, as discussed above in Data Collection Findings and Quality of Care Assurance, and respectfully suggests that, in addition to consulting with the Board of Regents and the State Board for Social Workers, SED also consult with the affected agencies when seeking amendments to law that may further impact their providers. Moreover, any further clarifications should be accompanied by an appropriate extension of the exemption from licensure to permit affected agencies/individuals to respond to these clarifications.

COST CONSIDERATIONS

Conservatively speaking, OTDA has assessed the fiscal impact of allowing the exemption to expire on its providers to be \$34.1 million on an annual basis. However, this figure takes into consideration only a very small number of positions (“case managers”) and only includes the salary and fringe benefit increases to personnel budgets. In reality, the impact goes deeper than just personnel costs.

Many direct-care employees at OTDA’s not-for-profit agencies have limited or no post-secondary education. Requiring licensure of these employees would require them to attend school for two to four years of additional, full-time education. This would significantly impact New York State’s human services industry because, presently, there are not enough licensed individuals available to fill the void that would result from vacated positions, nor are there enough individuals in the pipeline for immediate licensure. The New York State Civil Service Department reports that SED’s own statistics indicate that, at present, there are not enough licensed providers to fill the void that would be created should the current exemptions sunset. This would affect OTDA’s contract services providers, which currently employ at least 1,800 unlicensed staff persons who may require licensure under SED’s current definitions of restricted activities. These staff members fill critical, immediate needs for New York State’s homeless and at-risk populations, which have reached historic highs.

Allowing the exemption to expire at a time of record-high homelessness among both single individuals and families would devastate the homeless housing service provider community. Requiring that these staff members become licensed would also require their employers to raise salaries in order to remain competitive. Many of the positions that would be affected currently require only a high school diploma, or an Associate’s Degree; to require licensed individuals fill these positions could result in much more than a \$15,000 per year increase in salary. This type of pay-rate change could cripple the already struggling not-for-profit sector and, even more importantly, result in literally thousands of homeless single individuals and families having no place to reside, the social cost of which is incalculable.

SUMMARY AND CONCLUSIONS

In conclusion, OTDA respectfully recommends that the Legislature adopt the current exemptions on a permanent basis. In addition to the issues stated above, permanently extending the exemptions would prevent the affected state and provider agencies from having to revisit this issue continually, while the spirit of the law would be upheld for the reasons it was originally intended: to protect the public from unscrupulous individual practitioners, operating without supervision.

Permanently extending these exemptions would also allow State agencies to continue to regulate their providers, and to ensure they are appropriately and effectively delivering services. Not-for-profit providers are the backbone of OTDA’s services delivery system, with para-professionals and peer employees at the heart of many of their operations. Permanently exempting the providers that are operated, regulated, funded, or approved by affected State agencies would allow providers to continue to serve clients while

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remaining subject to monitoring and regulation by the current system of oversight designed to protect the public.

In the absence of a permanent (or extended) exemption, OTDA recommends additional clarification of the activities that SED has identified as restricted to licensed personnel only. As discussed above, OTDA finds SED's definitions of such activities problematic and maintains that its contracted service providers do not engage in activities that warrant licensure. OTDA welcomes the opportunity to assist with the clarification process.