

**Baseline of Competency:  
Common Licensing Standards for Mental Health Professionals**  
**A Report to the Minnesota Legislature**

Required by Laws of Minnesota 2006, Chapter 267, Article 1, Section 12

**January 15, 2007**



Minnesota Department of **Human Services**

This report is the product of the Mental Health Professional Licensing Standards Task Force and the Minnesota Department of Human Services, Divisions of Adult Mental Health and Children's Mental Health. Recommendations were developed by the Task Force. The report and the study leading to the report were mandated by:  
Laws of Minnesota 2006, Laws 2006, Chapter 267, Article 1, Section 12.

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## Executive Summary

A study ordered by the 2006 Legislature recommends a common set of minimum clinical licensure standards to qualify an individual as a mental health professional regardless of professional discipline. Licensed mental health professionals in Minnesota include psychiatric nursing, clinical social work, psychology, psychiatry, and marriage and family therapy.

The Legislature ordered the study to evaluate the qualifications of licensed mental health professionals regarding requirements for Medical Assistance (MA) reimbursement. Since qualification for MA payment requires mental health licensure, evaluating qualifications for MA reimbursement leads to a study of licensing standards.

Conducting the study was a task force comprising mental health stakeholders already engaged in evaluating licensing standards when the Legislature ordered the study. These stakeholders had come close to agreement on several key issues, which allowed the task force to build on their foundation. Participants included representatives from the mental health licensing boards, professional associations, professional training schools, providers, advocates, and consumer/family groups. The Department of Human Services provided staff and served as host. Some members expressed concerns about the process used to establish the Task Force: shortage of time, licensing boards' participation in planning, and selection of members. Nevertheless, they expressed that the recommendations in the report reflect a serious collaboration among some of the best thinkers of the five mental health professions and the broad mental health community.

### RECOMMENDATIONS

Recommendations reflect a high level of accord across the total mental health community. They establish a baseline of much-needed clinical standards for coursework, supervised practice, and supervision. They are a catalyst for more and better services to clients who need them.

[Effective date recommended is 4 years after enactment, unless specified.]

#### **Recommendation 1. Requirements for Supervised Clinical Practice.**

Licensure in each mental health professional discipline—except Psychiatric Nursing<sup>1</sup>—requires post-graduate supervised clinical experience, as follows:

4,000 hours of supervised, post-Masters degree professional clinical practice in the diagnosis and treatment of child and adult psychosocial function and mental, emotional, and behavioral illnesses and disorders:

- (a) including a minimum of 1,800 hours of direct clinical client contact; and
- (b) including 200 post-Masters degree hours of direct clinical supervision, of which:
  - a minimum of 50% must be one-on-one supervision, of which at least half must be in-person supervision and up to half may be via eye-to-eye electronic media;
  - up to 50% may be via group eye-to-eye electronic media, group in-person, or telephone. (A supervision group shall include a maximum of six supervisees.)E-mail or other electronic text communication is prohibited.
- (c) Supervision must be received under a written agreement and the supervisor must be a mental health professional with at least 2 years of post-licensure experience in the delivery of clinical services in the diagnosis and treatment of mental illnesses and disorders.

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<sup>1</sup> Psychiatric Nursing provides equivalent monitoring and evaluation using other means, as provided in statute.

## **Recommendation 2. Education Requirements for Licensure.**

Licensure requires completion of education requirements, as follows:

Masters or doctoral degree, including field experience, in a clinical discipline recognized by statute as a mental health profession. The overall degree program must include:

360 clock hours or 24 semester credit hours education, minimum, in specified *clinical knowledge areas* to be distributed approximately as follows:

- 30% Diagnostic assessment for child and/or adult mental disorders; normative development; and psychopathology, including developmental psychopathology;
- 10% Clinical treatment planning, with measurable goals;
- 30% Clinical intervention methods informed by research evidence and community standards of practice;
- 10% Evaluation methodologies regarding the effectiveness of interventions;
- 20% Professional values / ethics applied to clinical practice, including cultural context and diversity.

The requirements, all in the specified clinical knowledge areas, may be satisfied by a combination of the following methods:

- accredited Masters-level coursework
- post-graduate coursework
- continuing education units (with a post test and a program description with goals and objectives available for public review) may be used for up to 90 hours or 25% of total education in clinical knowledge areas

## **Recommendation 3: Continuing Education Requirement.**

Licensure requires continuing education, as follows:

Post-licensure, at least 40 hours of Continuing Education are required during each licensure renewal period or continuing education reporting period, of which a minimum of 60% must be in the clinical knowledge areas (defined in Rec. #2).

## **Recommendation 4: Qualifications of a clinical supervisor.**

An individual qualified to provide mental health clinical supervision to persons working toward licensure and to workers who require supervision must:

- (1) be licensed in a mental health discipline as an independent mental health professional;  
and
- (2) be competent, qualified, or certified in the activities being supervised; and
- (3) demonstrate knowledge and skills in clinical supervision by:
  - (a) having completed at least one (1) year of post-licensure experience with at least 1,000 hours in clinical practice, as defined by statute and rule.
  - (b) providing written verification of 30 hours of training in supervision, which may be satisfied by completing accredited coursework or continuing education courses in clinical supervision or verification of approved supervisor status by a licensing board.
  - (c) completing 6 continuing education hours in clinical supervision each licensure renewal period or continuing education reporting period. CEUs may include consultation regarding the practice of supervision.

Each individual providing clinical supervision must be certified, or in some other manner recognized, as a qualified clinical supervisor by the individual's professional licensing board.

**Recommendation 5. Payment for Clinical Supervision.**

Minnesota Health Care Programs should cover payments for mental health clinical supervision as a distinct medically-necessary activity.

**Recommendation 6: *Allied Fields* as a class of mental health professional.**

Eliminate the statutory class of "allied fields" as a category of mental health professional—as defined in the Adult Mental Health Act and Children's Mental Health Act.

(Delete Paragraph (6) in both §245.462, Subd. 18, and §245.4871, Subd. 27.)

[Recommended effective date: Upon enactment]

**Recommendation 7: Follow-up Study on Age-Related Practice Standards.**

The Task Force recommends that the Legislature order a follow-up study to evaluate and make recommendations regarding mental health professionals' scope-of-practice in order to prescribe practice categories by age of the client, namely:

- (a) early childhood mental health,
- (b) children and adolescent mental health,
- (c) adult mental health, and
- (d) geriatric mental health.

[No effective date recommended]

**Recommendation 8: Delete Exception to Psychiatric Nursing Standard.**

Delete language in the in the Adult and Children's Mental Health Acts that permits individuals to function as independent psychiatric nurses without credentialing as Advance Practice Registered Nurses. (Adults—§245.462, Subd. 18; Children—§245.4871, Subd. 27)

Current law permits practice with a master's degree in nursing or one of the behavioral sciences or related fields with 4,000 hours of post-master's supervised experience.

[Recommended effective date: Upon enactment]

**Recommendation 9: Consistent standards across insurers or payors.**

Enact these recommendations consistently across payment sources. Professional qualifications for receiving Medical Assistance reimbursement should be no different than qualifications to receive payments for services provided under the MinnesotaCare, General Assistance Medical Care, or other health care insurance programs. Further, professional qualifications should be undifferentiated between the MA fee-for-service program and managed care programs such as Prepaid Medical Assistance Program (PMAP).

[No effective date recommended]

(NOTE: The focus of the Task Force was development of the recommendations. Participation on the Task Force does not represent endorsement of the descriptive sections of the report.)



# **Baseline of Competency: Common Licensing Standards for Mental Health Professionals A Report to the Minnesota Legislature**

*Baseline of Competency* recommends common standards of qualification for mental health professionals practicing in Minnesota regardless of their professional discipline.

Recommendations were ordered by the 2006 Legislature in a study to evaluate the necessary qualifications of mental health professionals for payment under publicly-financed health care programs. Results were to be reported to the 2007 Legislature.

A variety of disciplines are licensed to practice as mental health professionals under state law. A mental health *professional* is an individual qualified to engage in independent clinical practice; one who is qualified to perform diagnostic assessments and to provide clinical supervision to mental health *practitioners* and to *paraprofessionals*.

Under both the Adult<sup>2</sup> and Children's<sup>3</sup> Mental Health Acts, individuals are qualified to practice as mental health professionals when they meet the qualifications set out in the licensure statute for their clinical discipline. The mental health clinical disciplines are:

1. psychiatric nursing<sup>4</sup>
2. clinical social work<sup>5</sup>
3. psychology<sup>6</sup>
4. psychiatry<sup>7</sup>
5. marriage and family therapy<sup>8</sup> and
6. allied fields, expressly, the behavioral sciences or related fields.

Inconsistent standards across the professional disciplines characterize current licensure laws. In recent years, debate has been rigorous among the disciplines over what education, skills, and experience a clinician must possess in order to provide quality mental health care. While each discipline brings its own unique strengths to the clinical encounter with a mental health client, consensus has evolved within the mental health community that each mental health professional—regardless of discipline—should possess a common and basic set of qualifications: common standards to bolster the safety of mental health consumers and afford them effective high-quality care. Licensing requirements must establish a “knowledge core” across all disciplines of mental health professional. That is, each mental health professional must possess a baseline of clinical competency.

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<sup>2</sup> Minnesota Comprehensive Adult Mental Health Act, Minnesota Statutes 2006, Sections 245.461 to 245.488

<sup>3</sup> Minnesota Comprehensive Children's Mental Health Act, Minnesota Statutes 2006, Sections 245.487 to 245.4887

<sup>4</sup> Minnesota Board of Nursing, M.S., §148.181 - 148.191

<sup>5</sup> Minnesota Board of Social Work, M.S., §148D.025 – 148D.030

<sup>6</sup> Minnesota Board of Psychology, M.S., §148.90

<sup>7</sup> Must be a physician licensed under M.S., §147 and certified by the American Board of Psychiatry and Neurology

<sup>8</sup> Minnesota Board of Marriage and Family Therapy, M.S., §148B.30

## Purpose and Conduct of this Study

Following more than a year of productive but unconcluded debate within Minnesota's mental health community over the appropriate qualifications for mental health professionals, the 2006 Legislature ordered the community to evaluate qualifications necessary for payment under the State's publicly-financed health care programs and to resolve their differences. The resolution was to be reported to the 2007 Legislature in the form of recommendations.

The mandate was given to the Department of Human Services (DHS)—which functions as the State Medicaid Agency and State Mental Health Authority (both under federal law) and as supervisor of local mental health systems (under state law). The study was to be conducted in conjunction with the state's mental health licensing boards, each of which operates under separate statutory authority to oversee mental health professionals practicing within the recognized disciplines. The mandate was as follows:

*Laws 2006, Chapter 267, Article 1, Section 12:*

**Sec. 12. STUDY; REPORT.**

The medical director for medical assistance and the assistant commissioner for chemical and mental health services of the Department of Human Services, in conjunction with the mental health licensing boards, shall evaluate the requirements for licensed mental health practitioners to receive medical assistance reimbursement under Minnesota Statutes, section 256B.0625, subdivision 38. The purpose of this study is to evaluate qualifications of all licensed mental health practitioners and licensed mental health professionals and make recommendations regarding requirements for medical assistance reimbursement. This study is to be completed by January 15, 2007. Written results of the study are to be submitted to the chairs of the house of representatives and senate committees with jurisdiction over health related licensing boards.

Since qualification for MA payment requires mental health licensure, evaluating qualifications for MA reimbursement leads to a study of licensing standards.

The mental health community already had been engaged in evaluating licensing standards when the Legislature ordered the study. To build upon work already done, DHS formed a study group with a roster comprised largely of the diverse group of stakeholders who had been engaged in these discussions over the previous year-and-a-half. This allowed the study group to utilize the Stakeholders' momentum and their familiarity with complex licensure issues from inter-disciplinary points of view. Indeed, the Stakeholders' Group had come close to agreement on several key issues before the 2006 Session began. Participants had gained trust in each other and were eager to finish the job they had started.

Because of the crucial importance of licensing standards for mental health consumers and the public, DHS invited several additional members to ensure a balance of voices across the mental health disciplines and representation of mental health consumers.

Categorically, membership in what was called *The Task Force on Mental Health Professional Licensing Standards* included:

- mental health licensing boards for each discipline,
- mental health professional associations (or professional guilds) for each discipline,
- professional training schools/programs for each discipline,
- mental health advocacy organizations representing both children and adults,

- consumer and family organizations representing both children and adults,
- mental health provider associations,
- a clinical expert,
- the chairwoman of an ad hoc mental health professionals group, and
- DHS staff knowledgeable in mental health and Medical Assistance policy.

The complete roster of Task Force members is attached as Appendix A. Also included is a listing of other key attendees who contributed immensely to the success of this study.

Note: The focus of the Task Force was development of the recommendations. Participation on the Task Force does not necessarily represent endorsement of descriptive sections of the report.

### **Task Force Process**

DHS treated the Task Force as a continuation of Stakeholders' work and constructed agendas based upon the status of discussions at the final Stakeholders Group meeting in Spring 2006: agendas considered agreements already achieved and topics that Stakeholders had identified as needing resolution.

A group process was set up that began developing and reviewing recommendations continually. DHS staff sent proceedings from each meeting to members for redistribution to their respective constituencies: In this way, the mental health community was provided with opportunity to review and respond to each succeeding tentative agreement. Following input from stakeholders, several key agreements were reconsidered between meetings and revised at the next. Constituent boards and associations possessed all substantive recommendations within a week of the final meeting, allowing members nine weeks to review and revise the draft. The Task Force met again to edit a draft report in mid-December and members' comments were incorporated through the second week of January.

Decision-making was by consensus in the beginning. Midway, majority voting was adopted in order to gauge and demonstrate the level of agreement on each recommendation. As it turned out, alliance was strong: the weakest accord was decided by a 3:1 ratio of votes and about half of the polls taken produced no dissenting votes.

Strong final accord cannot be taken as harmony. Discussions produced anxious concerns and strong conflicts. Perhaps the two most serious contentions were, first, from members who are unconvinced that changes to the educational requirements, alone, would produce skillful clinicians and, second, from rural members who were greatly worried that their communities will not have resources necessary to meet enhanced professional standards. In addition, some members voiced distrust as to whether DHS had a "hidden agenda" that would distort this report.

Some members expressed concerns about the process used to establish the Task Force: shortage of time, licensing boards' inclusion in the planning process, and selection of members. Nevertheless, they expressed that the recommendations in the report reflect a serious collaboration among some of the best thinkers of the five mental health professions and the broad mental health community. They expressed appreciation to DHS for creating a forum that supported the development of positive recommendations for clinical educational standards and where participants could debate and collaborate freely.

## Goals of the Task Force

- Evaluate the qualifications of mental health professionals
- Develop common licensing standards, including comparable preparation and competence, for masters-level mental health professionals, while maintaining the uniqueness of the professional disciplines
- Develop professional licensures that comply with Medical Assistance provider requirements and medically-focused federal Medicaid standards
- Enhance qualifications of the mental health workforce and enhance quality of care
- Expand the workforce and access to services
- Provide support for an expected proposal from the Board of Behavioral Health and Therapy to establish a licensure for Professional Clinical Counselors in accordance with the recommendations of this Study
- Make recommendations as a united mental health community
- Comply with the legislative deadline and submit a report by January 15, 2007
- Focus on the most urgent issues within the permitted time frame

**Scope of the Study.** The scope of the Study had to be limited to accommodate the deadline. In planning, DHS saw that it would not be feasible to encompass both mental health professionals and mental health practitioners. Further, DHS believed it prudent to focus attention on those classes of professionals directly affected by the ongoing debate: masters-prepared mental health professionals. With these considerations in mind, DHS set the scope of the Study on masters-level mental health professionals, excluding consideration of:

- Psychiatrists and other medical doctors (MDs)
- Doctoral-prepared Licensed Psychologists (LPs)
- Mental Health Practitioners (who must practice under the clinical supervision of mental health professionals)
- Paraprofessionals, such as mental health behavioral aides (MHBAs) and personal care attendants (PCAs)

Psychiatric nursing presented planners with a quandary. Advanced Practice Registered Nurses (APRNs) with certification in psychiatric/mental health care complete a masters-level education, placing them within the chosen scope of the Study. Yet, comparison of education and clinical preparation models showed that the APRN model for preparation and for determination of clinical competency was different from the approaches used by other disciplines. Additionally, licensing and credentialing of APRNs is significantly different from other providers included in the study. Most important: no one was taking issue with the nurses' qualifications. In the end, Task Force members acknowledged that some of the recommendations would not apply to APRNs—and that nursing preparation unquestionably satisfied the minimum standards the Task Force was contemplating.

## History of the Legislative Study Mandate

Legislation that prompted the *Baseline of Competency* design emerged from a very different kind of idea. In 2005, the Minnesota Counseling Association sought a bill that would offer Medical Assistance coverage for a class of behavioral health workers called Licensed Professional Counselors, or LPCs. A companion proposal sought to change laws defining mental health

professionals such that this group of workers could practice with authority commensurate to the psychiatrists, psychologists, and other mental health clinicians who have qualifications allowing them to diagnose severe mental disorders, supervise complex treatments, and to practice independently of clinical supervision.

Consumers, advocates, providers, other mental health disciplines and their licensing boards, and the state mental health agency opposed the proposals: standards defining LPCs' qualifications do not meet the education and experience necessary under the Adult and Children's Mental Health Acts.

At the urging of the bill authors, these stakeholders gathered during that Session with a charge to produce an acceptable alternative. Early efforts by the stakeholders focused on removing the bills from consideration, revising law related to disciplinary actions against LPCs, and discussing appropriate licensing standards. A notion emerged to create a new tier of licensure, tentatively to be called Licensed Professional Clinical Counselors, or LPCCs. In contrast to LPCs, licensing standards for this new class would ensure education and experience that would emphasize the clinical aspects of professional preparation. Some key agreements were reached and areas of disagreement clarified.

During the 2005-2006 Session Interim, the Board of Behavioral Health and Therapy approached DHS with a legislative proposal to establish the clinical-level of licensure (LPCC). Board representatives came to the Stakeholder Group meetings with the goal of assembling a set of standards comparable to other masters-prepared professionals. Stakeholders considered initial educational requirements proposed by DHS excessively rigorous. BBHT was concerned that imposing standards on professional counselors that were higher than those required for other masters-level professionals would put their discipline at a competitive disadvantage vis-a-vis clinical social workers and marriage and family therapists.

As the 2006 legislative session approached, Stakeholders meetings ended with the Counselors' challenge to the group: *If you are going to raise standards for professional counselors, you need to raise standards for other disciplines.*

All sides agreed to take up the challenge of devising a common set of licensing standards for masters-prepared mental health professionals that would qualify them all as Medical Assistance-eligible providers and improve the overall qualifications of the mental health workforce. So Stakeholders agreed to meet during the next Interim and develop a proposal for the 2007 Session. The original authors of the LPC bills emphasized their expectation for a consensus proposal by ushering through the study mandate that would drive the next phase of development.

In summer 2006 communications with a group of mental health professionals who had participated as members of the stakeholders group, DHS proposed to establish a broad-based task force with membership drawn largely from the Stakeholder group and the Steering Committee. Membership was expanded somewhat in order to achieve balance across the disciplines with regard to licensing boards, professional associations, and professional training schools.

With DHS as host and staff, the Task Force held four intensive meetings in October and November 2006. Without tensions created by a pending bill, members achieved an atmosphere of collegiality and ultimately achieved its goal of bringing forward a roster of common licensing standards, crafted by representatives of the total mental health community including advocate and consumer groups, provider associations, licensing boards, professional associations, educators, and state regulators.



## RECOMMENDATIONS

Recommendations presented by the Task Force reflect a considerable level of accord across the diverse segments of Minnesota's mental health community. Each recommendation is followed by a supporting rationale.

### **Recommendation 1. Requirements for Supervised Clinical Practice.**

Requirements for licensure in each mental health professional discipline—except Psychiatric Nursing—should include a minimum standard for post-graduate supervised clinical experience, as follows:

4,000 hours of supervised, post-Masters degree professional clinical practice in the diagnosis and treatment of child and adult psychosocial function and mental, emotional, and behavioral illnesses and disorders:

- (a) including a minimum of 1,800 hours of direct clinical client contact; and
- (b) including 200 post-Masters degree hours of direct clinical supervision, of which:
  - a minimum of 50% must be one-on-one supervision, of which at least half must be in-person supervision and up to half may be via eye-to-eye electronic media;
  - up to 50% may be via group eye-to-eye electronic media, group in-person, or telephone. (A supervision group shall include a maximum of six supervisees.)Use of e-mail or other electronic text communication for clinical supervision is prohibited.

Supervision must:

- (c) be received under a written agreement that identifies clinical practice and the clinical supervisor (qualified as defined in Recommendation 4) must be a mental health professional with at least 2 years of post-licensure experience in the delivery of clinical services in the diagnosis and treatment of mental illnesses and disorders.
- (d) be distributed over the course of the supervised professional practice.

This requirement does not apply to Advanced Practice Registered Nurses (APRNs). Nursing does not use clinical supervision as defined in the other mental health professions and, instead, provides equivalent monitoring and evaluation of practice by other means defined in statute.

Rationale: This standard would require a newly-graduated clinician to practice for two years under the watchful eye of a clinical supervisor who has assumed full professional responsibility for the new clinician's actions and decisions, and for the services and treatments provided. Further, the supervisor is responsible for the supervisee's training and for evaluating the supervisee's practice. Accepting full professional responsibility means that the license of the clinical supervisor is at risk for errors of the supervisee, providing motivation for careful monitoring and guidance. Only upon completion of such an "apprenticeship" may the new clinician practice independently.

The Effective Date will be four (4) years after enactment of this provision.

## **Recommendation 2. Education Requirements for Licensure.**

Licensure in each mental health professional discipline should include completion of education requirements, as follows:

Masters or doctoral degree, including field experience (e.g., practicum or internship), from an accredited program in one of the clinical disciplines recognized by statute<sup>9</sup> as a mental health profession. The overall degree program must include:

360 clock hours or 24 semester credit hours education, minimum, in specified *clinical knowledge areas* to be distributed approximately as follows:

30% Diagnostic assessment for child and/or adult mental disorders; normative development; and psychopathology, including developmental psychopathology;

10% Clinical treatment planning, with measurable goals;

30% Clinical intervention methods informed by research evidence and community standards of practice;

10% Evaluation methodologies regarding the effectiveness of interventions;

20% Professional values / ethics applied to clinical practice, including cultural context and diversity.

The graduate education requirements may be completed as part of masters-level programs approved by the licensing boards for mental health professionals. The requirements, all in the specified clinical knowledge areas, may be satisfied by a combination of the following methods:

- accredited Masters-level coursework
- post-graduate coursework
- continuing education units (with a post test and a program description with goals and objectives available for public review) may be used for up to 90 hours or 25% of total education in clinical knowledge areas

### Rationale:

Completion of educational requirements and a clinical practicum do not guarantee competent clinical practice. However, they are essential and foundational for clinical preparation. Effective and ethical clinical practice requires mastery of core clinical knowledge, skills, and ethics in the content areas outlined above.

This requirement is expressed in equivalent values of clock hours and semester credits in order to accommodate differing curriculum structures among professional training schools and the varying practices among licensing boards. It is common in psychology programs, for example, to find an entire course devoted to diagnostic assessment: the value of the course toward satisfying the requirement is easily defined in semester credits. In another discipline, one course may comprise components of diagnostics, treatment planning, and professional values. Expressing the value of each component in clock hours allows the school to identify how the course satisfies the requirement. By expressing requirements for the five specified clinical

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<sup>9</sup> M.S., §245.462, Subd. 18, and §245.4871, Subd. 27

knowledge areas as a percentage of the total requirement, the schools and licensing boards may use either approach with identical results.

The Effective Date will be four (4) years after enactment of this provision.

**Recommendation 3: Continuing Education Requirement.**

Requirements for licensure in each mental health professional discipline should include a continuing education requirement, as follows:

Post-licensure, at least 40 hours of Continuing Education are required during each licensure renewal period or continuing education reporting period, of which a minimum of 60% must be in the clinical knowledge areas (as defined in the Recommendation 2, *Education Requirements for Licensure*).

Rationale: New illnesses emerge. Research produces new understandings of illnesses. New treatment methodologies are being developed and new medications are approved. Old skills need honing and new skills make a clinician more effective. New populations arrive, challenging clinicians to learn culturally appropriate methods to treat them. A mental health professional cannot stop learning.

The Effective Date will be four (4) years after enactment of this provision.

**Recommendation 4: Qualifications of a clinical supervisor.**

Qualifications for an individual providing mental health clinical supervision to individuals working toward licensure and to workers who require supervision should be enhanced and standardized in statute and rule, as follows:

An individual qualified to provide clinical supervision must:

- (1) be licensed in a mental health discipline as an independent mental health professional; and
- (2) be competent, qualified, or certified in the activities being supervised; and
- (3) demonstrate knowledge and skills in clinical supervision by:
  - having completed at least one (1) year of post-licensure experience with at least 1,000 hours in clinical practice, as defined by statute and rule.
  - providing written verification of 30 hours of training in supervision, which may be satisfied by completing accredited coursework or continuing education courses in clinical supervision or verification of approved supervisor status by a licensing board.
  - completing 6 continuing education hours in clinical supervision each licensure renewal period or continuing education reporting period. CEUs may include consultation regarding the practice of supervision.

Each individual providing clinical supervision must be certified, or in some other manner recognized, as a qualified clinical supervisor by the individual's professional licensing board.

This provision does not apply to psychiatric nursing, which does not utilize “clinical supervision” in the same manner as the other disciplines.

The Effective Date will be four (4) years after enactment of this provision.

Rationale: Clinical supervision promotes competent and ethical services to clients through development of the clinician’s knowledge, skills, and values. It is an essential professional relationship between a supervisor and a practitioner: the supervisor provides evaluation of and direction to services provided by the practitioner. In emerging treatment methodologies, which increasingly rely on practitioner-level clinicians and paraprofessionals for delivery, more clinical supervisors are needed to oversee workers who require clinical supervision by law. As a result, there are demands for more clinical supervisors with higher skills.

The role of clinical supervision in training clinicians is crucial: Historically, professional preparation has been a shared responsibility of the professional, academia, and the service delivery system. With the non-stop demand to learn emerging research, new treatment methods and technologies, and new skills—health and mental health care professionals spend years in intensive education and closely-monitored skill-building. Upon graduating from school, they move on to an apprenticeship, called supervised practice, where they further refine skills and deepen knowledge under the tutelage of a clinical supervisor. The system shares responsibility for ongoing professional training in the form of the supervisor’s compensation and time commitment.

Unfortunately, the inability to pay for clinical supervision in the midst of overall dwindling resources has forced provider agencies to abandon training and supervision. Training has become the sole individual responsibility of the professional. Many practicing professionals believe that clinical supervision has suffered both in quantity and quality and that the mental health system has lost the “culture of training” that once helped to prepare mental health professionals. Given the complexity of clinical work, client care is compromised.

The role of clinical supervision in delivering newly-emerging treatments will become increasingly important. Supervision has assumed new and larger roles in service delivery as providers seek to make efficient use of insufficient numbers of clinicians. Clinicians and researchers have developed interventions that are effective treatments for particular client populations and that can be delivered to the client by lesser-trained workers. This can stretch resources so long as these workers can rely on the guidance and oversight by mental health professionals specially trained as clinical supervisors. Well-prepared clinical supervision is, and will increasingly become, the medium in which mental health workers perform. Without the clinical expertise of a supervisor attending to both the technical and the relational aspects of treatment, these mid-level workers would not be able to intervene effectively with clients.

**Recommendation 5. Payment for Clinical Supervision.**

Minnesota Health Care Programs should cover payments for mental health clinical supervision as a distinct medically-necessary activity.

State-only funding would be necessary except in the unlikely event that federal reimbursement becomes available for an activity that the federal Medicaid agency historically has considered a cost of doing business.

Rationale: Minnesota’s mental health system is facing an unprecedented demand for clinical supervision: a greater number of clinical supervisors and more highly qualified clinical supervisors. Demands arise both from the deficiencies of the current system and from the promise of the emerging system.

The shortage of mental health professionals is forcing providers to utilize practitioners and paraprofessionals to the greatest extent possible: these are workers who require clinical supervision.

Professional preparation is breaking down from the shortage of clinical supervisors to guide and oversee the on-the-job training components of the state’s partial-apprenticeship training model.

In the future, the mental health system will increasingly utilize clinical supervision as a means to improve efficiency and expand workforce capacity, enhance treatment effectiveness, assure quality, and guide the training and early practice of new professionals.

The Effective Date will be four (4) years after enactment of this provision.

**Recommendation 6: *Allied Fields* as a class of mental health professional.**

Eliminate the statutory class of "allied fields" as a category of mental health professional—as defined in the Adult Mental Health Act and Children's Mental Health Act. Statute provides as follows:

*"Mental health professional" means a person providing clinical services in the treatment of mental illness who is qualified in at least one of the following ways...*

*(6) in allied fields: a person with a master's degree from an accredited college or university in one of the behavioral sciences or related fields, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness."*

The Task Force recommends deletion of Paragraph (6) in both of the following sections: §245.462, Subd. 18, and §245.4871, Subd. 27.

Rationale: The vagueness of this category is harmful to the public. It conveys authority to diagnose and treat children and adults with severe mental disorders to unknown, undefined, and unqualified individuals. The category is dangerous because it fails to clearly circumscribe a class of practitioners or the qualifications of the class. The term “*behavioral sciences*,” itself, is broad enough to include such non-clinical fields as sociology, or anthropology—both of which are unqualified by training and experience to function as mental health professionals. Aggravating the vagueness by adding the phrase “*or related fields*,” renders this provision devoid of any meaning as a professional qualification standard. Yet, by definition as mental health professionals, practitioners in any of these fields possess authority to provide mental health services alongside psychiatrists, doctoral-level psychologists, psychiatric nurses, and others with extensive clinical training.

Historically, the Mental Health Acts used this vague terminology in attempts to extend the mental health work force. Its utility is past, as the mental health system moves to expand its capacity by other, more effective, means.

The Effective Date will be upon enactment of this provision.

**Recommendation 7: Follow-up Study on Age-Related Practice Standards.**

The Task Force recommends that the Legislature order a follow-up study to evaluate and make recommendations regarding mental health professionals' scope-of-practice in order to prescribe practice categories by age of the client, namely:

- early childhood mental health,
- children and adolescent mental health,
- adult mental health, and
- geriatric mental health.

The purpose of the study would be to make recommendations regarding age-specific licensing or certification standards that would be applicable to all mental health professional disciplines without regard to payment source.

The Commissioner of Human Services, with a broad-based stakeholders task force, should be asked to conduct the study. The study would be due to the Legislature at the beginning of the 2009 Session.

Rationale: To be effective, mental health interventions must consider the client's age or, more accurately, the client's developmental level. The meaning of symptoms presented, the nuances of diagnosis, the selection of effective treatments, the nature of clinician-client communication, effectiveness of medications, and approaches to medication management all vary by age.

Developmental variation begins early in life and continues into old age. Children's mental health advocates have long argued that "children are not just small adults" and that children are fundamentally—that is, developmentally—different from adults. In recent years, developmental experts have begun to argue that even a distinction between child and adult mental health is insufficient. "Early childhood mental health" and "geriatric mental health" have emerged from research and best-practice models.

Licensure in most mental health professional disciplines does not recognize developmental differences when setting education and experience requirements for practice.<sup>10</sup> In a common scenario, a professional may complete professional training and supervised practice with a focus on the adult population but, once licensed, the professional may begin an independent practice with a children's population. Despite an expectation that a clinician "must have the knowledge base to support their areas of practice," according to a Task Force member, no proscription exists in most licensures to restrict a caseload.

**Recommendation 8: Delete Exception to Psychiatric Nursing Standard.**

Delete language in the in the Adult and Children's Mental Health Acts that permits individuals to function as independent psychiatric nurses without credentialing as Advance Practice Registered Nurses. Psychiatric/mental health clinical nurse specialists and psychiatric/mental health nurse practitioners meet nationally accepted competency standards and are credentialed to independently provide clinical services to psychiatric/mental health clients. Nurses who are not credentialed as clinical nurse specialists or nurse practitioners are not authorized to provide these services.

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<sup>10</sup> Advanced Practice Registered Nurses are the exception. As noted elsewhere psychiatric nursing certifies practice in age-specific populations.

The phrase proposed for deletion is shown in bold italics:

Both the Adult Mental Health Act (M.S., §245.462, Subd. 18) and the Children’s Mental Health Act (M.S., §245.4871, Subd. 27) define a mental health professional in psychiatric nursing as an individual who has been certified as a psychiatric/mental health clinical nurse specialist or a psychiatric/mental health nurse practitioner ***“or who has a master’s degree in nursing or one of the behavioral sciences or related fields from an accredited college or university or its equivalent, with at least 4,000 hours of post-master’s supervised experience in the delivery of clinical services in the treatment of mental illness;”***

Medical Assistance does not recognize persons defined under this legal exception as eligible providers for payment.

Effective Date: Upon enactment of this provision

**Recommendation 9: Consistent standards across insurers or payors.**

The Task Force supports consistent professional qualification standards regardless of payment source. Clients whose care is covered by Medical Assistance should receive care from professionals who are equally qualified as those professionals who treat non-MA covered clients. “The payor should not drive credentialing,” according to a Task Force member.

Professional qualifications for receiving Medical Assistance reimbursement should be no different than qualifications to receive payments for services provided under the MinnesotaCare, General Assistance Medical Care, or other health care insurance programs. Further, professional qualifications should be undifferentiated between the MA fee-for-service program and managed care programs such as Prepaid Medical Assistance Program (PMAP).

Rationale: The current system includes dysfunctions including cost-shifting between payers, perverse incentives, and gaps in services in which a medically necessary treatment is available under one health care program—but not another. These inefficiencies occur at the expense of the consumers.

Some individuals now enrolled in GAMC and MinnesotaCare have access to needed services only to the extent that funds are available through capped state grants or county funds. As a result, access to mental health services varies from region to region and county to county. Eliminating access and quality discrepancies between health coverage programs is a primary goal of the Minnesota Mental Health Action Group (MMHAG).



## Issues Affecting Mental Health Professional Qualifications

### Enhancing Quality in the Midst of Rural Resource Shortages

The Task Force rejected calls for lower qualification standards in rural communities. All mental health consumers deserve high-quality care from highly-qualified professionals, according to Task Force discussion. No mental health professional should be exempt from education and experience standards, despite resource and workforce shortages.

Members representing “Greater Minnesota” said that setting standards too high could threaten the viability of rural providers. In general, however, rural providers favored high quality standards—so long as implementation dates permit time to enhance their capabilities. “We’re in favor, if you give us time,” said a Mankato participant.

DHS asserted medical and legal principles supporting statewide standards of quality and said that both the Adult and Children’s Mental Health Divisions view any move to lower quality of care in rural communities as unacceptable.

Instead of lowering quality in rural areas, the Task Force supports policies to enhance the number of rural mental health professionals and the quality of the rural workforce, as well as policies to improve access to high-quality care in rural communities.

In particular, the Task Force supports an expected proposal from the Board of Behavioral Health and Therapy to establish a new clinical tier of licensure in the field of Professional Counseling that would satisfy the new standards proposed in this Report. The new class of mental health professionals—to be called *Licensed Professional Clinical Counselors (LPCC)*—could offer a boon of qualified mental health clinicians to Greater Minnesota.

According to DHS, both the Legislature and the Department of Human Services have undertaken recent initiatives to enhance rural access and quality; they include the following:

**Mental health telemedicine implemented.** October 1, 2006, saw the implementation of a new Medical Assistance (Medicaid) benefit covering mental health services provided via interactive video media. The new benefit permits any mental health service otherwise covered as a face-to-face service to be provided via interactive video media unless it is clinically inappropriate; few exceptions are envisioned. Rural and other under-served communities are expected to be the primary beneficiaries of this new benefit.

**Payment for psychiatric consultation implemented.** Another new benefit allows primary care physicians to bill Medical Assistance for consultations with psychiatrists. The benefit was effective October 1, 2006, following enactment by the 2005 Minnesota Legislature. The entire state is expected to gain; in particular, rural and other under-served communities will benefit.

**Integration of mental health and primary care.** Few approaches could expand mental health capacity and broaden access to care more rapidly than expanding the ability of primary care clinics to identify, refer, and provide treatment for mental disorders. For children, primary care is second only to schools in functioning as a nearly-universal point of contact, offering the ability to identify children who may suffer from mental or emotional problems. DHS has taken the following approaches to integrate children’s mental health and primary care:

- Sponsoring trainings for physicians focusing on mental development and on identification of emotional disorders (including the use of specific screening tools and an early childhood diagnostic classification scheme);
- Training primary care physicians in intervention methods;
- Developing a billing mechanism for screening;
- Establishing financial incentives in managed care contracts to perform screenings; and
- Promoting co-location—by placing mental health professionals in primary care staff positions and by building physically-adjointing mental health and primary care practices.

**State-sponsored core training expanding.** Following on the immense success of the Adult Mental Health Division’s *Core Competency Training Program*, the Children’s Mental Health Division of DHS secured funding, in 2006, to develop a training program aimed at providers of children’s mental health services and at parents of children with emotional disturbances. Curricula will be developed around evidence-based practices, Medical Assistance compliance, rehabilitation service-provider certification, cultural competence, and tribal mental health capacity enhancement. The Adult Division continues its training program, will disseminate detailed materials on core competencies for evidence-based practices, and expects to initiate dialogue on curriculum enhancement with mental health professional education programs.

### **Evidence-Based Practices May Impact Future Provider Preparation**

Core competencies for the adult evidence-based practices (EBPs) will not be an issue for licensure in the near future, according to DHS. However, preparation for the delivery of EBPs ultimately will be a necessary component of professional qualifications.

Though EBPs are now “in the infancy of development” in Minnesota, they are part of a commitment shared by the Adult and Children’s Mental Health divisions to a quality workforce of mental health professionals and practitioners. DHS is working with a stakeholders group to define the “core competencies” necessary for professionals and practitioners to competently deliver each specific EBP.

Since the Adult EBP models are designed largely for delivery by practitioner-level clinicians, demands on clinical supervisors are going to increase. Expansion of clinical supervision—both in scope and qualifications—will be crucial over the next three to five years.

### **Context of the Study on Mental Health Licensure**

Consumers’ needs and professional evolution already are driving changes in licensing requirements and professional schools’ curricula.

This Study takes place in the context of ongoing transformation of the mental health system—shaping it from both within and without. From the perspective of the Department of Human Services, the Study’s recommendations are part of a far-reaching strategy to improve the mental health service delivery system with its myriad branches, governing jurisdictions, and fragmented financing.

According to DHS, challenges facing the system include the following:

- Minnesotans with mental illness are suffering from an acute and longstanding shortage of people who have committed themselves to mental health as their field of endeavor. This “workforce shortage” is particularly severe in rural parts of the state and for people whose health coverage is financed publicly. The shortage is inclined against the most highly-trained clinicians. (Psychiatrists and psychologists, particularly those trained to work with children and adolescents, are in the shortest supply.) The system attempts to compensate by stretching clinicians with descending levels of preparation over its growing demands. Ultimately, using workers not qualified for independent practice steals highly-qualified professionals from direct client therapy in order to perform clinical supervision.
- Clients are presenting with more serious conditions. This is especially true of children. Parents, doctors, teachers, and mental health professionals are finding more first-time clients with more severe conditions, at earlier ages, and with fewer compensating environmental supports.
- Even as demands grow, the federal government—the largest funder of public mental health—is placing more stringent constraints on reimbursement and has begun to question the most innovative interventions.

Among the positive forces:

- Treatment methodologies have improved to such an extent that it is now possible for some adults with mental illnesses to look forward to recovery from a condition that heretofore would have confined them to lifelong dependence on social, familial, and economic supports. For children, research-proven treatments now increase their resilience to environmental traumas and ameliorate some conditions before the child reaches maturity.
- Minnesota is in the process of implementing evidence-based practices as research identifies practices that are effective on a wider variety of people and effective with a wider spectrum of conditions. While methodologies differ for adults and children, the goal and expectation is the same: reduction or cessation of mental disorder.
- With more mental disorders being recognized as biologically-based in the physiology or chemistry of the brain—and fewer seen as socially, environmentally, or parentally induced—inroads are being made against social stigma and toward parity between mental and medical health.
- Primary care doctors are learning to treat mental health problems, hiring mental health professionals into their clinics, consulting more often with mental health experts, and locating their clinics within conversational range of mental health clinics—all to address the mental health conditions among their patients that these physicians are increasingly learning to recognize. This serves to extend the capacity of the mental health system
- In fact, DHS is developing a transformation initiative that promises to integrate mental health with the state’s health care system and with local social services. It would utilize the strategies of Minnesota’s ongoing health care reform movement to overcome some of the threats of federal constrictions.

## **Appendix A: Roster of Task Force Members<sup>11</sup> and List of Other Contributors**

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<sup>11</sup> The focus of the Task Force was development of the recommendations. Participation on the Task Force does not necessarily represent endorsement of descriptive sections of the report.

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