Recommendations on Merging the Minnesota Boards of Behavioral Health and Therapy and Marriage and Family Therapy

A Report to the Minnesota Legislature

June 15, 2004

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I. Introduction

In the creation of the Board of Behavioral Health and Therapy (BBHT), the Legislature included as part of the enabling legislation a requirement that the BBHT, in conjunction with the Board of Marriage and Family Therapy (BMFT), provide a report to the Legislature and address a recommendation for the merger of the two boards. Specifically, the Legislature requires that:

> The boards of behavioral health and therapy and marriage and family therapy shall develop recommendations on merging the two boards into one inclusive board that would encompass the regulatory authority for all behavioral therapy licensed occupations. The recommendations shall include a timeline for accomplishing the merger, the possibility of including other occupational-related boards, and all necessary legislative changes. These recommendations shall be submitted to the legislature by January 15, 2004. [1]

This report is submitted in response to the Legislature's mandate.[2]

II. Background
Minnesota Boards of Marriage and Family Therapy and Behavioral Health and Therapy

Forty six states and the District of Columbia currently license marriage and family therapists (MFTs), and forty eight states regulate licensed professional counselors (LPCs).[3] There are several structural models for regulation of LPCs just as there are for MFTs throughout the country. In some cases, MFTs and LPCs are under the jurisdiction of a composite board and members are appointed from each of the respective professions as well as from the public. Independent boards for marriage and family therapy and professional counseling also operate in over 25% of the jurisdictions that regulate LPCs.

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[1] Session Laws 2003, Chapter 118, section 25

[2] The first organizational meeting of the Board of Behavioral Health and Therapy occurred on December 4, 2003. Due to the limited time in which to respond to the Legislature's mandate, by letter dated January 14, 2004, Robert C. Butler, Executive Director of the Board of Marriage and Family Therapy, and Larry Spicer, Interim Executive Director of the Board of Behavioral Health and Therapy, notified the legislative sponsors of the bill and legislative leaders and requested an extension until June 15, 2004, to respond to the mandate (*see* Exhibit "A")

[3] Christopher Faiver, Sheri Eisengart & Ronald Colonna, *The Counselor Intern's Handbook* (3rd ed. 2004)

In 1987, the Minnesota Legislature provided for the licensure of marriage and family therapists, social workers, and the oversight of unlicensed mental health practice under the "Office of Social Work and Mental Health." After three years of operation the Legislature created a task force under the Commissioner of Health to investigate the viability of this structure. Based on the resulting report, the Legislature made social work and marriage and family therapy autonomous boards in 1991. The Board of Marriage and Family Therapy currently licenses and regulates approximately 900 MFTs, staffs a part-time "Executive Aide" (Department of Employee Relations pay scale) and a full-time office manager. Staff members perform the investigative work on complaints that are non criminal/non sexual in nature.

The Board of Marriage and Family Therapy consists of seven members appointed by the governor. Four members are licensed, practicing marriage and family therapists, one member must be engaged in the professional teaching and research of marriage and family therapy, and two members are representatives of the general public who have no direct affiliation with the practice of marriage and family therapy. Marriage and family therapy as defined in statute

> means the process of providing professional marriage and family psychotherapy to individuals, married couples, and family groups, either singly or in groups. The practice of marriage and family therapy utilizes established principles that recognize the interrelated nature of the individual problems and dysfunctions in family members to assess, understand, and treat emotional and mental problems. Marriage and family therapy includes premarital, marital, divorce, and family therapy, and is a specialized mode of treatment for the purpose of resolving emotional problems and modifying intrapersonal and interpersonal dysfunction.[4]

In 2003, the Minnesota Legislature established the Board of Behavioral Health and Therapy to license and regulate professional counselors and alcohol and drug counselors (the

[4] Minn. Stat. section 148B.29, subd. 3

latter group to be regulated by BBHT effective in 2005). The Board first met in December of 2003 and began issuing licenses for professional counselors in May of 2004. It is projected that 500 counseling licenses will be issued by the end of the first year and 1000 by the end of the second. The new board expects to be regulating 2500 or more professionals by the end of its fifth year in operation. The Board of Behavioral Health and Therapy currently employs a full time executive director, a full time licensing coordinator, and a full time communications coordinator. It is anticipated that at least one additional board staff position will be added once the transition of alcohol and drug counselor regulation from the Department of Health is complete.

The Board of Behavioral Health and Therapy consists of thirteen members appointed by the governor. Five of the members are professional counselors licensed or eligible for licensure, five of the members are alcohol and drug counselors licensed under chapter 148C, and three of the members are public members as defined in Minn. Stat. section 214.02. Licensed professional counseling as defined in statute

> means the application of counseling, human development, and mental health research, principles, and procedures to maintain and enhance the mental health, development, personal and interpersonal effectiveness, and adjustment to work and life of individuals and families.[5]

Part of the legislation creating the BBHT included the elimination of the Office of Mental Health Practice (OMHP) in the Minnesota Department of Health to occur on July 1, 2004. This was done in anticipation that the majority of the currently unlicensed mental health practitioners would be eligible for licensure as professional counselors and would become so licensed. However, it has become apparent that only a minority of the currently unlicensed practitioners are eligible for licensure as professional counselors, leaving the

[5] Minn. Stat. section 148B.50, subd. 4 (2003)

majority of such practitioners unregulated. To respond to this potential shortfall in public protection, BBHT supported legislation extending OMHP for one additional year so that the issue of how to deal with unlicensed practitioners could be explored and a solution addressed by the current mental health boards.[6]

III. Board Governance Structure in General

Review of the literature suggests that the issue of board structure is grossly understudied. One of the major reasons for this is that there is considerable state-by-state variation in regulatory models creating difficulty when comparing between and among states. Furthermore, states have failed to conduct controlled studies of the models of board structure they employ at any given time, so there is little historical record of what has worked well over time. In a study prepared for the Minnesota Health Licensing Boards in 2003 to examine governance structure and board effectiveness, Research Analyst Anna Bonelli concluded that:

- ✓ No consensus exists on the most effective board governance structure. There are no universally recognized "best practices" for evaluating board performance.
- ✓ Cost savings from consolidation of boards is inconclusive.
- ✓ The effectiveness of various governance models regarding disciplinary matters remains speculative.
- ✓ Scope of practice disputes can result in a reduction of access to care for consumers. Although there is speculation that consolidation or an oversight board can mitigate these disputes, evidence is sparse.
- ✓ Centralized access to board information can help to address consumer concerns whereas multiple and discreet agencies might increase consumer confusion.

[6] HF2175, signed into law by the Governor on May 29, 2004

- ✓ Board structure should attempt to minimize political bias by having clear lines of accountability and efficacious public representation.[7]

Governance structure for regulating health professionals varies among states with a general trend towards consolidating board functions, staff, and resources from previously autonomous boards. Currently, sixteen states maintain independent occupational licensing boards with four additional states allowing for shared administrative resources among boards. Thirty states have consolidated occupational licensing boards that are part of a centralized agency, and the boards have varying degrees of decision-making authority in these organizational models. While Minnesota health-related licensing boards are set up to operate as autonomous boards, they all are located in the same building and share certain administrative functions.[8]

The primary appeal of board consolidation is potential administrative cost savings. Such savings arguably may be derived from reduced staff and elimination of redundant overhead expenses. Proponents of consolidation also maintain that it provides boards with the opportunity to "promote overlapping scopes of practice and share expertise for like occupations" and "encourage standardization of policies among boards."[9] Opponents of consolidation suggest that it results in the loss of clear lines of authority and decreased control over the allocation of funds, resulting in the licensure fees of one professional license being used to regulate another.

The disciplinary function of boards is at the heart of a board's mission of providing public protection from those practitioners providing sub-standard care. Consolidated boards

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[7] Anna Bonelli, *Health Licensing Boards and Governance Structure—Prepared for the Minnesota Health Licensing Boards,* December 1, 2003, p. 5 (on file with BMFT and BBHT)
[8] Bonelli, pp. 10-11
[9] Bonelli, p. 4

are often viewed as providing objective standardized disciplinary procedures where the bias of professional board members will have less impact. However, some studies indicate that consolidated boards take fewer disciplinary actions than independent boards.[10] Proponents of autonomous boards argue that not only do the investigative procedures across several occupations dilute the staff's expertise but also makes them less effective than if they served one occupation.[11] More importantly, because board consolidation results in fewer board members holding a particular professional license, it may result in the *de facto* vesting of decisionmaking authority in disciplinary matters in these limited few.

Bonelli's findings generally support aspects of the February 1999 Program Evaluation Report on Occupational Regulation prepared by the State of Minnesota Office of the Legislative Auditor. The report contains the following conclusion: "we found no convincing evidence that any particular organizational arrangement or process provides an assured solution to any given problem associated with occupational regulation."[12]

IV. Minnesota's Regulatory Structure

As mentioned above, Minnesota was a pioneer in the trend toward collaboration and shared administrative expenses and services among autonomous boards. In 1990, all health licensing boards were co-located at a single site and began sharing equipment, conference rooms, utility rooms, and other physical space. In 1993, all of the Minnesota health boards joined together to form the "Administrative Services Unit" (ASU), and ASU began providing services to all the health boards in May 1995. The boards' collaborative operational model is based on centralizing business functions in the ASU. The ASU manages payroll and

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[10] Bonelli, p. 22; *Occupational Regulation –A Program Evaluation Report*, Office of the Legislative Auditor, State of Minnesota, February 1999, p. 9

[11] Bonelli, p. 25

[12] *Occupational Regulation –A Program Evaluation Report*, p. 86

personnel functions for all the boards as well assisting boards with purchasing, contracts, Minnesota Accounting and Procurement System (MAPS) entries, budgeting, employee education, computer technology, and assistance and finalizing of each board's biennial report in a common format. ASU prepares a report summarizing the individual health board reports. The individual board reports plus the summary report are published as parts of a combined report. The boards improved their biennial reporting process in response to a discussion in the Legislative Auditor's 1999 report that "well-prepared biennial reports from the boards could be useful to the Governor and the Legislature."[13] In essence, ASU performs common administrative functions for all the boards, leaving individual boards free to concentrate on the technical and unique aspects of licensure and discipline in order to better serve and protect the public.

The health licensing boards also cooperate in other ways to operate with more cost-effectiveness and consistency. The boards address common issues through the Executive Directors Forum, which is a coordinating and planning body voluntarily created by the executive directors of the boards. A representative from the Attorney General's Office also attends the monthly meeting of the Executive Directors Forum. This helps to ensure that the boards receive consistent legal advice and representation in the licensure, complaint investigation, and disciplinary processes. The boards also respond to legislative proposals relating to health occupation regulation through the Council of Health Boards, a consortium voluntarily created by the boards and including both executive directors and board members. At the initiative of the boards, the council now has statutory responsibilities under Minnesota Statutes chapter 214. In addition, the boards created and manage the Health Professionals

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[13] *Occupational Regulation –A Program Evaluation Report*, p. 58

Services Program, a diversion program to assist and monitor health professionals with substance, psychiatric, or physical disorder which could impair their ability to practice safely.

The health boards also share disciplinary investigative costs when a person is licensed by more than one board. There are marriage and family therapists who are also licensed by the boards of psychology, social work, medical practice, or nursing. When common ethical or legal standards are allegedly violated, investigative costs are usually shared. When the BBHT starts issuing its licenses, it too will likely regulate licensees who desire dual licensure with at least one other health-related board.

The boards of Psychology, Social Work, Marriage and Family Therapy, Nursing, and Medical Practice all license persons whose occupations involve providing mental health services. These boards have cooperated on several research and public education issues. Examples include a review of the ethical issues related to internet education and therapy and a "Sex is Never Right" campaign that reviewed the ethical and legal issues related to therapists' sexual contact with clients, interns, and students.

V. Potential Cost Savings in Consolidating the BBHT and BMFT

In the spring of 2004, all of the health-related licensing boards signed long term leases for their office space. The term of the lease agreements is for six years and eight months commencing on June 1, 2004 and continuing through January 31, 2011. The office space for the BBHT was planned to accommodate staff to regulate LPCs and LADCs. The BBHT office does not have adequate work space for additional staff or licensure records for the BMFT. Further, both the BBHT and the BMFT are responsible for paying for their leased space regardless of whether they merge. While it is possible that the boards could

consolidate and have offices on two separate floors, it would not result in any cost savings related to payment for office working space.

It is impossible to predict with any degree of certainty whether cost savings will result from a reduction in staffing levels with a merger of the two boards, especially in light of the anticipated transfer of the regulation of LADCs from the Department of Health to the BBHT in the summer of 2005. It is the committee's view that the staffing level for BMFT will likely remain as it is in order to handle the license regulation duties for the BMFT's 900 licensees.

There will be administrative costs related to a merger between the two boards. Some that can be readily identified include giving written notice to licensees, other interested stakeholders, and the general public; making changes to the web sites for each board, changing the board stationery, reviewing and amending contracts each board has entered into, addressing each board's relationship with testing organizations, issuing new licenses and wall certificates to LMFTs, and training staff members during the transition period. Adding BMFT licensure responsibilities to the BBHT will result in staff members dividing their time to work with each separate class of licensees (LPCs, LADCs, and LMFTs). Developing knowledge and gaining efficiency in regulating more than one profession will likely result in delays in issuing and renewing licenses during the transition and staff training period. It is difficult to put a price tag on these administrative expenses, but the merger is likely to cause at least some frustration for the public, applicants for licensure, licensees, board members and staff.

Eventual cost savings, if any, would not be realized by the state's general fund because the health licensing boards' budgets are outside that fund. The boards' revenues are

generated 100% from fees paid by applicants and licensees. The sole beneficiaries of any costs savings would be licensees through potentially lower licensure fees.

VI. Inclusion of Other Occupational-Related Boards

The Boards of Social Work and Psychology regulate professionals engaged in occupations which include provision of some services similar to those provided by LPCs and LMFTs. It is this committee's view that these boards have been successfully operating as autonomous boards for many years and should remain autonomous. Several thousand licensees would be affected on multiple levels by further consolidation. It is noteworthy that the 1987 Legislature provided for the licensure of marriage and family therapists and social workers, and the oversight of unlicensed mental health practice, under the Office of Social Work and Mental Health. After three years of operation with a multitude of problems, the Legislature created a task force under the Commissioner of Health to investigate the viability of this structure. Based on the resulting report recommendations,[14] the Legislature made social work and marriage and family therapy autonomous boards in 1991. In its first year of independent operation, the BMFT cut its operational expenses by 25 percent. Since 1987, the BMFT has raised its licensure fees only once from $115.00 to $125.00 where it currently stands. This lends support to the findings of other studies that board structure (*e.g.*, consolidation) does not necessarily result in greater efficiency or significant savings. A 1992 publication by the Council of State Governments "cautions policy makers who assume that efforts to reorganize executive branch agencies will result in costs savings" and "the political influences of budget making often result in a negation of savings."[15]

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[14] *Interagency Task Force on Mental Health Regulation: Recommendations for Changes in Minnesota's Mental Health Regulatory System*, Report to the Commissioner of Health and to the Minnesota Legislature, Minnesota Department of Health, Health Systems Development Division; March 1991, pp. 4, 21

[15] Bonelli, pp. 22-23

VII. Necessary Legislative Changes

It is difficult to identify "all necessary legislative changes" as requested by the legislative mandate to do so. However, at least the following statutes will need to be reviewed or amended if a merger of the two boards were to occur: chapters 13 (data practices), 14 (administrative procedures), 148B (each board's practice act), and 214 (occupational regulation). Legislation will need to address abolishing or sunsetting the BMFT. Careful consideration will need to be given to the composition and size of the board that will protect the public through the regulation of LPCs, LMFTs and LADCs. Legislation may also be required granting the consolidated board rulemaking authority to address all the diverse practice issues of each individual licensure group.

VIII. Recommendations and Timeline Should Merger Occur

The following recommendations for legislative consideration are included if a consolidation of the two boards were to occur. A timeline for such a merger is also included. The recommendations are intended to assist in the transition of marriage and family therapy occupational regulation with the board of behavioral health and therapy.

1. It is recommended that a transition committee be created to assist in merging the BMFT with the BBHT. This committee will consist of an equal number of members from each board, as appointed by the board chairs. The executive directors of each board will also serve on the committee. The committee will minimally address and provide recommendations for a) board membership, b) board staffing requirements, c) how to notify affected persons and organizations of the change, d) budget adjustments, and e) identifying and addressing merger impact issues and necessary legislative changes identified in this report.

2. The time-line for such a merger will not exceed one year beyond the effective date of any legislation requiring the boards to consolidate.
3. Current BMFT staffing levels should be maintained and their duties should be dedicated to processing MFT licenses and all other matters related to regulation of MFTs for the one-year transition period.

IX. Conclusion

Many states have moved to consolidate their boards or board functions in the last several decades motivated by a) the expectation of cost savings as a result of economies of scale, b) the prospect for small occupations to share otherwise redundant administrative inputs, c) the opportunity to promote overlapping scopes of practice and share expertise for like occupations, and d) to encourage standardization of policies among boards. Through location in the same building, development of the Administrative Services Unit for sharing services and costs, development of the Executive Directors Forum and the Council of Health Boards, and other interagency activities between boards, Minnesota's health-related licensing boards have demonstrated a spirit of consolidation and shared administrative resources while maintaining the benefits of autonomous board structure and functioning.

Furthermore, although the idea of consolidating smaller boards is theoretically appealing, there is little convincing evidence that one board governance structure is qualitatively more effective than another. As stated in the Minnesota Office of the Legislative Auditor's 1999 study of occupational regulation:

> In sum, despite the flexibility that our federal system allows, no state we studied appears to have solved the subtle yet chronic problems that accompany occupational regulation...We found no convincing evidence that any particular organizational arrangement or process provides an assured solution to any given problem associated with occupational regulation.[16]

[16] *Occupational Regulation –A Program Evaluation Report*, p. 86

Based on a thorough discussion of the issues and a review of literature, including three studies on the subject specific to Minnesota, it is the consensus and recommendation of this committee that a merger of the BMFT and the BBHT will not result in greater efficiency or appreciable cost savings and should not occur at this time.

Minnesota Board of Marriage and Family Therapy
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January 14, 2004

Senator Sheila Kiscaden
G-25 State Office Building
St. Paul, Minnesota 55155

Dear Senator Kiscaden:

In the last legislative session, the new Board of Behavioral Health and Therapy and the Board of Marriage and Family Therapy were mandated to develop recommendations on the merging of the two boards and report to the legislature by January 15, 2004. The legislation creating the new board became effective on July 1, 2003, and it was assumed that six months would be available for that board to become organized and acquainted with state operating procedures prior to the report's due date. However, board membership was only partially appointed when the board held an orientation meeting in December of 2003. As of this date, the board still has not been fully appointed. Thus, it is most difficult to submit an educated report by January 15, 2004.

Both boards believe that a reasoned report can be submitted by June 15, 2004 and hereby request permission to extend the due date.

If there are questions on this matter, please contact either of the undersigned.

Sincerely,

Larry Spicer, DC
Interim Executive Director
Board of Behavioral Health and Therapy
(612) 617-2222

Sincerely,

Robert C. Butler
Executive Director
Board of Marriage & Family Therapy
(612) 617-2220

Exhibit A

The January 14, 2004, letter to Senator Sheila Kiscaden from Larry Spicer and Robert C. Butler was also sent to the following persons:

Representative Jim Abeler
369 State Office Building
St. Paul, Minnesota 55155

Senator Linda Berglin, Chair
Health and Human Services Budget Division
309 Capitol Building
St. Paul, Minnesota 55155

Representative Linda Boudreau, Chair
Health and Human Services Policy Committee
339 State Office Building
St. Paul, Minnesota 55155

Representative Fran Bradley, Chair
Health and Human Services Finance Committee
363 State Office Building
St. Paul, Minnesota 55155

Senator Dick Day, Minority Leader
147 State Office Building
St. Paul, Minnesota 55155

Representative Matt Entenza
House Minority Leader
267 State Office Building
St. Paul, Minnesota 55155

Senator Dean Johnson, Majority Leader
147 State Office Building
St. Paul, Minnesota 55155

Senator Becky Lourey, Chair
Health and Family Security
G-24 Capitol Building
St. Paul, Minnesota 55155

Representative Steve Sviggum
Speaker of the House
463 State Office Building
St. Paul, Minnesota 55155