Sunrise Review Application

1. Provide a statement of support for the regulation, signed by at least ten members of the professional or occupational group for which regulation is sought. Include the name, address, telephone number and organizational affiliation of the person(s) designated to represent the applicant.

   The West Virginia Association of Alcoholism & Drug Abuse Counselors, Inc- hereafter "WVAADC" & the West Virginia Certification Board for Addiction & Prevention Professionals- hereafter "WVCBAPP" are comprised of board members from all over the state. The primary authors of this application are:

   WVAADC contact: Susie Mullens, President; Technology Assisted Care Program Director at First Choice Health System 304-614-7177; email susielmullens@gmail.com and

   WVCBAPP contact: Tammi Lewis, President; Therapist at CAMC Women's & Children's Family Resource Center; 5305 Big Tyler #9 Crosslanes, WV; 304-545-1163; email tlewis68@suddenlink.net

   Both boards have been supplied with the documents and given ample opportunity for input and participation in the application process. Please accept the attached letters of support as the "signatures" required. See Appendix A. For Letters of Support .

2. What is the occupational group for which the applicant is seeking regulation? Is this group known by more than one name?

   This regulation is for alcohol & drug counselors. This group was formerly known as addiction counselors and other names associated are: alcoholism & drug abuse counselors, substance abuse counselors and chemical dependency counselors. The current organization which certifies Alcohol & Drug Counselors is the West Virginia Certification Board for Addiction and Prevention Professionals ("Cert board") which have been the certification body for addiction professionals in WV since 1991. WVCBAPP is the state affiliate of the International Certification and Reciprocity Consortium (IC&RC). Since 1981, the International Certification & Reciprocity Consortium (IC&RC) has protected the public by establishing standards and facilitating reciprocity for the credentialing of addiction-related professionals. Today, IC&RC represents 76 member boards, including 24 countries, 47 U.S. states and territories, all branches of the U.S. military, and five Native American territories.

   IC&RC's credentials include Alcohol and Drug Counselor (ADC), Advanced Alcohol and Drug Counselor (AADC), Clinical Supervisor (CS), Prevention Specialist (PS), Certified Criminal Justice Addictions Professional (CCJP), Certified Co-Occurring Disorders Professional (CCDP), and Certified

Co-Occurring Disorders Professional Diplomate (CCDPD). The organization is currently developing a Peer Recovery Coach (PRC) credential.

IC&RC represents 45,000 reciprocal-level credentialed professionals. Up to half of all substance abuse professionals in the U.S. hold IC&RC certificates.

The other organization which supports WVCBAPP is WVAADC- West Virginia Association of Alcoholism & Drug Abuse Counselors, Inc. which is a membership organization optional for all counselors who are interested in drug & alcohol issues. We are the state affiliate of the National Association of Alcoholism & Drug Abuse Counselors (NAADAC). See appendix B for details about the state and national organizations.

3. Identify the associations, organizations and other groups representing the practitioners in this state and estimate the number of WV practitioners in each group.

WVAADC- West Virginia Association of Alcoholism & Drug Abuse Counselors, Inc. which is a membership organization optional for all counselors who are interested in drug & alcohol issues currently has 147 members.

There are currently 380 Certified Prevention and Addiction Professionals in WV (As of May 2013). There are 5 subgroups represented. 118 Alcohol & Drug Counselors (ADC); 158 Advanced Alcohol & Drug Counselors (AADC); 45 Clinical Supervisors (CS); 47 Certified Criminal Justice Professionals (CCJP); and 12 Certified Prevention Specialists (CPS). The other 5 are "CIS" which is Counselor in Service which was an entry level credential that is no longer recognized.

Credential	Numbers
ADC- Alcohol & Drug Counselor (Bachelor's Level Education)	118
AADC- Advanced Alcohol & Drug Counselor (Master's Level Education)	158
CS-Clinical Supervisor	45
CCJP-Certified Criminal Justice Professional	47
CPS-Certified Prevention Specialist 1 & 2	12

There are other professional associations and licensing boards in WV who may have members who are also included in the above numbers (i.e. members of the WVLPCA, WVCA, WVNASW, etc. and licensees under the WVBEC, WV Board of Examiners for Psychology, etc.) but these other professional associations and licensing boards do not "represent" ADC's, AADC's, CS's & PS's per se. Many of them are eligible for the current certification process and would be eligible for licensure

and/or grandparenting in our proposal. There is no short cut to certification and no other license or certification can be substituted. A grandparenting period and process will be available and can be found within the legislation in item 28. The application and examination process is necessary to establish knowledge and competency in alcohol & drug counseling.

4. Describe the functions performed by members of this occupational group. Note which functions are unsupervised or supervised and by whom, the nature of the supervision, the degree of independent judgment which they are required to exercise, the level of skill and experience required to exercise that judgment. In addition, indicate functions which are similar to those performed by other groups and identify those groups. How do the functions performed by this group vary from other groups' functions.

   There are 12 Core Functions of Alcohol & Drug Counseling according to IC&RC which are recognized as the standard benchmarks to demonstrate knowledge & competency for Alcohol & Drug Counselors. The functions include: Screening, Intake, Orientation of Clients to Program, Assessment, Treatment Planning, Counseling, Case Management, Client Education, Referral, Report Writing & Record Keeping, and Consultation.

   See Attached document from the Substance Abuse & Mental Health Administration (SAMHSA) TAP 21: Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice which can also be accessed at the following link. This document was published in 1998 and the attached summary/preface describes the collaborative partnership and process that resulted in the document which serves to define addictions counseling.
   http://www.kap.samhsa.gov/products/manuals/pdfs/tap21_08r.pdf See Appendix letter C and the entire document is on the attached flash drive.

   All of these functions are supervised by an experienced counselor with appropriate credentials of Clinical Supervisor (CS) or the Advance Alcohol & Drug Counselor (AADC) credential. SAMHSA also created a companion manual which lists competencies necessary for effective supervision in alcohol & drug abuse treatment programs. The document provides administrators with step-by-step guidelines for implementing a comprehensive supervisory training and workforce development component which can be found at the following link.
   http://kap.samhsa.gov/products/manuals/pdfs/tap21_a_08r.pdf See Appendix letter D and the entire document is on the attached flash drive. SAMHSA has an additional document Clinical Supervision and Professional Development of the Substance Abuse Counselor TIP 52
   http://store.samhsa.gov/shin/content//SMA09-4435/TIP52.pdf

   An additional well-accepted training resource for supervisors of alcohol & drug counselors is "Clinical Supervision in Alcohol and Drug Abuse Counseling: Principles, Models, Methods" David J. Powell & Archie Brodsky .

The main purpose of clinical supervision is protection of the client. The nature of supervision is a face to face; one on one supervision relationship with minimum of 1 hour supervision meeting for every 20 hours of direct service provided. The ratio of supervision/direct service time is the same for LPC's & Psychologists under supervision. Methods used within supervision include in vivo (live observation) or audio/ video recorded sessions which are reviewed and critiqued by the supervisor. In addition to the 12 core functions, case consultation, review of documentation, ethical dilemmas and issues related to personal growth and development are also integral issues processed within the supervision relationship. The supervisor credential, "Clinical Supervisor" (CS) requires a separate test. WV LPC's supervisor credential is an ALPS which doesn't include a testing process. WV LPC's & Psychologists are required to take additional continuing education and complete an application process but are not required to take an exam demonstrating their knowledge or competency as is required for the CS. Psychologists are not required to have ongoing continuing education in order to supervise others.

Additional information is attached regarding specific criteria for WV ADC's & AADC's in the Appendix letter E-"Certification Manuals" which are found on the attached flash drive or may be accessed electronically at http://wvcbapp.org/content.aspx?Topic=Resources

Although many of the skills and functions of alcohol & drug counseling are similar to "counseling in general" alcohol & drug counseling is recognized as a distinct profession due to the complexities and physiological impact of the disease of addiction. The Substance Abuse & Mental Health Administration (hereafter SAMHSA) created a document dated September 2010 which is attached in appendix F "Scopes of Practice & Career Ladder for Substance Use Disorder Counseling" the introduction to the document states "the provision of culturally relevant evidence-based practices and the demonstration of significant treatment outcomes depend on an effectively trained and supported workforce" and goes on to say "the substance use disorder treatment field will be held to the same standards and requirements as the primary health field. Therefore, the substance use disorder treatment profession needs to be ready to document and codify its services and service delivery systems". SAMHSA convened key stakeholders to develop this document and they included higher education, the National Association of State Alcohol/Drug Abuse Directors (NASADAD), State Association of Addiction Services (SAAS), the IC&RC, NAADAC, and Addiction Technology Transfer Centers (ATTC).

This document outlines the various levels of practitioner and the scope of practice for each. Each has a recommended education, licensing and credentialing, training and advanced course work, supervised work experience, activities, settings and supervisory responsibilities.

Allow a few analogies: Alcohol & Drug Counseling is to Counseling as School Psychology is to Psychology; both are the practice of psychology and licensed by the WV Board of Examiners of Psychologists but have different scopes of practice, different educational curricula and stand-alone separate licenses. Another example in WV would be the Licensed Marriage & Family Therapist

(LMFT) and the Licensed Professional Counselor (LPC). LMFT's have a different scope of practice & different curricula from the LPC and are licensed separately. The LMFT may see individuals in addition to families & couples. These are "sister" professions but do have credibility as separate licenses. Many states also have mandatory certification for "specialties" rather than separate licenses.

Alcohol & drug counseling not only addresses the intrapsychic or "phase of life" issues that bring many people to counseling but also address co-occurring conditions such as depression, bi-polar disorder, anxiety and others. In fact, the Diagnostic & Statistical Manual which is used to diagnose mental disorders requires clinicians to assess and distinguish whether or not the symptoms are attributable to the use of alcohol or other substances prior to assigning a diagnosis. Further, credentialed alcohol & drug counselors are well aware of "post acute withdrawal symptoms" which may mimic symptoms of other mental disorders. Inaccurate diagnoses may lead to the application of inappropriate therapy or inadequate treatment recommendations.

Addiction is recognized as a threat to public health and can result in functional changes (i.e. unemployment, prostitution, involvement with CPS (child protective services), criminal activity, physiological changes such as HIV, hepatitis, STI's) which don't necessarily impact a client without alcohol or drug addiction at the same rates.

Additionally, alcohol & drug counselors bring an understanding of the pharmacology of addiction which makes them better able to assist the client in recovering from addiction to alcohol and drugs.

Recovery support networks such as Twelve Step groups like Alcoholics Anonymous or Narcotics Anonymous not only have their place in the history and development of addictions counseling as a profession but are unique to the modern day drug & alcohol counselors as adjunctive support systems that assist in the ongoing recovery of the client. Addiction counselors have a thorough knowledge and understanding of the Twelve Steps how to use them in the counseling process and how to help the client use them in their daily lives.

Alcohol & drug counseling has undergone a drastic professionalization since the early days in part due to the technological and medical advances which has provided hard science evidence of addiction as a brain disease. According to Dr. Joan Standora Director of the Chemical Dependency Counseling degree program and Substance Abuse Certificate program at Kingsborough Community College in NY "It is time to take a hard line on advocating the licensing of addiction counseling to reflect a special area of expertise not shared by the generalist counselors. Certainly, with 2.5 million patients requiring some kind of care and approximately 25 million individuals at risk for substance abuse-related problems, there is a strong case for these addiction specialists to become a nationally recognized profession." She goes on to say : "What will be expected of this "expanded workforce?" The possession of credentials, licenses, national standards and outcome measures for

client success is certain." See "PROFESSIONALIZING THE ADDICTION WORKFORCE" Addiction Professional article in Appendix G.

The increased focus In WV on the issues of substance abuse is largely due to the formation of Governor's Substance Abuse Task Force by Governor Tomblin. As you are aware, the Legislature passed Substance Abuse Bill 437 Substance Abuse during the 2011-2012 session. §60A-9-8. Creation of Fight Substance Abuse Fund: "There is hereby created a special revenue account in the state treasury, designated the Fight Substance Abuse Fund, which shall be an interest-bearing account and may be invested in accordance with the provisions of article six, chapter twelve of this code, with interest income a proper credit to the fund. The fund shall consist of appropriations by the Legislature, gifts, donations or any other source. Expenditures from the fund shall be for the following purposes: to provide funding for substance abuse prevention, treatment, treatment coordination, recovery and education." See appendix H for the bill 437.

It is very important to raise awareness of the devastation that is caused by this disease and substance abuse is the "hot topic" and many are advertising themselves as qualified to treat our citizens who are afflicted with alcohol and drug problems. Now more than ever protection of the public should be a priority.

According to the Governor's Comprehensive Substance Abuse Strategic Action Plan:
"To address this problem, the Bureau for Behavioral Health and Health Facilities (BHHF) within the West Virginia Department of Health and Human Resources (WVDHHR) has developed a Comprehensive Substance Abuse Strategic Action Plan. The Plan has four overarching strategic goals to include prevention, early intervention, treatment and recovery services. They are broad in scope to allow for flexibility and change to occur as our system of care evolves. Solving this problem will require different levels of care. We must provide care in our communities, in our state facilities, in our private facilities and even in our homes. We must coordinate our efforts across traditional treatment lines to ensure maximum success. We must be able to measure our results."

Goal number two of the plan: "To achieve effective, high-quality, person-centered substance abuse services, it is necessary to recruit, train and maintain a competent workforce. Efforts to improve existing employee performance are imperative because of ongoing changes from the federal government and other trends in the industry. New research in the prevention and treatment of substance abuse must reach providers in a relevant and affordable manner. It is necessary to partner with practitioners and with higher education to ensure addiction education is included in programs of study. The healthcare community must receive opportunities to learn the most current industry-accepted methods of providing assessments, brief interventions, proper prescribing methods and treatment protocols." These supporting documents can be found in Appendix I.

According to the U.S. Department of Labor, " Employment of substance abuse and behavioral disorder counselors is expected to grow by 27 percent from 2010 to 2020, faster than the average for all occupations. Growth is expected as more people seek treatment for their addictions or other behaviors and drug offenders are increasingly sentenced to treatment rather than jail time." www.bls.gov.

Recent political developments in the U.S. also mean that it is a critical time for the field. Both the Affordable Health Care for America Act of 2010 and President Obama's National Drug Control Strategy have the "potential to transform how the profession is practiced in North America."

5. Describe the client group(s) with which this occupational group deals.

Alcohol & drug counselors potentially deal with all West Virginians as addiction does not discriminate or limit itself by gender, age, or socio-economic status. Prevention and treatment professionals work with individuals, families, employers, veterans, communities and any entity affected by substance-related disorders as defined by the American Psychiatric Association's DSM-IV-TR. See Appendix J.

Alcohol & drug counselors often provide services across the continuum of care usually described as "prevention, early intervention, treatment & recovery". In WV we recognize two levels of Prevention Specialists, I & II and those professionals usually provide services in community organizations to work with environmental strategies to prevent substance abuse. "Prevention is a proactive process which empowers individuals and systems to meet the challenges of life events and transitions, by creating and reinforcing healthy behavior and lifestyles and by reducing risk factors contributing to alcohol, tobacco and other drug usage and other related issues."

Addiction, says Dr. Mark Willenbring, director of Treatment and Recovery Research at the National Institute on Alcohol Abuse and Alcoholism, "is a disorder of young people." The vast majority of people who suffer from addiction encountered the beginnings of their illness when they were teenagers. Ninety-five percent of people who are dependent on alcohol or other drugs started before they were 20 years old.

According to SAMHSA in 2008/2009 the average age of first use of marijuana was 12 years of age.

"About 90% of people with substance abuse dependence disorders started using under age 18 (half under 15) and end up using for several decades." Dr. Michael Dennis, Senior Research Psychologist, Lighthouse Institute.

It is clear that we need to have more addictions counselors providing early intervention services to interrupt the progression of the disease of addiction. WV students, grades 9-12, reported ever using heroin on one or more times during their life is almost double that of the national average.

According to the WV Governor's Substance Abuse Task Force Strategic Action Plan, it is estimated that 152,000 West Virginians over the age of 18 have a substance abuse problem. Drug overdose is the leading cause of death for West Virginians under 45; overdose deaths from 1999-2004 increased by 550%. Senior citizens are at risk for substance abuse and dependence and vulnerable to theft of their prescription medications. "An estimated 3 million American seniors suffer from alcoholism or drug dependency, government reports show. The aging baby boomer population has experts planning for that number to triple by 2020."

WV has the highest annual per capita number of retail prescription drugs filled at pharmacies nationwide. A 2009 umbilical cord study in eight West Virginia hospitals concluded that almost 20% of babies tested had been exposed to drugs. A newer 2010 study revealed that this number had increased in one hospital to 33% (study includes alcohol and other drugs), compared to a national average of 4%."

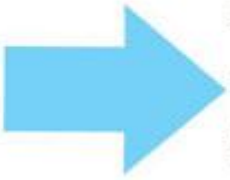
There were almost 8,000 illicit drug arrests in West Virginia in 2009 according to the Governor's Substance Abuse Strategic Action Plan. Currently there are 847 individuals incarcerated in WV State Prisons for Narcotic Drug Offenses which equals 12.4% of the total population and an additional 169 are incarcerated for DUI offenses which is 2.5% of the total population. That doesn't include people in the regional jails, juvenile facilities, those involved diversion programs such as community corrections or probation/parole. Nor does it include those in the federal prison facilities within West Virginia.

6. Describe and provide examples of typical work settings of this group. Alcohol & drug counselors function in many settings such as private practice, community mental health centers, non-profit behavioral health centers, correctional facilities, community corrections programs, DUI programs, drug courts,hospitals, fellowship homes, residential alcohol and drug treatment programs, intensive outpatient alcohol/drug treatment programs and medication assisted treatment centers, Employee Assistance Programs (EAP), college counseling centers, Vet Centers and other Veteran Administration facilities. If you refer to the Substance Abuse Services Directory you will see a plethora of work settings that alcohol and drug counselors may be found. The full directory is located on the attached flash drive. Alcohol & Drug Counselors also utilize a specific set of diagnostic criteria as defined by the Diagnostic & Statistical Manual to diagnose substance abuse & dependence. The American Society of Addiction Medicine designed placement criteria to assist in matching the level of treatment to the severity of the symptoms to assist in a comprehensive plan of care for the client. Alcohol & drug counselors may provide services on an outpatient basis, intensive outpatient basis, inpatient setting and as part of relapse prevention services. See appendix K for the details of the ASAM placement criteria. "The ASAM Patient Placement Criteria

provide separate placement criteria for adolescents and adults to create comprehensive and individualized treatment plans. Adolescent and adult treatment plans are developed through a multidimensional patient assessment over five broad levels of treatment that are based on the degree of direct medical management provided, the structure, safety and security provided, and the intensity of treatment services provided.

Five Levels of Care Assessed Over Six Dimensions

Level 0.5	Early Intervention
Level I	Outpatient Services
Level II	Intensive outpatient/partial hospitalization services
Level III	Residential/inpatient services
Level IV	Medically managed intensive inpatient services



1. Acute intoxication and/or withdrawl
2. Biomedical conditions and complications
3. Emotional, behavioral, or cognitive conditions and complications
4. Readiness to change
5. Relapse, continued use, or continued problem potential
6. Recovery environment

Through this strength-based multidimensional assessment the ASAM Patient Placement Criteria addresses the patient's needs, obstacles and liabilities, as well as the patient's strengths, assets, resources and support structures" (ASAM)

7. Listed below are methods of regulation, starting with the least restrictive method and ending with the most restrictive. Based on the following alternatives, what is the least restrictive method or methods of regulation that will adequately protect the public? Explain the reasons and include examples of regulation from other states.

Certification addresses basic minimum standards and a minimum knowledge base required. Licensure is the highest standard and knowledge base required. Currently certification is not required for social workers, licensed professional counselors, psychologists, marriage and family therapists and other allied professionals who work with those who have alcohol & drug diagnoses. Certification is a voluntary process in WV. We seek to make certification and licensure mandatory for all practitioners who provide counseling and treatment for WV citizens with alcohol and drug related disorders and not allow any practitioner to identify themselves as "alcohol and drug counselors" unless they are certified or licensed at the level for which they are qualified as dictated by education and experience.

Certification- IC&RC is the international credentialing body as previously stated, they credential 76 member boards, including 24 countries, 47 U.S. states and territories, all branches of the U.S. military, and five Native American territories.

Certification is currently voluntary in WV, however half of the areas that border WV require licensure, two require mandatory registration/certification and one has voluntary certification. The states that require registration state within their regulations that certification is a mandatory condition of registration. Representatives from the Pennsylvania Certification Board stated that the providers themselves require counselors to obtain the voluntary certification. "Half of the states (in the U.S.) mandate a specific substance abuse counseling credential, whereas more than 85% of states require a master's degree for the mental health practitioner licensee. It is estimated that there are currently 86,100 individuals working in counseling positions in the labor force; a number of these counselors are not in the substance abuse treatment field per se, but many treat clients with substance abuse disorders" according to Dr. Standora (article in appendix G).

Mandatory certification would be the least restrictive method of regulation however the three states that we share the largest borders with are licensure states. A WV Licensure Board would also allow those licenses to be reciprocated. Theoretically WV Licensure would increase the number of qualified professionals available to treat West Virginians with substance use disorders. Currently there are clinicians who are licensed in other states who practice in WV. Once certified in WV they are not able to bill third party payors or recognized professionally as they are in their home states. Other state's regulations and standards for certification and licensure can be found in Appendix L and many full documents can be found on the attached flash drive.

	WV	Virginia	Ohio	Maryland	District of Columbia	Pennsylvania	Kentucky
Voluntary Certification	X					X	
Mandatory Registration/Certification					X		X
Mandatory Licensure		X	X	X			In process

*DC has mandatory certification for anyone who works for a publicly funded programs or contracts a publicly funded provider.

List of States with certification & licensure. Page numbers relate to the pages in Appendix L. "NATIONAL REVIEW OF STATE ALCOHOL AND DRUG TREATMENT PROGRAMS AND CERTIFICATION STANDARDS FOR SUBSTANCE ABUSE COUNSELORS AND PREVENTION PROFESSIONALS" which was published in 2005. See the entire document on the attached flash drive and the excerpts in Appendix M. The page numbers with details of the requirements are indicated for states if they had licensure at that time. Many states have added licensure in the last 7 years.

Name	Certification	Licensure	Name	Certification	Licensure

Alabama	X		Montana	X	X p 148
Alaska	X		Nebraska	X	X
Arizona	X	X	Nevada	X	X p 156
Arkansas	X	X	New Hampshire	X	X p 162
California	X mandatory within 5 years if practicing in state program		New Jersey	X	X-with LMFT board
Colorado	X	X p53	New Mexico	X	X p 170
Connecticut	X	X	New York	X	
Delaware	X mandatory		North Carolina	X	X
Florida	X	X p73	North Dakota	X	X p 188
Georgia	X		Ohio	X	X
Hawaii	X mandatory		Oklahoma	X	X
Idaho	X		Oregon	X those working in state or government funded position must be certified within 2 years	
Illinois	X		Pennsylvania	X voluntary but providers themselves require employees to be certified	
Name	Certification	Licensure	Name	Certification	Licensure
Indiana	X	X	Rhode Island	X	X p 213
Iowa	X		South Carolina	X	
Kansas	X	X 2011	South Dakota	X mandatory with state oversight	
Kentucky	X mandatory		Tennessee	X	X 2011
Louisiana	X	X	Texas	X	X p 232
Maine	X	X	Utah	X	X p 238
Maryland	X	X p 114	Vermont	X	X
Massachusetts	X	X p 124	Virginia	X	X p 249
Michigan	X		Washington	X mandatory but under licensure category state oversight	
Minnesota	X	X p 135	West Virginia	X voluntary	
Mississippi	X mandatory		Wisconsin	X	
Missouri	X		Wyoming	X	X p 269

According to the Governor's Substance Abuse Task Forces Comprehensive Substance Abuse Strategic Action Plan, "Treatment Principles and Criteria" all treatment programs are encouraged to utilize nationally accepted principles and levels of treatment. NiaTx Principles promote consumer focused care that is efficient and outcome based. Levels of treatment are determined through ASAM criteria. The ASAM criteria constitute the most comprehensive framework and specific descriptors for matching the patient's multidimensional clinical severity to a placement in the most appropriate level of care. They embody important concepts that promote individualized, cost-effective treatment. These concepts include the need for a broad continuum of care and for comprehensive assessment and treatment to address patients' physical, psychological, and social needs. These criteria are included in all agreements with providers as well as the independent peer review process promoting continuous quality improvement. Evidence based program training, technical support and resources are available to providers upon request." (BBHHF)

8. What would be the impact of the proposed regulation on the supply of practitioners in the occupation, including the degree to which existing practitioners would be excluded from practice?

The regulation would positively impact supply of practitioners in the occupation and existing certified alcohol & drug counselors would be eligible for "grandparenting" into licensure depending upon their current level of certification. There are many social workers, licensed professional counselors, marriage and family therapists and psychologists who are and who would be eligible for certification and licensure and enacting legislation to require certification and licensure would likely increase the supply of practitioners. Many who are currently eligible, decline to undertake the application, testing, supervision and certification process because the certification is currently voluntary and they are already licensed in a different discipline which allows them to bill Medicaid and insurances so they don't voluntarily take on the additional expense to substantiate their specialty expertise.

The Lewin Group, a Maryland-based consulting firm, reports that "5,000 new addictions professionals are needed each year just to replace those who are leaving the field. This need is created by the rising number of addicting materials created and used each year. Individuals all over the world are losing the battle to any number of addictions".

9. To what degree would the proposed regulation either directly or indirectly affect the cost of goods or services provided by the occupational group? Specify those costs as they now exist and as they would change after the imposition of regulation.

The cost of services is not anticipated to increase. Licensure would open the door for practitioners and agencies to make a case for reimbursement as they would be recognized as being "on par" with other licensed professionals. If an agency can be reimbursed for a practitioner with such a select skill set, it stands to reason that everyone would benefit and it would allow for the most effective treatment for

the 152,000 West Virginian's who are estimated to need services. Medicaid already covers treatment with suboxone and has adopted specific protocols and with the Medicaid expansion this is likely to increase. The WV DUI Safety & Treatment programs require the services in their programs to be provided by a certified addiction professional . Further the United States Department of Transportation requires that professionals who conduct evaluations and treatment be certified as "SAP" (Substance Abuse Professional) above and beyond any professional training. Physicians, psychologists, counselors, etc. who wish to perform these services have to undergo additional certification, testing and re-newal of education.

10. What is the applicant seeking to gain through regulation of the occupational group?
    We are seeking to enhance the protection of the public so that they can be assured that the professional is qualified to treat the specialty issue of alcohol & drug abuse and dependence. It will also elevate the credential to the same level as other behavioral health professionals who are regulated through state licensure. We would also be elevating West Virginia professionals to a standard enjoyed by those in many other states. As stated in #7 Arizona, Arkansas, Colorado, Connecticut, Florida, Indiana, Louisiana, Maine, Maryland, Massachusetts, Minnesota, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Rhode Island, Tennessee, Texas, Utah, Vermont, Virginia and Wyoming all have licensure. Delaware, Hawaii, Kentucky, Mississippi, South Dakota, Washington and the District of Columbia have mandatory certification and California and Oregon require certification for those who work in state programs within 5 and 2 years respectively.

11. Indicate how the public would be protected by regulation of this occupational group. Do current legal remedies offer inadequate protection to the public? If so, explain.

    Current legal remedies protect the public from being treated by individuals who have no training or demonstrated expertise in general behavioral health treatment (i.e. social work, counseling, marriage & family counseling, psychology, school psychology); however, as previously stated those with alcohol & drug abuse or dependence generally present a complex clinical array of issues; from tremendous impact on the immediate and extended families to employment and economic problems. Many are involved with multiple "systems" such as the legal system and child protective services, among others. They are also very likely to have physiological complications, unmet medical needs and communicable disease that put them at risk and the public as well. Currently in WV it is <u>not illegal</u> to practice alcohol & drug counseling without being certified. Anyone may identify themselves as an alcohol & drug counselor (addictions, chemical dependency counselor) and the public <u>is not</u> currently protected against those who are not obligated to a code of ethics and do not meet an educational or experience standard. Although it is not easily determined, we know it is not uncommon to find those who identify themselves as "alcohol/drug/addiction" counselors due to their "classification or title" particularly in the correctional arenas (jails, prisons,

community corrections) and until recently in the opioid/opiate treatment programs (commonly referred to as “methadone clinics”).

Currently the State of WV DHHRR/BHHF requires that Opioid Treatment Program (OTP) Staff have to be in process of certification and or licensure in order to provide addiction treatment which indicates that they recognize the importance of certification. This is an excerpt which can also be found in appendix N

17.2. Counseling Staff.

17.2.a. The program shall assign a primary counselor to each patient. The counselor shall have:

17.2.a.1. A bachelor’s degree and either licensure, certification or enrollment in the process of licensure as a social worker, or certification as an addictions counselor;

17.2.a.2. A master’s degree and licensure, certification or enrollment in the process of licensure or certification in the individual’s chosen field, or as an addictions counselor; or

17.2.a.3. Certification or enrollment in the process of obtaining certification as an addictions counselor.

17.2.b. Ratios of primary counselor to persons served shall be adequate to allow sessions to occur as mandated and to allow persons served access to their primary counselor if more frequent contact is merited by need or requested by the patient.

17.2.c. The program shall provide direct supervision by a master’s level clinical staff person who is either licensed or certified, or who has one year’s direct experience in the field of opioid treatment and two years of overall experience in a behavioral health field for counselors who are not independently certified or licensed. At a minimum, the supervisor shall provide at least one hour of supervision per twenty hours of direct service. Supervision may be group in nature, but must consist of case consultation and discussion and/or clinical training rather than administrative oversight. The administrator is responsible for documentation of supervision, which shall be available for review at all times.

17.2.d. Newly employed counselors without experience in an opioid treatment program and other non-physician clinical staff without experience in an opioid treatment program shall receive initial training lasting at least twenty hours and consisting of, at a minimum, the following:

17.2.d.1. Addictions overview;

17.2.d.2. Opioid treatment and basic pharmacology and dosing;

17.2.d.3. Characteristics of the opioid dependent population;

17.2.d.4. Toxicology screening and observation of sample collection;

17.2.d.5. Program policy and procedure;

17.2.d.6. Confrontation, de-escalation and anger management;

17.2.d.7. Cultural sensitivity as necessary and appropriate;

17.2.d.8. Current strategies for identifying and treating alcohol, cocaine and other drug abuse;

17.2.d.9. Identification of co-occurring mental health or developmental disorders; and

17.2.d.10. Other clinical issues as appropriate for the population served.

17.2.e. The program may document that experienced counselors newly employed from other opioid treatment programs may be exempted from mandatory initial training.

17.2.f. Counselors with less than one year of full time experience in the field of opioid treatment shall accompany an experienced counselor at all times for a minimum of two weeks before seeing persons served without immediate and constant supervision."

As you can clearly see, we are making progress in helping systems understand the importance of certification however there are some significant concerns. In 17.2.a.1. it indicates a social work license and in 17.2.1.2 master's degree & licensure…in "chosen field" ***OR 17.2.1.3. certification…in the process.. as an addictions counselor.*** ***These things are NOT created equal.*** Yet they are being held up as equal in a treatment delivery setting for a condition that is requiring a psychoactive medication that has to be supervised while administered. Imagine, if you will, someone receiving cancer treatment- Chemo-therapy which simply means "the treatment of disease by the use of chemical substances."

Moreover, the current voluntary certification process does not expect the application or any information from the applicant until AFTER they have met all the requirements so the people who are "in the process" are not technically overseen by anyone who has vicarious liability for the actions they perform. There is no way to identify who is or might be considered to be "in the process" other than their verbal statement of such and no regulation over their actions should they cause damage.

Additionally West Virginia Restore (WV Restore) is a monitoring and recovery program for nurses, "in order to assure patient safety while the nurse is healing. A nurse seeking admission into West Virginia Restore (WV Restore) is initially screened by program staff and completes an evaluation by an ***approved certified addictions counselor*** to assess their immediate needs, identify and evaluate the nature and severity of their chemical dependency and/or psychiatric problems, determine an appropriate treatment plan, and gain an understanding of their motivation in entering the program."

12. Within the usual practice of this occupation, document the physical, emotional or financial harm to clients from failure to provide appropriate service, or erroneous or incompetent services. Give specific, verifiable examples.

As stated in the original application in 1999, specific case examples cannot be included due to the Federal law 42 C.F.R. Part 2 which protects clients seeking services for the treatment of substance abuse/dependence. See appendix O. In fact, "this law was created in the early 1970's, Congress recognized that the stigma associated with substance abuse and fear of prosecution deterred people from entering treatment and enacted legislation that gave patients a right to confidentiality. For the almost three decades since the Federal confidentiality regulations (42 CFR Part 2 or Part 2) were issued, confidentiality has been a cornerstone practice for substance abuse treatment programs across the country." (SAMHSA)

Also, as stated in the original application in 1999 alcohol & drug abuse/dependence "is routinely missed as a factor in numerous cases unless it is blatant." Universal screening/assessment to determine the presence or extent of an alcohol/drug abuse is not a common practice in the medical and behavioral health settings. However, there have been improvements. Through a national program, SBIRT (Screening, Brief Intervention & Referral to Treatment), there has been progress especially in the medical and behavioral health fields. West Virginia was the recipient of a federal SAMHSA grant to establish and implement SBIRT and over 600,000 have been screened. The increase of SBIRT is a recommendation in the Governor's Advisory Council on Substance Abuse Progress & Recommendations Report to the Governor dated April 2012. See appendix P.

Additionally, as stated in the 1999 application, "neglect (to screen/assess) does enormous harm by prolonging the progression of this disease to the point that physical, emotional and financial costs mount for the individual, their family and society as a whole."

According to National Institute on Drug Abuse (NIDA) "Drug abuse costs the United States economy hundreds of billions of dollars in increased health care costs, crime, and lost productivity. The total costs of drug abuse and addiction due to use of tobacco, alcohol and illegal drugs are estimated at $524 billion a year. Illicit drug use alone accounts for $181 billion in health care, productivity loss, crime, incarceration and drug enforcement."

It is difficult to determine and document physical, emotional or financial harm to clients when dealing with alcohol and drug abuse/dependence. Many of these clients are tremendously disadvantaged and do not have funds for attorney fees. Many of them have criminal records so they are not likely to have the financial or emotional resources to lodge complaints or undertake litigation through civil suits which require legal representation. Moreover, the disease of addiction many times ends in death which certainly prohibits filing complaints related to the care they have received. Further, the families are devastated by the disease and have often gone to great lengths to get help for their loved ones. The stigma of being an addict or being the family of an addict is still very prevalent. The practice of therapy is not black and white- there are no "sponges" to be

left behind as with a medical or dental surgery; there are no “infections” or “outbreaks” that can be traced back to a bad tomato. West Virginia has professional licensing boards for several dozen professional groups from barbers, cosmetologists, landscape architects, acupuncturists to funeral directors and laws were created to protect the public and ensure the competence of those professionals.

13. Do clients have access to this occupational group directly, or are they referred by members of another occupational group?

Depending upon a client’s health insurance plan a client may have direct access to this occupational group however some have to be referred by primary care physicians, other mental health professionals, employers, EAP’s and others. Self pay clients have access to this group directly. Many clients are referred through local, state and federal judicial or correctional systems as part of alternative sentencing, conditions of probation or parole and drug court programs.

14. Are clients routinely referred to practitioners in this group? If so give examples of who refers clients and for what reason.

Yes. Clients are routinely referred by Primary Care Physicians, emergency room or urgent care physicians, psychiatrists, psychologists, counselors, marriage & family therapists, social workers and other allied professionals who recognize the specialty of treating alcohol & drug abuse and dependence is outside of their scope of practice or expertise. Courts and employee assistance programs are also sources of referrals. Clients are referred for alcohol & drug abuse and dependence treatment. As stated in #13 many clients find their way to treatment and relapse prevention through judicial and correctional systems.

15. Does the current lack of regulation of this group make its practitioners ineligible for third party insurance payments or federal grants.

Potentially. Insurance companies do not reimburse for “certification” only for those possessing a license such as LICSW, LPC, Licensed Psychologists. Providers who do not possess licensure are not eligible for third party payment. Some insurance companies do not accept the WV Psychology License for those licensed at the Master’s level. The information is not readily available about which states do reimburse for licensed addictions counselors or those with mandatory certification. With the passage of the Affordable Care Act and with the Medicaid expansion approval we are not certain how regulation may come into play for reimbursement. We know that there is a shortage of qualified providers and programs in WV with the current Medicaid recipients and it only stands to reason that once the expansion is in effect there will be a large number of residents in need of services from qualified providers.

16. Describe the minimum competencies necessary to enter this occupation.

It depends upon the state in which one lives as to the minimum competencies "required". That is one of the problems with not having mandatory certification or defined scopes of practice. It is up to each employer to write the job descriptions for their agency/organization and the can write those competencies and minimum requirements with no oversight.

The recommended competencies are also found in the appendix TAP 21 also noted in #4. Currently WV (and all other states which utilize the IC&RC credentials) minimal competencies for certification are contained in the appendix noted in #4.

17. List institutions and program titles offering accredited and non-accredited programs in WV to prepare practitioners for entry into this program. What is the cost of completing these programs? If programs are not available in WV, what is the cost of out of state programs?

There are three programs that advertise associate degree programs in WV. Southern WV Community & Technical College offers an addictions counseling associate degree in applied science http://www.southernwv.edu/programs/addiction-counseling. Their website reports that they are accredited by HLC- North Central Association. Mountain State College in Parkersburg, WV advertises an Associate degree Dependency Disorders Technology http://www.msc.edu/programs-of-study/dependencydisorders
Kanwha ValleyCommunity & Technical College advertises (pg 72 & pg 86) Community Behavioral Health, health technology addictions concentration Associate in applied science
Leading to a B.S. in Health Science and

These programs are associate degree programs and would not lead to any current licensure available (sw,lpc,psychologist) it is not obvious if either of these programs would fulfill the requirements to sit for certification through IC&RC.

WV is in dire need of additional specific programs to help address the work force development issues for alcohol & drug counselors. The Comprehensive Substance Abuse Strategic Action Plan WV Strategic Goal 2 is "Capacity" and states "services to ensure that proven efforts are utilized by trained provider with the necessary credentials to meet the needs of individuals served….levels of treatment, or other competent principles and levels of treatment as approved by the SSA, as determined through ASAM2 criteria." Appendix K.

There is an effort on a national level through SAMHSA & CSAT / NASAC & INCASE to introduce a set of national curriculum standards, due to the current United States Supreme Court hearings on the Affordable Care Act and pending ruling, these standards have not been released to the public. A 2011 pre-release copy of these standards can be found in Appendix__

Indiana Wesleyan University www.indwes.edu offers a bachelor's degree, master's degree and graduate certificate program in addictions counseling. These programs are available online and are fully accredited. Bachelor's degree requires 45 hours at $319 each; Master's program requires 48 hours at $467 each and the graduate certificate is 15 hours at $467 each. Appendix Q.

Waynesburg State University (Waynesburg, PA) www.waynesburg.edu has a Master of Art program in Counseling with a concentration in Addictions Counseling. They also have a certificate program for professionals already working in the behavioral health field who want to become certified in Pennsylvania as an addiction counselor. The MA program is 60 hours and tuition is $580 per credit hour. Appendix __

18. Is there an examination currently used to measure qualifications for entry? If so, who constructs and administers the examination? Please submit documentation on the validity and reliability of such exams.

IC&RC has separate examinations for the ADC & AADC credentials. The exams are standardized 150 items and are constructed by Schroeder Measurement Technologies, Inc. (SMT) located in Clearwater, FL. The exams are administered via computer based format and WV has two testing sites. Validity and reliability details can be found in the attached documents. Coefficient alpha for the ADC exam is greater than .88 and the intraclass correlation reliability estimates for each of the 8 domains was .92 or greater. Coefficient alpha for the AADC exam is .72 and the intraclass reliability estimates for each of the 10 domains was .89 or greater. Due to the expense of these documents one copy of each has been provided for the reviewers to share. "Appendix R"

19. Is this occupational group affiliated with an association which sets and enforces standards? If so, please explain the process and standards.

Yes. WVCBAPP sets out the standards consistent with their international organization IC& RC (International Certification & Reciprocity Consortium) although certification in WV is voluntary the WVCBAPP can suspend ones certification if there is negligence, unethical behavior or malpractice. WVCBAPP recognizes NAADAC's ethics code as the ethical standard by which certified professionals are held. NAADAC is WVAADC's national organization. See appendix S.

20. What federal, WV, county or local laws currently apply to the practice of this occupational group?

All relative federal, state, county and local laws, rules and regulations apply to this group the same as they apply to other behavioral health therapists. Those include rule and regulations governing Medicare and Medicaid, as well as private insurers. In addition, some laws pertain specifically to addictions counseling including but not limited to US Confidentiality Laws (42 CFR as detailed in #

12) and US Department of Transportation standards. Specific regulations to the profession such as state legislative rules do not apply as the profession is not regulated by the state.

21. What type of private credentialing is or could be available as an alternative to government regulation?

There are options for private credentialing (such as what WVCBAPP currently provides through IC&RC) but not regulatory as the credential in WV is voluntary. There are no "private credentialing" per se such as 3rd party payors or contractors that would provide "private credentialing". NAADAC has a Master Addictions Counselor Credential and the eligibility requirements are detailed on a file on the flash drive attached to this application. WV is an IC&RC state and we recommend using the IC&RC examination process to reduce confusion and standardize the credentials.

22. Provide a detailed statement of the fee structure conforming to the statutory requirements of financial autonomy as set out in WV Code 30-1-6 (C).

(WV Code 30-1-6 (C) Boards may set by rule fees relating to the licensing or registering of individuals, which shall be sufficient to enable the boards to carry out effectively their responsibilities of licensure or registration and discipline of individuals subject to their authority: Provided, That when any board proposes to promulgate a rule regarding fees for licensing or registration, that board shall notify its membership of the proposed rule by mailing a copy of the proposed rule to the membership at the time that the proposed rule is filed with the secretary of state for publication in the state register in accordance with section five, article three, chapter twenty-nine-a of this code.

TITLE 27 ***DRAFT***
LEGISLATIVE RULE
WEST VIRGINA CERTIFICATION & LICENSING BOARD FOR ADDICTION & PREVENTION PROFESSIONALS
SERIES 2
LICENSED ALCOHOL & DRUG COUNSELORS AND LICENSED ADVANCED ALCOHOL & DRUG COUNSELORS
FEES RULE

27-2-1. General.
1.1 Scope.—This rule establishes fee requirements related to the licensing of alcohol & drug counselors and advanced alcohol & drug counselors, renewal of the licenses and application and monitoring of continuing professional education providers and their programs.
1.2 Authority.-W.Va. Code 30-31-6
1.3 Filing Date.-June 29, 2012
1.4 Effective Date- ??

27-2-2 Fee Schedule

2.1. Fees paid to the Board are not refundable.

2.2. Fees, including examination fees, are payable to the West Virginia Certification & Licensing Board for Addiction & Prevention Professionals (WVCLBAPP).

2.3. Fees.

2.3.a. Initial application for licensure-$150.

2.3.a.1. The fee required for the issuance of the initial license certificate shall be calculated on the current renewal rate set in this rule, the date the license is issued and the number of days remaining in the current biennial renewal cycle;

2.3.b Reciprocity application processing- $ 100 payable to International Certification & Reciprocity Consortium (IC&RC) or its designee.

2.3.c. Biennial license renewal -$ 200

2.3.d. Late Renewal during 60 day period- $75.00

2.3.e. Reinstatement for licensure renewal after the end of the 60 day period or reinstatement following revocation or suspension of license-$250

2.3.f. Name change on all records- $5.00;

2.3.g. Duplicate certificate $10.00

2.3.j. Filing a request for public information, print or electronic data or other services relating to the Board, its members or licensed professional counselors, is based on the actual cost of materials, employee time and services required to comply with the request; and,

2.3.k. Bad check fee-as provided for in 61-3-39e.

2.4 Continuing professional education provider and program fees.

2.4.a Certification as an approved provider of continuing professional education triennially (every 3 years)- $300.

2.4.b. Certification as an approved provider of continuing professional education for one event- $50.00 per day per event.

2.4.c. Monitoring the continuing professional education records and activities of an approved provider for the purpose of quality assurance - $50.00 for one event in each triennial year cycle and $100 for more than one event in each triennial year cycle; and,

2.4.d. Biennial fee to recertify as an approved provider -$ 100 payable only after the Board has notified the provider that it is eligible to re-certify.

(1). An approved provider who does not pay a fee to re-certify within 30 days of notice forfeits all rights and privileges of an approved provider.

2.5 Examination fees.

2.5.a. Fee for the examination required by the Board is established by and payable to the West Virginia Certification & Licensure Board for Addiction & Prevention Professionals (WVCLBAPP).

See Appendix T Draft of Licensed Alcohol & Drug Counselor Fees Rule

23. Provide a detailed statement of the location and manner in which the group plans to maintain records which are accessible to the public as set out in WV code 30-1-12.

§30-1-12. Record of proceedings; register of applicants; certified copies of records prima facie evidence; report to governor and Legislature; public access.

(a) The secretary of every board shall keep a record of its proceedings and a register of all applicants for license or registration, showing for each the date of his or her application, his or her name, age, educational and other qualifications, place of residence, whether an examination was required, whether the applicant was rejected or a certificate of license or registration granted, the date of this action, the license or registration number, all renewals of the license or registration, if required, and any suspension or revocation thereof. The books and register of the board shall be open to public inspection at all reasonable times, and the books and register, or a copy of any part thereof, certified by the secretary and attested by the seal of the board, shall be prima facie evidence of all matters recorded therein.

The WVCBAPP currently has a secretary position on the board, a certification chair and an office administrative assistant. The board secretary takes minutes during the meetings. The certification chair reviews applications, registers applicants for the examination, completes notification of test results and assists in record keeping. The administrative assistant is responsible for maintaining the applicant and certified person's file and all other clerical and administrative duties.

(b) On or before the first day of January of each year in which the Legislature meets in regular session, the board shall submit to the governor and to the Legislature a report of its transactions for the preceding two years, an itemized statement of its receipts and disbursements for that period, a full list of the names of all persons licensed or registered by it during that period, statistical reports by county of practice, by specialty if appropriate to the particular profession, and a list of any complaints which were filed against persons licensed by the board, including any action taken by the board regarding those complaints. The report shall be certified by the president and the secretary of the board, and a copy of the report shall be filed with the secretary of state and with the legislative librarian. The WVCBAPP, is registered with the state as such and maintains the required documentation. They would be equipped to produce the report to the governor and legislature as required by law.

(c) To promote public access, the secretary of every board shall ensure that the address and telephone number of the board are included every year in the state government listings of the Charleston area telephone directory. Every board shall regularly evaluate the feasibility of adopting additional methods of providing public access, including, but not limited to, listings in additional telephone directories, toll-free telephone numbers, facsimile and computer-based communications. The secretary of the board and administrative assistant would be responsible to provide the required information. A current system is in place through the WVCBAPP.

24. Identify any other states in which the subject occupation or profession is regulated and the manner in which the regulation has resulted in greater protection of the public health and safety. Provide copies of regulations from other states. The reponses to #4 & #7 and the attached documents fully answer this question. The public would have greater protection because those who were under mandatory certification & licensure would be accountable by state law.

25. Fully identify the minimum education, experience and examination requirements proposed in the legislation, including a comparison of those minimum requirements to the minimum requirements in other states, the adequacy of those minimum requirements and the rationale for any exemptions or waivers from those minimum requirements.

    The responses to #4 & #7 and the attached documents fully answer this question. See appendices L & M.

26. If the occupational group has been deregulated (sunsetted) by the Legislature, and the applicant is requesting re-regulation, the applicant should provide documentation on harm to consumers since deregulation that necessitates re-regulation by the state. This group has not been deregulated.

27. If the occupational group is a former applicant re-submitting a sunrise application, please include updated information that will substantiate the request for regulation. I believe that most of the updated information that substantiates the request for regulation has been included in the previous items. Under Finding 1, we were unable to secure the same information that was included in the initial 1999 application as it relates to "table 1 & 2" which indicate the education level of the 365 certified professionals and the licensure they may currently hold. The number of certified professionals has grown from 190 as stated in the 1999 application to the current 365. Our review of other states' regulations indicates that there are 29 states with licensure; 6 states & the District of Columbia have mandatory certification and 2 others mandate certification within 2-5 years if practicing in a state program. We have made a substantial case in the information contained hereto that alcohol & drug counseling is a profession unto itself and without mandatory certification and licensure the public cannot be assured that a clinician possesses the minimum qualifications to treat the chronic disease with which they are afflicted. Recognizing the alcohol and drug counseling as a profession unto itself technically unregulated in WV at this time. Under the original finding number 1 from PERD seemed to be very confusing "This suggests that the certification title has value by itself and that its value is enhanced when combined with one of the available licenses. A person with only a license is not as credible as someone who also is a CAC. Therefore, it does not stand to reason that the state risks losing licenses CAC's". It depends upon how one defines value. If you define value by money or money making ability the ADC/AADC (formerly CAC/CCAC) who does not hold any other allied professional license is at a disadvantage although most likely far more qualified to treat substance use disorders. A person with a license can bill and be reimbursed. Third party payors do not pay for those who are "certified".

Additionally since the initial application the requirements for LPC's have been modified which presents an additional host of issues. Further, the LPC board (WVBEC) has added a provisional license for those who are in the process of being licensed so the issue that was addressed stating that it would be "unfair to those who were not given such a provision, and it is an unnecessary administrative burden to impose on an existing board". We are respectfully asking for an independent licensing board which would be combined with and/or overseen by the current certification board, WVCBAPP. We are not interested in imposing on the existing LPC, SW or Psychology boards. Regarding Finding 2 " it is already the common practice of state licensing boards to not license specialties of a general occupation or profession", The WVBEC (LPC board) has assumed oversight of the marriage and family therapists which suggests that a precedent has been set. As stated previously, the content and supporting documents we have provided establish ample rationale for a separate mandatory certification & licensing board for addiction professionals in addition to the 36 other states & DC which have come before us. Regarding Finding 3, we agree that mandatory certification could be an alternative to licensure but as PERD stated in the response "mandatory certification is fundamentally equivalent to licensure in that it sets a standard enforceable by the state." If the recommendation for mandatory certification was made it would seem to make just as much sense to recognize alcohol & drug counselors as the professionals they are, by endorsing the profession with a licensure board and avoiding the "unnecessary administrative burden to impose on an existing board" when an existing certification board is available and willing to accept the responsibility for a group of professionals with whom they are already well acquainted with established processes that would fit well within the requirements of the WV code.

28. Provide a copy of the proposed legislation. See Appendix U.