State of Vermont
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Sarah Copeland Hanzas, Secretary of State
S. Lauren Hibbert, Deputy Secretary
Kevin Rushing, Director

April 12, 2023

To: Senator Ruth Hardy, Chair
Senate Committee on Government Operations

From: S. Lauren Hibbert, Deputy Secretary of State
Lauren Layman, General Counsel, Office of Professional Regulation

Re: H.305 – An act relating to professions and occupations regulated by the Office of Professional Regulation

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Dear Committee,

Thank you for the opportunity to provide further testimony on H.305. The Secretary of State's Office and the Office of Professional Regulation are seeking amendments in three areas: 1) fee adjustments for professions within OPR and Corporations; 2) pharmacy; and 3) regulation of art therapists and music therapists.

Fee Adjustments

Our Office has not sought a fee adjustment for any of our programs since 2019. We are seeking fee adjustments consistent with inflation unless it creates a significant or untenable burden for the profession or corporation. A budget overview is included in this testimony.

Pharmacy

The Office of Professional Regulation (OPR) is grateful for the opportunity to work with stakeholders on amendments to the pharmacy provisions in H. 305. Collectively, we have been able to achieve consensus around the following amendments:

- Allows for pharmacists and pharmacy technicians to provide the flu vaccine, COVID-19 vaccine or subsequent formulations or combination products for patients 5 years or older.

Vermont Secretary of State's Office; Office of Professional Regulation

Secretary of State Special Funds

The Secretary of State's Office operates almost entirely through Special Fund revenue. For FY'23 our total budget is $17.7 million.

- Our main sources of funding are:

  Secretary of State Services Fund (21928); and,

  Professional Regulatory Fee Fund (21150).

- We also receive grant funds through the EAC (U.S. Election Assistance Commission) under the Help America Vote Act (HAVA) Federal HAVA program which funds a portion of our election work.

Secretary of State Services Fund (21928)

The Secretary of State Services Fund was created by 3 V.S.A. § 118.

This fund receives revenue from all of the business filings of the Corporations Division and the revenues received from reference research activities and authentication fees collected by VSARA. These revenues have averaged $7.9M over the past five years. These revenues fund the general operation, staff costs, and all operating expenditures, of the following divisions within the Secretary of State's Office:

- Elections Division (not eligible for grant funding),
- Administration,
- VSARA,
- Business Services (Corporations), and
- Information Technology. In comparison, expenditures during that same five-year time period averaged approximately $5.3M.

Historically Finance and Management has swept 1.5 to 2 million per year.

This fund is currently stable. However, we requested that the Administration not sweep the traditional amount into the General Fund. We are at the beginning stages of two planned large IT projects that will require additional funds, closing the gap between revenues and expenditures. In addition to that, there will be ongoing maintenance and support charges associated with these systems. We are also cognizant that staff costs are projected to increase year after year and without additional revenue being generated, this fund will soon not be able to sustain itself on an annual basis.

Secretary of State Services Fund (21928)

Fee Adjustments

- We are currently reviewing the fee structure for Corporations' filings.
- We are reviewing when the fees were last updated, and the fees in surrounding states.
- We plan to make recommendations to this committee when we next testify on our funds.
- Our fee amounts are being compared against other New England states and/or states with similar filing volumes.
- Any recommendations for fee increases would be limited to items where we fall below the median in the New England states.

Professional Regulatory Fee Fund (21150)

The Professional Regulatory Fee Fund is created under 3 V.S.A. § 124.

The revenues in this fund are received through licensing fees (applications and renewals) for the 81,000 licensees under the Office of Professional Regulation's umbrella. The revenues received into this fund are solely for the purpose of supporting the activities of OPR, including staff costs and all operating expenditures. Revenues deposited into this fund have averaged $6.1M over the past five years. In comparison, expenditures from this fund for that same five-year period have averaged $7.3M over the same time period.

In 2017, this fund had a surplus in it. Work began on the Next Generation Licensing Platform (NGLP). The Office did not ask for an IT allocation because it was assumed that the surplus in this fund would be adequate to cover the costs of building this system. We have learned that this most definitely was not the case. Work, and expenditures, related to this project continue still today. We are getting closer to the finish line but there is still work to do.

Removing the work of the contractor on the NGLP system, expenditures from the Regulatory Fee Fund are essentially flat with revenues. Again, however, staff costs do not go down and the costs associated with maintenance and support of the system will be ongoing as well. The fees currently set for the professions that OPR licenses will not be adequate to support their operations over the long term.

OPR's Budget Allocation to Professions

OPR regulates professions in two different models:

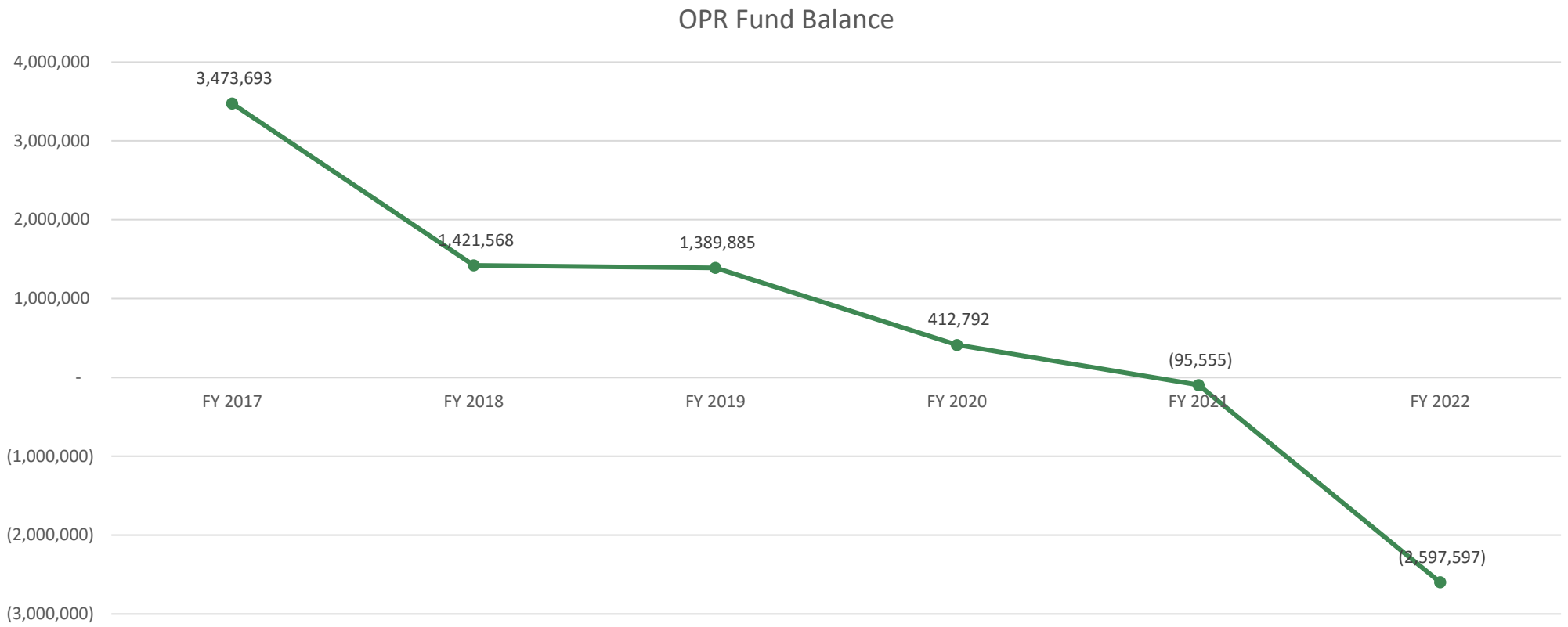
1. **The Board Model:** In this model, the licensing funds are siloed and can only be used to support the profession
2. **The Advisor Model:** In this model, the licensing funds are pooled between professions and are used to support those professions.

OPR has two types of expenses:

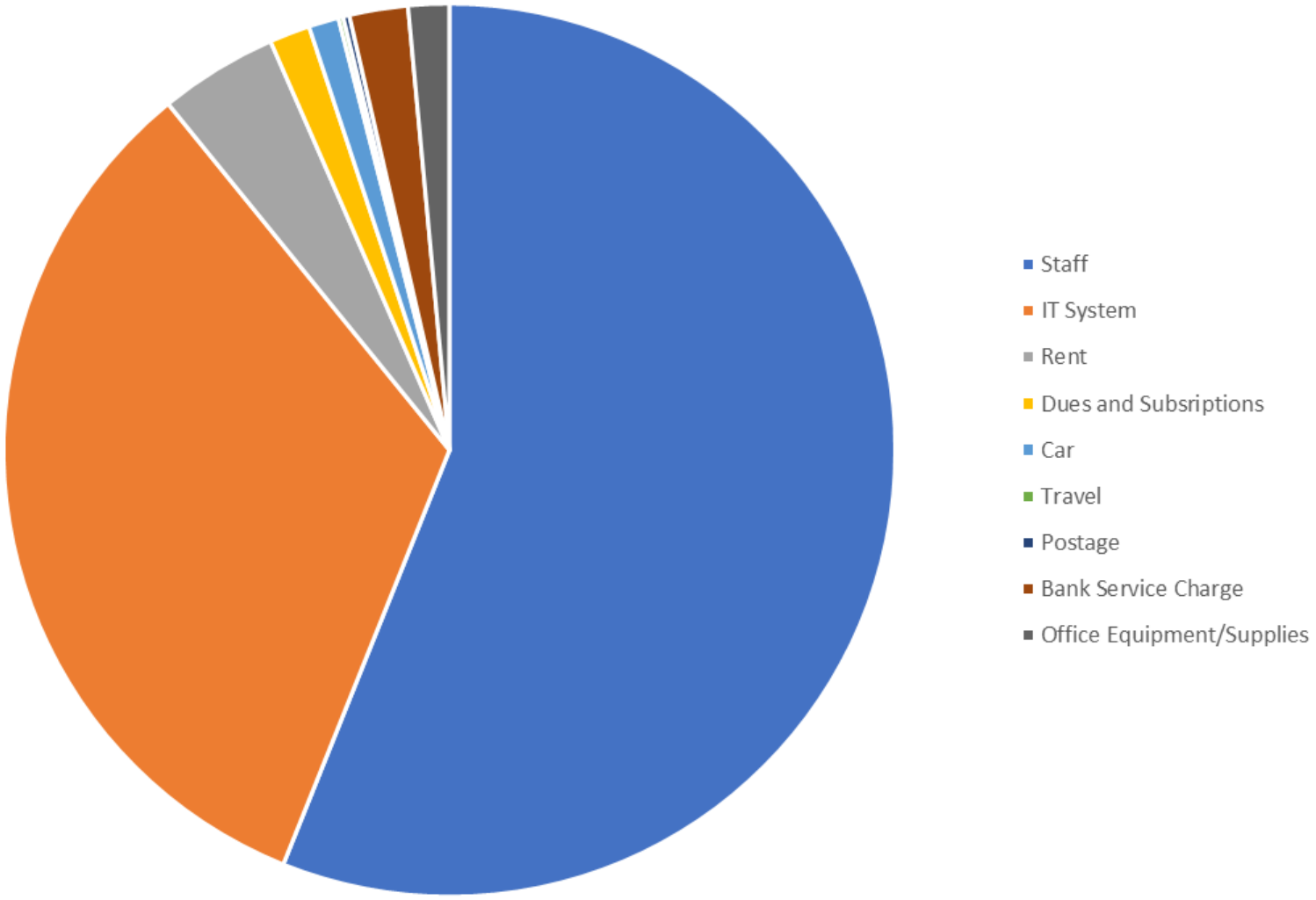
- **Direct Expenses**: include per diems & Enforcement costs. These expenses are directly billed to professions.
- **Indirect Expenses:** include staff, administrative law officers, rent, dues office supplies, dues, and IT systems. These expenses are allocated to the profession based on the number of licensees the profession has.

[1] *3 V.S.A. § 124(a)* A licensing fee reflects the cost of regulating that one profession; cost of regulating a profession should be borne by the profession; one profession should not subsidize the cost of regulating another profession.

Snapshot of the OPR Fund Balance



Expenses: OPR's largest expenses are Staff, IT, and Rent



Costs are Increasing

COVID-19 and unfunded mandates

- We did receive a one-time 1.35 M allocation to help offset these costs, but they do not fully cover the loss of licensees and the IT spend.

Rising Regulatory Demands

- Reducing regulatory barriers and process improvement to meet consumer demands lead to increased IT costs

Expenses

- Costs are increasing- the largest cost drivers are staff, IT, and rent; inflation is a factor

Fee updates have been irregular

- Ideally, fees would be updated on a regular cycle and be tied to:
  - Fund Balance
  - Inflation
- Most fees have not been updated since 2019, pre-COVID
  - Prior significant updates occurred in 1997, 2006 and 2017

$100	Value of $100 in 2022
1997	$184
2006	$147
2017	$120
2019	$115

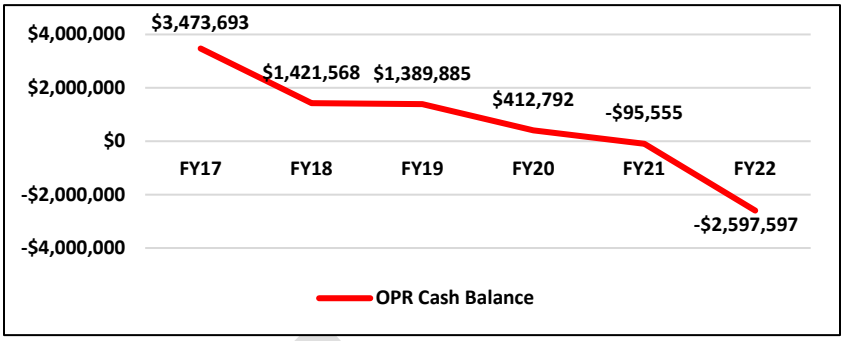
Fee Adjustment Discussion

Guiding Principles

- Adjust renewal and application fees to reasonably correct for inflation and stabilize fund balance (by profession)
- Sensitive approach for health care professions
- Align license types where possible

Office of Professional Regulation
Secretary of State

Summary: OPR is a special fund agency where revenue from licensing fees funds its operation. OPR has historically maintained a positive cash flow, however, balances became negative in FY21. Contributing factors include an IT project that is over budget, COVID-19 initiatives and unfunded mandates, inconsistent fee adjustments, and the rising cost of regulatory demands, including nurse discipline. OPR is concerned about the impact of necessary fee adjustments on licensees, specifically healthcare licensees.



Background

COVID-19 initiatives: OPR implemented several programs to increase access to healthcare while minimizing the financial burden to licensees during COVID-19. OPR also allocated considerable staff resources to coordinating with state partners for the reopening of businesses, specifically close contact services, and vaccination initiatives. OPR did not receive any outside funding for these services and does not charge licensees for the programs.[1]

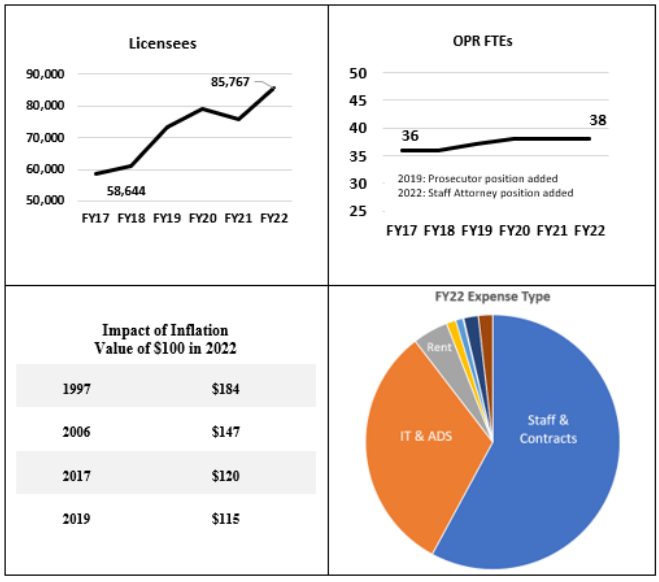
Unfunded Mandates: A licensing fee reflects the cost of regulating that one profession (3 V.S.A. § 124(a)). [2] As Vermont works to reduce licensing barriers across the board, several new programs that are not profession-specific cannot be charged back to a single profession and must instead be absorbed by the cash balance. Therefore, innovative systemwide programs like fast-track endorsement and second chance determination are considered unfunded mandates. The Office also conducts Sunrise Reports about professions where we have not received any funds and may never receive funds. The cost of those reports is currently shifted to licensed professions.

Rising Regulatory and Demands: Better and necessary operations have come at a cost. Paper-based processes are not efficient, and IT is expensive. New and necessary regulations are more challenging to enforce and nurse discipline has increased in both volume and complexity.[3] OPR has paid for these improvements and increased volume/complexity through its cash balance.

Fee Adjustment History: Fees have not kept up with inflation. Some fees were last adjusted in 2019 and prior increases occurred in 2017, 2006, and 1997. OPR's goal is to move away from intermittent/reactionary adjustments and towards routine proposals tied to inflation and the actual cost of regulation. However, in the meantime, fees have not kept up with inflation.

Outside Funds: OPR does not normally receive outside funds, however twice in the last 5 years OPR has received outside funds: a grant from the federal Department of Labor and a one-time allocation from the General Assembly. These new revenue sources represent a shift in how systemwide projects at OPR can be funded.

Expenses: As the cost of regulation increases, OPR has identified its largest cost drivers (staff, IT, and rent) and continues to look for ways to decrease expenses while maintaining operations. OPR has eliminated positions through attrition, delayed hiring for new positions, downsized its IT contract, and is working with BGS to address expensive overhead.



[1] E.g. EMGY, temporary and retiree credentials; emergency guidance for close contact health care providers (dental, veterinary, pharmacy, and mental health).
[2] 3 V.S.A. § 124(a) cost of regulating a profession should be borne by the profession; one profession should not subsidize the cost of regulating another profession.
[3] E.g. massage therapy requires complex investigations into human trafficking and coordination with partner law enforcement agencies; prosecution of chain pharmacies requires an unprecedented amount of investigation and prosecutorial resources; as the nurse workforce struggles to keep up with rising healthcare demands, unintentional and deliberate incidents of unprofessional conduct have increased.

VERMONT SECRETARY OF STATE
OFFICE OF PROFESSIONAL REGULATION
PRELIMINARY SUNRISE ASSESSMENT: ART THERAPY (2016/17)

In 2014, the Art Therapy Association of Vermont (ATAV) and its parent organization, the American Art Therapy Association, filed with the Office of Professional Regulation (OPR) an *Application for Preliminary Sunrise Review Assessment*.[1] The associations proposed to remove art therapists from the ambit of the Board of Allied Mental Health Practitioners, which licenses counseling professionals and registers psychotherapists without regard to modality, and to establish, through a new chapter in Title 26, a distinct art therapy license directly administered by the Director of Professional Regulation.

OPR conducted a preliminary sunrise analysis. In a report submitted to the Legislature January 9, 2015[2], the Office recommended against creating a new regulatory structure specific to art therapists, concluding "that existing regulation of art therapists adequately protects the public."[3]

The associations disagreed with the 2015 recommendation, arguing that OPR's first analysis had misunderstood aspects of their proposal, and more important, that new developments among non-governmental mental-health-education accrediting bodies created new urgency around separate licensure. In view of these concerns, new legislative developments outside the State, and ongoing legislative interest inside the State, the House Committee on Government Operations asked that OPR take in new information and conduct a new sunrise assessment.

I. Legal Standards and Analytical Structure

Vermont law sets clear policies and objective standards for legislative review of proposed licensing statutes. *See* 26 V.S.A. Chapter 57. In short, the law calls for a structured cost-benefit policy analysis of proposals for new professional regulation. The law places unambiguously upon the proponents of new regulation the burden to demonstrate the genuine necessity of that regulation to the protection of the public.

> ***It is the policy of the State of Vermont that regulation be imposed upon a profession or occupation solely for the purpose of protecting the public.*** *The General Assembly believes that all individuals should be permitted to enter into a profession or occupation unless there is a demonstrated need for the State to protect the interests of the public by restricting entry into the profession or occupation.* ***If such a need is identified, the form of regulation adopted by the State shall be the least restrictive form of regulation necessary to protect the public interest****. If regulation is imposed, the profession or occupation may be subject to review by the Office of Professional Regulation and the General Assembly to ensure the continuing need for and appropriateness of such regulation.*
> --26 V.S.A. § 3101 (subsection labels omitted; emphasis added).

[1] 2014 *Application for Preliminary Sunrise Review Assessment*, available at: https://www.sec.state.vt.us/media/522903/Art-Therapy_Application-for-Preliminary-Sunrise-Review-2014.pdf.
[2] Winters, C.; *Art Therapists Sunrise Application Review: Preliminary Assessment on Request for Licensure*, available at: https://www.sec.state.vt.us/media/664176/Art-therapist-Sunrise-Report-2015-0109.pdf.
[3] *Id*, p. 12.

"Any new law to regulate [a] profession or occupation shall be based on the relevant criteria and standards in [26 V.S.A. § 3105]." *Id*. § 3102(c). "Prior to review … and consideration by the General Assembly of any bill to regulate a profession or occupation," OPR is to prepare for the Legislature a preliminary, written assessment of whether a "request for regulation meets the criteria set forth in [26 V.S.A. § 3105(a)]." *Id.* § 3105(d). OPR "shall base its written preliminary assessment upon information contained in the request for regulation, oral comments received at the public meeting, written comments submitted after the public meeting, its own budget analysis, and any other information pertinent to the request." CVR 20-4-1: 2.3.

Section 3105(a) provides:

> *A profession or occupation shall be regulated by the state only when:*
>
> > *(1) it can be demonstrated that the unregulated practice of the profession or occupation can clearly harm or endanger the health, safety, or welfare of the public, and the potential for the harm is recognizable and not remote or speculative;*
> >
> > *(2) the public can reasonably be expected to benefit from an assurance of initial and continuing professional ability; and*
> >
> > *(3) the public cannot be effectively protected by other means.*

If and only if regulation of the profession is found necessary by the Legislature based upon the § 3105(a) criteria "and considering governmental and societal costs and benefits," then "the least restrictive method of regulation shall be imposed, consistent with the public interest" and the policies set out at *id.* § 3105.

Chaper 57 recognizes a three-part hierarchy of regulation: registration, certification, and licensure:

> ***"Registration"*** *means a process requiring that, prior to rendering services, a practitioner formally notify a regulatory entity of his, her, or its intent to engage in the profession or occupation. Notification may include the name and address of the practitioner, the location of the activity to be performed, and a description of the service to be provided*
>
> ** * **
>
> ***"Certification"*** *means a voluntary process by which a statutory regulatory entity grants to a person who has met certain prerequisite qualifications the right to assume or to use the title of the profession or occupation, or the right to assume or use the term "certified" in conjunction with the title. Use of the title or the term "certified," as the case may be, by a person who is not certified is unlawful.*
>
> ** * **
>
> ***"Licensing"*** *and* ***"licensure"*** *mean a process by which a statutory regulatory entity grants to a person who has met certain prerequisite qualifications the right to perform prescribed professional or occupational tasks and to use the title of the profession or occupation. Practice without a license is unlawful.*
>
> --26 V.S.A. § 3101a(7), (1), & (2) (ordered respectively; emphasis added).

The law establishes five enumerated policies by which to identify the least restrictive regulatory response:

> *(1) if existing common law and statutory civil remedies and criminal sanctions are insufficient to reduce or eliminate existing harm, regulation should occur through enactment of stronger civil remedies and criminal sanctions;*
>
> *(2) if a professional or occupational service involves a threat to the public and the service is performed primarily through business entities or facilities that are not regulated, the business entity or the facility should be regulated rather than its employee practitioners;*
>
> *(3) if the threat to the public health, safety, or welfare including economic welfare is relatively small, regulation should be through a system of registration;*
>
> *(4) if the consumer may have a substantial interest in relying on the qualifications of the practitioner, regulation should be through a system of certification; or*
>
> *(5) if it is apparent that the public cannot be adequately protected by any other means, a system of licensure should be imposed.*
> -- 26 V.S.A. § 3105(b)(1)-(5).

Finally, Chapter 57 requires that proponents of new regulation explain ten factors judged by the Legislature to be relevant to sunrise analysis. These ten factors are substantially incorporated in the sunrise review application form promulgated by OPR and completed by applicants for regulation. They are:

> *(1) Why regulation is necessary …*
>
> *(2) The extent to which practitioners are autonomous…*
>
> *(3) The efforts that have been made to address the concerns that give rise to the need for regulation…*
>
> *(4) Why … alternatives to licensure … would not be adequate to protect the public interest…*
>
> *(5) The benefit to the public if regulation is granted…*
>
> *(6) The form and powers of the regulatory entity…*
>
> *(7) The extent to which regulation might harm the public…*
>
> *(8) How the standards of the profession or occupation will be maintained…*
>
> *(9) A profile of the practitioners in this state, including a list of associations, organizations, and other groups representing the practitioners including an estimate of the number of practitioners in each group.*
>
> *(10) The effect that registration, certification, or licensure will have on the costs of the services to the public.*
>
> --26 V.S.A. § 3107 (omitting more descriptive subcategories).

II. Supplementary Questions, Submissions, Comments, and Hearing

To avoid duplication of effort, ATAV was invited to let its 2014 application stand and to provide a 2016 supplement.[4] The Office sought first to elicit correction of any errors in the 2015 sunrise analysis, and second to elicit focused responses in those areas that drove the conclusions in the first analysis. ATAV provided a helpful and comprehensive reply, identifying points of factual dispute in the 2015 analysis and supplying supplemental information.[5]

OPR published a sunrise website[6] to elicit public comment on the proposal and to advertise a public hearing. A hearing Friday, October 28th, 2016, was broadly advertised to ATAV's membership and OPR licensees in the mental health professions. The hearing was broadcast by webinar to facilitate participation by interested parties unable to be present in Montpelier. A dedicated email address was established to receive public comment.

III. Existing Landscape for Art Therapists in Vermont

Most applications for new regulation under Chapter 57 invite the State to involve itself for the first time in regulating a profession or occupation that is wholly unregulated. That is not the case here. Situated as they are among the counseling and therapy professions, art therapists already are regulated under a thick blanket of State law—just not by name. Consequently, in this analysis, as in the 2014 analysis that preceded it, the relevant question is not whether the unregulated marketplace for art therapy services harms the public in ways that might be mitigated by regulation, but instead, whether State regulation of therapists and counselors harms the public by treating those professions generally, without a specific license distinguishing art therapists from other therapists.

Today, professionals wishing to offer art therapy to the public may do so in a number of recognized and regulated professional roles. Art therapy may be employed as a treatment modality by, among others, a psychologist licensed under Chapter 55 of Title 26; a psychiatric nurse practitioner licensed under 26 V.S.A. § 1611; a psychoanalyst certified under Chapter 77 of Title 26; an independent clinical social worker licensed under 26 V.S.A. § 3205; a clinical mental health counselor (LCMHC) licensed under Chapter 65 of Title 26; or a marriage and family therapist licensed under Chapter 76 of Title 26. A person ineligible for any of those licenses or certifications could yet register to be placed on the Roster of Psychotherapists who are Nonlicensed and Noncertified, under Chapter 78 of Title 26.

In a sense, legislators and regulatory authorities already have done the work of identifying what core competencies or other requirements should attend various types of licensed counseling and therapy. Over time, they have delivered a robust continuum of regulatory programs. Recalling the hierarchy of regulatory responses discussed in the preceding section, these programs span from mere registration, on the Roster, to full licensure predicated upon doctoral-level training, for psychologists and

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[4] For the particular questions posed, *see*, Gilman, G., letter to Elizabeth Myers, LCAT, CCMHC, ATR-BC, Government Affairs Chair, Art Therapy Association of Vermont, April 15, 2016; available at: https://www.sec.state.vt.us/media/775758/elizabeth-myers-letter.pdf.

[5] For ATAV's response, including supplemental application information, *see*, Myers, L., letter to Gabriel Gilman, General Counsel, and Colin Benjamin, Director, Office of Professional Regulation, July 11, 2015, available at: https://www.sec.state.vt.us/media/775757/2016-atav-supplement.pdf.

[6] https://www.sec.state.vt.us/professional-regulation/sunrise-review/art-therapists-2016.aspx

independent clinical social workers. In an effort to unify disparate counseling professions and set common standards for licensure, the Legislature established a six-member Board of Allied Mental Health Practitioners. 26 V.S.A. § 3262a. Represented on that Board are two licensed clinical mental health counselors, one licensed marriage and family therapist, one nonlicensed and noncertified psychotherapist, and two members of the public. *Id*. § 3262a(b).

It is the law of Vermont that "No person shall practice or attempt to practice clinical mental health counseling … unless the person is licensed …" 26 V.S.A. § 3262. Although the applicants are at pains to define art therapy as a fundamentally different profession from licensed clinical mental health counseling—the obvious, master's-level box into which a naive regulator would fit them—comparison of the statutory definition of "clinical mental health counseling" to art therapists' proposed statutory self-definition shows that the latter fits neatly within the former.

> *'Clinical mental health counseling' means providing, for a consideration, professional counseling services that are primarily drawn from the theory and practice of psychotherapy and the discipline of clinical mental health counseling, involving the application of principles of psychotherapy, human development, learning theory, group dynamics, and the etiology of mental illness and dysfunctional behavior to individuals, couples, families, and groups, for the purposes of treating psychopathology and promoting optimal mental health. The practice of clinical mental health counseling includes diagnosis and treatment of mental conditions or psychiatric disabilities and emotional disorders, psychoeducational techniques aimed at the prevention of such conditions or disabilities, consultations to individuals, couples, families, groups, organizations, and communities, and clinical research into more effective psychotherapeutic treatment modalities.*
> --26 V.S.A. § 3261(2) (bolded to emphasize common terms).

Compare the proposed statutory definition of *art therapy*:

> *'Practice of art therapy' means to engage professionally and for compensation in art therapy and appraisal activities by providing services involving the application of art therapy principles and methods in the diagnosis, prevention, treatment, and amelioration of psychological problems and emotional or mental conditions that includes, but is not limited to:*
>
> *(A) Clinical appraisal and treatment activities during individual, couples, family or group sessions which provide opportunities for expression through the creative process;*
>
> *(B) Using the process and products of art creation to tap into client's inner fears, conflicts and core issues with the goal of improving physical, mental and emotional functioning and well-being;*
>
> *(C) Using diagnostic art therapy assessments to determine treatment goals and implement therapeutic art interventions which meet developmental, mental, and emotional needs; and*
>
> *(D) Employing art media, the creative process and the resulting artwork to assist clients to:*
>
> *(i) reduce psychiatric symptoms of depression, anxiety, post traumatic stress, and attachment disorders; (ii) enhance neurological, cognitive, and verbal abilities, develop social skills, aid sensory impairments, and move developmental capabilities forward in specific areas;*
>
> *(iii) cope with symptoms of stress, anxiety, traumatic experiences and grief;*
>
> *(iv) explore feelings, gain insight into behaviors, and reconcile emotional conflicts;*
>
> *(v) improve or restore functioning and a sense of personal well-being;*
>
> *(vi) increase coping skills, self-esteem, awareness of self and empathy for others;*

> *(vii) improve healthy channeling of anger and guilt; and*
> *(viii) improve school performance, family functioning and parent/child relationship.*

--Application, p. 19 of 28 (setting out draft legislation).

The offered definition of *art therapy* describes a modality within clinical mental health counseling, a robustly regulated profession. Indeed, the definition of *clinical mental health counseling* at § 3261(2) recognizes that clinical mental health counseling cannot be a one-size-fits-all practice, and anticipates that practitioners will engage in "clinical research into more effective psychotherapeutic treatment modalities." Art therapy is one such modality, and by all accounts heard during the sunrise review, an extremely promising and important one.

The existing statutory requirements to become a clinical mental health counselor are structurally and substantively similar to those proposed for new and additional regulation of art therapists.

> *To be eligible for licensure as a clinical mental health counselor an applicant …:*
>
> > *(1) Shall have completed a minimum of **60 graduate hours and received a master's degree or higher degree in counseling or a related field**, from an accredited educational institution, after having successfully completed a course of study as defined by the board, by rule, which included a supervised practicum, internship, or field experience, as defined by the board, by rule, in a mental health counseling setting.*
> >
> > *(2) Shall have documented **a minimum of 3,000 hours of supervised work in clinical mental health counseling over a minimum of two years of post-master's experience**. Persons engaged in supervised work shall be entered on the roster of nonlicensed, noncertified psychotherapists[7] and shall comply with the laws of that profession, and shall have documented a minimum of 100 hours of face-to-face supervision over a minimum of two years post-master's experience. Clinical work shall be performed under the supervision of a licensed physician certified in psychiatry by the American Board of Medical Specialties, a licensed psychiatric nurse practitioner, a licensed psychologist, a licensed clinical social worker, a licensed marriage and family therapist, a licensed clinical mental health counselor, or a person certified or licensed in another jurisdiction in one of these professions or in a profession which is the substantial equivalent, or a supervisor trained by a regional or national organization which has been approved by the board.*
> >
> > *(3) **Shall pass the examinations** required by board rules …*

--26 V.S.A. § 3265.

The Legislature could not have intended, when establishing licensure of clinical mental health counselors, that each counseling modality explored within the profession, when found to be effective, necessarily would launch a new and separate regulatory program and profession. In fact, the Legislature went out of its way to leave sub-specialty regulation to the private marketplace, specifying that

[7] Note this use of the roster, on which psychotherapists who do not fit any regulatory box are permitted to practice, but required to register with the Board of Allied Mental Health Professionals, and in turn, to provide disclosure statements to patients. Within the roster are two groups: (1) therapists ineligible for certification or licensure under state law, who intend to remain so, and (2) therapists in training for licensure, who are required to register while practicing, but who intend to graduate to a more formal credential subject to more rigorous requirements. Registration is a final destination for some; a springboard for others.

"Nothing in this chapter shall be construed to prohibit the use and incorporation into the title of a clinical mental health counselor of a professional designation issued by a nationally recognized professional licensing organization." 26 V.S.A. § 3272. Thus are Vermont-licensed clinical mental health counselors expressly permitted and encouraged to earn and use professional designations just like the ATR and ATR-BC designations that art therapists seek to make the basis of a parallel and duplicative regulatory regime.

Chapter 57 sets out a decisive legislative policy that disfavors new professional and occupational regulation unless that new regulation is justified by a compelling need to protect the public that cannot be met by other means. As we move forward in this analysis under Chapter 57, in relation to a regulatory proposal that launches one profession from within another, the questions Chapter 57 challenges us to ask are: Is the regulatory *status quo* deficient in a way that demands new regulation?

IV. Regulation Proposed

The applicants propose minimum standards for governmental licensure of art therapists substantially equivalent to those required to obtain board certification by the non-governmental Art Therapy Credentials Board.[8] The Credentials Board offers three designations:

1. The ATR credential denotes Registered Art Therapist, while neatly addressing the difficulty of making an appealing initialism of that term.

2. The ATR-BC credential denotes Board Certified Art Therapist.

3. The ATCS credential denotes Art Therapy Certified Supervisor.

Individuals who hold one of those three credentials are easily located at the Art Therapy Credentials Board's online directory, under the heading, *Find a Credentialed Art Therapist*.[9] As of January, 2016, the directory identifies 35 Vermont residents who hold either the ATR or ATR-BC designation from the Art Therapy Credentials Board.[10] Of those, only 18 hold the more senior designation, ATR-BC, that exists as a private parallel to the governmental license proposed. Two of the 18 ATR-BCs in Vermont are inactive with the Credentials Board.

The applicants propose that the General Assembly establish a licensing mandate that effectively restricts the use of the terms "art therapist" or "art therapy" by any other practitioner—whether a psychologist, mental health counselor, independent clinical social worker, psychologist, or psychiatrist— no matter how qualified he or she otherwise may be, who does not qualify for the ATR-BC. Proposed minimum standards for licensure would include:

- a master's or doctoral degree in art therapy from an accredited educational institution;

[8] The Art Therapy Credentials Board maintains a website at https://www.atcb.org/. A handbook available at https://www.atcb.org/resource/pdf/ATR_ApplicationHandbook.pdf explains the levels of certification available, as well as application and annual maintenance fees.

[9] https://www.atcb.org/verify

[10] See 2014 *Application for Preliminary Sunrise Review Assessment,* p. 21 of 28, available at https://www.sec.state.vt.us/media/522903/Art-Therapy_Application-for-Preliminary-Sunrise-Review-2014.pdf.

- a minimum of 60 graduate credit hours in an art therapy program approved by the American Art Therapy Association, or a substantially equivalent program approved by the Director;
- 2 years consisting of not fewer than 2,000 hours of supervised art therapy experience, earned under the supervision of someone holding the ATCS credential or its equivalent, of which half followed receipt of the master's degree; and
- a passing score on the Board Examination of the Art Therapy Credentials Board.[11]

The draft legislation, at draft § 4907(c)[12] would make holders of the ATCS credential gatekeepers and guardians of the 2,000-hour supervision program required for licensure; however, at the printing of this report, only one such person resides in Vermont, according to the Art Therapy Credentials Board's website.[13] Consequently, a graduate student or recent graduate aspiring to an art therapy license would be obligated to complete a supervision program equivalent to fifty full-time weeks, where only one person in the State is known to be eligible to provide the required supervision. If Vermont is equipped to turn out exactly one new art therapist per year, one can expect that most applicants will go where the supervisors are. Maine and New Hampshire have none; Massachusetts and Connecticut each have one; New York, with a population of almost twenty million, has fourteen. To accommodate this problem, the draft legislation allows supervised experience under "[an]other qualified supervisor approved by the Director," in lieu of an ATCS. But among the in-state professionals who would fit that bill almost certainly would be licensed LCMHCs, calling further into question the practical utility of creating a parallel licensing regime to protect a subspecialty title.

Proposed coordination-of-practice language would create an exemption from art-therapist licensure as follows: "This chapter does not restrict a person licensed or certified under any other law of this state from engaging in the profession or practice for which that person is licensed or certified if that person does not represent, imply, or claim that he or she is an art therapists or a provider of art therapy."[14] This accommodation with other professions—some with doctoral-level training—would create a scenario where other qualified professionals may use art therapy, but they may not talk about it or advertise the service in terms comprehensible to consumers. Because one generally cannot provide therapy using art without implying to the observer that he or she is a "provider of art therapy," one might expect, as a consequence of the legislation proposed, that more qualified professionals are apt to stop using art therapy than to start.

Owing to (1) an exceedingly narrow path to licensure that bottlenecks at supervision, and (2) the probable effects of restrictive, art-therapy-specific title protection upon the marketplace behavior of qualified counselors and therapists holding other licenses, the regulatory regime proposed could have the paradoxical effect of sharply reducing the availability of art therapy to Vermonters.

[11] Application, pp. 21-22 of 28, available at https://www.sec.state.vt.us/media/522903/Art-Therapy_Application-for-Preliminary-Sunrise-Review-2014.pdf.
[12] *Id*, p. 22 of 28.
[13] *See* https://www.atcb.org/verify, where a *Credential Verification Search* identifies one Burlington resident as the State's only holder of the ATCS.
[14] Application, p. 20.

V. Summary and Analysis of Arguments for and Against Regulation

Based upon information contained in the request for regulation, interviews with interested parties and regulators of other counseling professions, written comments submitted, and independent legal and public health research, substantive arguments for and against regulation are identified and discussed in separate subcategories below. *Accord*, CVR 20-4-1: 2.3.

a. Prevention of Harm

There is no evidence that the existing programs regulating the practice of art therapy cause harm to the public that could be prevented by licensing art therapists under a freestanding, modality-specific license. Instances of reputed harm arising from insufficiently-regulated persons practicing therapy using art as a modality arrived by word of mouth, without names, times, or places, and consequently were not susceptible to verification. Those instances included, for example, the story of a psychology intern inappropriately using plaster to create a mask for a troubled child, causing the child to become agitated and to get plaster in her hair. A similar story related to a psychologist unwisely giving paint supplies to a child prone to physical agitation. Also by way of illustrating harm, the applicants asserted, without reference to any specific instance, that many professionals in Vermont use body tracings of children, and that such an activity could be distinctly threatening to victims of physical or sexual abuse. This analysis has been unable to confirm that body tracing is a common practice among Vermont therapy professionals. The propositions that (1) some art materials are inappropriate for volatile clients, or (2) that body tracing may be a very threatening incursion on the physical boundaries of an abuse victim, are not very much in doubt. What is, though, is that the particular master's level training suggested for art therapists is an exclusive means of imparting awareness of those propositions.

All professionals licensed by the Office of Professional Regulation, including those who are merely registered on the Roster, may be prosecuted and disciplined for unprofessional conduct for "[p]erforming treatments or providing services which the licensee is not qualified to perform or which are beyond the scope of the licensee's education, training, capabilities, experience, or scope of practice," or "failure to practice competently," which includes, "performance of unsafe or unacceptable patient or client care." 3 V.S.A. §§ 129a(a)(13) & 129a(b). This analysis was unable to identify any disciplinary prosecution arising from the inappropriate use of art practices or art materials by any registered or licensed therapist or counseling professional.

The legal standard set out at 26 V.S.A. § 3105 is that a profession or occupation shall be regulated only when "it can be demonstrated that the unregulated practice of the profession or occupation can clearly harm or endanger the health, safety, or welfare of the public, and the potential for the harm is recognizable and not remote or speculative." The harms supposed in this case are distinctly remote and speculative.

b. Assurance of Competence

Over the years, the Legislature has established licensing programs in clinical social work, psychology, clinical mental health counseling, and alcohol and drug counseling—each serving to assure the consumer of these sensitive services that a particular practitioner meets minimum standards of initial and continuing professional competency. This history implies a longstanding legislative finding that the public does benefit from the assurance of initial and continuing competence derived from regulation of

counseling and therapy professions generally. But nothing suggests that this assurance is enhanced when driven to the level of the particular modality used.

Fundamentally, it is unnecessary for the government to regulate specialty practices at the suggested level of granularity, because credible, non-governmental certifying bodies offer board certifications and other assurances of competency upon which consumers, referrers, and potential employers reasonably may rely. Today, most non-governmental certifications, like most government licenses, are databased and readily available to anyone with an internet connection. Excellent examples are found in the ATR and ATR-BC credentials offered by the Art Therapy Certification Board. Existing Vermont law unambiguously permits licensed clinical mental health counselors to earn and use the ATR and ATR-BC credentials offered by the Art Therapy Certification Board.

c. Reimbursement and Access

Proponents of new regulation argue that a separate and freestanding art-therapy license would facilitate payment by insurers, governmental healthcare payers, and public school systems, thereby improving access to care. Institutional payers generally will compensate only what they can understand and verify, and licensure does much for the required understanding and verification.

For art therapists practicing as licensed clinical mental health counselors, reimbursement rarely is problematic, as the LCMHC license is broadly recognized. For art therapists practicing as rostered psychotherapists, however, reimbursement often is problematic, because payers generally insist upon licensure as a precondition to reimbursement. LCMHC licensure ensures relevant training in terms of education, practical experience, and examination. Registration on the roster does not. As between licensure as an LCMHC and registration as a psychotherapist, it should be unsurprising that payers consistently favor the enhanced assurance of competence that comes with the former. Under the policies articulated in Chapter 57, this is as it should be. Marketplace pressure, not legislative mandates, naturally encourages therapists to avail themselves of the competitive benefits of LCMHC licensure. The governmental license provides an effective means of reducing information asymmetry between therapist and client or payer, thereby reducing uncertainty in the market for professional services. That the LCMHC credential provides a competitive advantage to practitioners of art therapy, in a context where some have the lawful option to do without it, is a signal that the credential is credible, meaningful, and effective at providing the assurances it is meant to provide.

Although this analysis did find frustration among graduates of art-therapy programs with the difficulty of receiving reimbursement for services, that frustration was exclusive to graduates who did not meet minimum qualifications for the LCMHC credential. Any art therapist who meets LCMHC criteria may, under existing law, obtain that license, and with it, much broader access to reimbursement than is available without it. To the extent that graduate programs are out of alignment with minimum statutory standards for a particular license, the public may be better served when the programs conform to the licensing standard than when the licensing standard is changed for the benefit of a non-conforming program.

d. Protection from Outside Control

Urgent appeals to the states to codify in statute a separate and parallel regulatory apparatus for art therapists arise from anxiety that national accrediting bodies are planning to standardize counselor

education in a manner that will marginalize art therapists and diminish the value of art-therapy degrees within the regulatory landscape. Asked what has changed since 2014, ATAV explains:

> *Of continuing concern is the progress that has been made by the National Board of Certified Counselors (NBCC) to define counseling more precisely and distinguish it more clearly from other "helping professions" as a clinical mental health discipline. The NBCC has moved aggressively to create a uniform image and training standards for all counselors based on the Council for Accreditation of Counseling and Related Educational Programs (CACREP) criteria. The united effort of the NBCC and other professional counseling groups has resulted in changing licensing standards in increasing numbers of states and eliminating licensing options for art therapists and others with counseling-related degrees. When AATA initially described this effort by the NBCC during the July 2014 San Antonio national art therapy conference, it was noted that 17 states (out of the 40 states that have AATA chapters or member groups seeking licensure) had adopted CACREP-only degree requirements or CACREP or equivalent degree requirements for counseling licenses. Some of the standards for the CACREP equivalent degrees were written so tightly as to apply only to CACREP-accredited programs or those in the process of gaining accreditation. Since that time, 8 additional states have enacted similar restrictions on counselor licenses, most recently in Connecticut. At least one additional state, Virginia, is completing a regulatory process to do so.*[15]

If art therapists saw the world with the prudent skepticism of a regulator, and if all regulators were prudently skeptical, there would be less cause for anxiety all around. Excessive and unmonitored delegation to accrediting bodies is a tendency inherent to governmental licensing, and one we must be careful to check. But unwise policy in other states does not portend, and certainly does not compel, unwise policy in this one.

Importantly, this analysis found nothing to suggest malign intent or malignant output emanating from CACREP and the NBCC. Accrediting bodies exist, in some sense, to eliminate options. Anyone who sets a standard eliminates the options below that standard. Seen in this light, an accrediting body working hard to enforce consistent training standards and uniformity among academic programs is an accrediting body doing its job.

More important, the applicants' underlying fear— that Vermont regulators "will adopt CACREP-only degree requirements or CACREP or equivalent degree requirements for counseling licenses"—is unwarranted. The *Administrative Rules of the Board of Allied Mental Health Practitioners* wisely avoid delegating, to CACREP or to any other non-governmental body, untrammeled authority to define what degrees are acceptable for licensing in Vermont. The rule governing acceptable non-CACREP degrees, CVR 04-030-350, § 3.8, Sub-Part- A, stands as the State's existing, independent standard of mandatory degree content, and consequently bears reproducing in full:

> *(a) To be considered an "acceptable" master's or higher degree in "counseling or a related field," the degree must contain no fewer than 3 graduate credits in "Diagnosis, Assessment and Treatment."*
>
> *(b) Diagnosis, Assessment and Treatment means: studies that provide an understanding of psychopathology. Studies in this area include the Diagnostic and Statistical Manual and its use in counseling, and assessing psychopathology. The course shall also include the development of*

[15] Myers, pp. 2-3.

treatment plans and the use of related services, and the role of assessment, intake interviews, and reports, if that material is not covered in another treatment course.

(c) If the degree does not contain 3 graduate credits in Diagnosis, Assessment and Treatment, the degree does not qualify as a degree in "counseling or a related field" and cannot be used as the basis for licensure as a clinical mental health counselor. The course work in Diagnosis, Assessment and Treatment must be completed within the degree conferred. This deficiency cannot be remedied by taking post degree course work. It cannot be supplemented.

(d) The degree must contain course work from no fewer than five of the seven areas (1) through (7) below:

> ***(1) Human Growth and Development:*** *3 Graduate credits. Studies that provide an understanding of the nature and needs of individuals at all developmental levels throughout the life span. Studies in this area would include theories of individual and family development and transitions across the life span, and theories of learning and personality development.*
>
> ***(2) Theories:*** *3 Graduate credits. Studies that survey counseling theories (e.g., Psychodynamic, Humanist, Behavioral, Transpersonal) and their historic and functional relationship to specific counseling approaches (e.g., Cognitive Behavior Therapy, Psychoanalysis, Family Systems, Solution Focused Therapy, Rational Emotive Therapy).*
>
> ***(3) Counseling Skills:*** *3 Graduate credits. Studies that provide an understanding of the counseling and consultation processes, development of student self-awareness, and the skills necessary for developing a positive therapeutic relationship.*
>
> ***(4) Groups:*** *3 Graduate credits. Studies that provide an understanding of group development and group dynamics. Studies in this area would include group counseling theories, group counseling methods and skills, group leadership styles, and other group work approaches.*
>
> ***(5) Measurement:*** *3 Graduate credits. Studies that provide an understanding of group and individual educational and psychometric theories and approaches to measurement. Course work would cover data and information-gathering methods, validity, reliability, psychometric statistics, factors influencing measurements, and use of measurement results in the counseling process.*
>
> ***(6) Professional Orientation and Ethics:*** *3 Graduate credits. Studies that provide an understanding of the professional counselor's roles and functions. Course work would cover professional counseling organizations and associations, history and trends within the counseling profession, ethical and legal standards, and counselor preparation standards and credentialing.*
>
> ***(7) Treatment Modalities:*** *3 Graduate credits. Studies that provide an understanding of specific treatment approaches such as Cognitive Behavioral Therapy, Feminist Therapy, Narrative Therapy, and Psychoanalytic Psychotherapy. Studies will focus on one or more modalities. Emphasis will be placed upon the application of theories to practice, including case conceptualization and corresponding therapeutic interventions.*

(e) If the degree does not contain the required credits in 5 of the 7 areas, the degree does not qualify as a "degree in counseling or a related field." It cannot be used as the basis for licensure as a clinical

mental health counselor. This deficiency cannot be remedied post degree. It cannot be supplemented.

(f) The degree must contain a supervised internship of at least 600 hours, as set forth below.

(g) A degree based from a program with fewer than 600 hours of supervised internship does not qualify as a degree in "counseling or a related field" and cannot be used as the basis for licensure as a clinical mental health counselor. This deficiency cannot be remedied post degree. It cannot be supplemented.

The rule above mandates, as a prerequisite to degree acceptance for the LCMHC credential, satisfactory credit hours in at least five of the seven counseling-related topics enumerated. The holder of a degree accepted with fewer than seven of the enumerated categories satisfied must make up the remainder post-degree. CVR 04-030-350, § 3.8, Sub-Part-B(a). To complete the argument that LCMHC degree requirements are excessive or irrelevant, proponents of art-therapist regulation would identify which of those seven core areas reasonably are expected of all LCMHCs except those who specialize in art therapy. That has not been done.

Though arguments against the application of LCMHC *degree* requirements to art therapists are unavailing, art therapists argue persuasively that *course* requirements[16], found just below, at CVR 04-030-350, § 3.8, Sub-Part- B(b), are strikingly rigid and of dubious relevance to the practice of art therapy. Specifically, LCMHC candidates must earn three graduate credits each in (1) multi-cultural studies, (2), research and evaluation, and (3) career development and lifestyle appraisal. Art therapy degree commonly satisfy Sub-Part-A requirements, but without satisfying Sub-Part-B career-development courses. Graduates of rigorous art-therapy degree programs understandably chafe at the result: many must return to graduate school to earn credits in career development and lifestyle appraisal, further described as including "studies that provide an understanding of career development theories, occupational and educational information services, career counseling, and career decision making."

Few art therapists or aspiring art therapists work through career issues with clients. To them, this LCMHC licensing requirement appears uniquely arbitrary and odious. The efficient solution, though, is not the establishment of a new regulatory program, but rather prompt review and reform, if warranted, of CVR 04-030-350, § 3.8, Sub-Part- B course requirements. This relatively simple fix would resolve the overwhelming majority of equity, mobility, and reimbursement problems described by commenters and hearing participants.

e. Balkanization: Regulating Modalities and Specialties vs. Core Competencies

Government regulation of professions and occupations historically has worked by gathering professional communities, defining core competencies common across each profession, codifying those in law or regulation, and then judiciously declining invitations to adjudicate, in the absence of compelling

[16] The distinction takes some chewing: Five of the seven *degree* content categories must have been part of the curricular program leading to a degree, or the degree is ineligible for recognition. *Course* requirements, by contrast, may be supplemented post-degree. Graduates of art-therapy programs, and other forms of modality-specific therapy curricula, earn much more *modality* credit than is required. This excess goes to waste under the existing LCMHC licensing rules. In view of the growth of quality, modality-specific curricular programs, regulations should be modernized to permit substitution of excess modality-based credit for mandatory credit requirements of dubious relevance, career-development conspicuous among them.

evidence, intra-professional disputes about which of a competing set of approaches, techniques, theories, or methods is best. In one telling, this is how progress toward professionalization is made. Where the government steps in prematurely to legislate winners and losers among competing modalities, the intrusion may harm the public by retarding innovation and freezing practitioners in old ways. As a general principle of professional regulation, we can most effectively and efficiently regulate a field by focusing on the health of its trunk rather than describing in law the nooks and crannies of its branches and leaves. This principle is the raison d'être for the Board of Allied Mental Health Professionals. Governmental nano-credentialing of the type proposed would risk advancing the professional fragmentation the Board of Allied Mental Health Professionals was created to prevent and cure.

That the government should stay out of nano-credentialing does not mean that specialty certifications have no utility. Where they offer market utility, specialty certifications tend quickly to become available from non-governmental certifying boards focused upon one or another specialty springing from core profession. To see this phenomenon in action, one need look no further than the Art Therapy Credentials Board, which will offer the ATR or ATR-BC to any Vermont practitioner who meets its criteria, whether or not Vermont issues a special art-therapist license. A practitioner wishing to distinguish himself with such a credential may do so, right now, under existing law. A consumer or healthcare payer wishing to have the extra assurance of competence attendant to such a credential may do so, right now, under existing law.

Those alarmed that the State does not license art therapists should be terrified to learn that the State equally declines to license cardiologists, otolaryngologists, cardiothoracic surgeons, pulmonologists, nephrologists, merger-and-acquisition attorneys, Freudian analysts, cognitive-behavioral therapists, and others practicing any number of deeply unique and highly consequential professions. Instead, we offer these practitioners more general licenses that recognize core competencies—a medical license; a law license; a psychology license. This regulatory model works if, and because, being a professional is synonymous with having the knowledge, duty, and obligation to understand one's own limitations. Our law reflects this. It is unprofessional conduct for any Vermonter licensed, certified, or registered, including rostered psychotherapists, to "perform[] treatments or provid[e] services which the [he or she] is not qualified to perform or which are beyond the scope of the [his or her] education, training, capabilities, experience, or scope of practice." 3 V.S.A. § 129a(a)(13).

The application in this case urges the Legislature to write a new chapter of Title 26 for a subspecialty of an existing profession. Regulation by subspecialty or modality is easy to start and hard to stop. Within the counseling and therapy professions alone, it is impossible to say why art therapists have superior claim to independence by comparison to narrative therapists, dance therapists, equine therapists, play therapists, drama therapists, feminist therapists, or music therapists. The achievable task of government regulation is to ensure that individuals entering these diverse fields have a common core of knowledge respecting the fundamentals of counseling theory, human psychology, clinical expertise, and professional ethics. Attempting to describe the branches of a field as they grow is a task to which legislatures and regulators are unsuited, and the attempt of it tends unfortunately to stunt growth. For reasons both principled and pragmatic, an invitation to engage in nano-regulation of subfields and modalities is best declined.

f. Scale

The very small number of prospective art-therapist licensees augers against independent licensure. We estimate that fewer than fifty Vermonters would seek licensure specifically as art therapists. But regulatory programs have fixed costs that become more burdensome and more difficult to justify when their beneficiaries are few in number. The costs of rulemaking, for example, include weeks of attorney time, the administration of public hearings, and publication of legal notices in newspapers of record. A parallel regulatory program for art therapists would require that investigative and prosecutorial staff invest hours orienting themselves to inconsistent statutes and rules from those attending mental health counselors. Demands inevitably would follow for enforcement of art-therapist title protection against other professionals alleged to be intruding upon protected territory. Litigation would follow as necessary to keep other practitioners in their respective boxes.

The parade of horrible expenditures set out above is little but a pejorative recitation of expected regulatory costs. But costs do not scale down to match the number of regulatees. The high per-capita cost of a new licensure program specific to art therapists is particularly difficult to justify where remarkably similar work is going on within the Board of Allied Mental Health Practitioners, with much lower expense per licensee, both because the licensees are more numerous and because the regulatory edifice already has been built.

g. Delegation

As described above, proponents of separate licensure for art therapists are driven in significant part by a fear that state governments throughout the country have over-delegated credentialing responsibilities affecting art therapists, such that non-governmental actors can effectively make state licensing policy. There is some irony, then, in the solution proposed: over-delegating to a different non-governmental actor. Instead of CACREP-or-equivalent degrees—which are not actually required in Vermont—we would require AATA-or-equivalent degrees.[17]

Fortunately, all that is required to avoid the perils of over-delegation is awareness. The Board of Allied Mental Health Professionals' rule on degree recognition, excerpted at length above, illustrates such awareness. By structuring a rule that recognizes a credible accreditor without giving away the store, the Board has effectively leveraged the benefits available from the accrediting body while avoiding the liabilities that arise from excessive delegation.

VI. Application of Statutory Criteria; Recommendations

We inquire first into the risk of harm presented by inaction. The applicant associations have not demonstrated the practice of art therapy under existing regulatory structures "can clearly harm or endanger the health, safety, or welfare of the public" with a "potential for … harm [that] is recognizable and not remote or speculative." 26 V.S.A. § 3105(a)(1). Instances of harm identified have been apocryphal and speculative. But more important, in those few cases where risk to the public arguably was shown to have arisen in relation to art therapy, the licensure program proposed would have done nothing to mitigate the risks identified.

[17] Application, p. 21 of 28.

We inquire next into whether "the public can reasonably be expected to benefit from an assurance of initial and continuing professional ability." 26 V.S.A. § 3505(a)(2). But because the fields in which one might practice art therapy as a modality already are pervasively regulated in Vermont, the question remaining for analysis is narrower: whether a public already able to rely on a range of counseling and therapy credentials would benefit yet more from specific assurance that an otherwise competent practitioner will use art competently as a therapeutic modality. To be sure, some would. However, members of the public wanting that assurance can have it from the non-governmental board certification offered by the Art Therapy Credentials Board. New regulation transforming non-governmental board certification into a statutory licensing mandate would add complexity, bureaucracy, and cost, with no countervailing benefit to the public health, safety, or welfare.

Finally, the applicant associations have not shown that "the public cannot be effectively protected" by means other than the creation of new regulation specific to art therapists. 26 V.S.A. § 3105(a)(3). A considerable regulatory apparatus already protects the public from incompetent or unscrupulous therapists, including art therapists. By available measures, that apparatus is effectively protecting the public right now, without need of new regulation. Although it is lawful to practice art therapy with a registration only, market pressure from consumers and payers desirous of enhanced assurances of competence impels many art therapists to pursue mental-health-counselor licenses. Where those licenses are too general to ensure competence in art therapy specifically, certification is available from the non-governmental Art Therapy Credentials Board and readily verifiable online.

The Office concludes that new regulation specific to art therapists does not meet the criteria required by 26 V.S.A. § 3105(a). New regulation creating a monopoly on the use of the term "art therapist," though proposed in hopes of increasing access to care, is likely to have the paradoxical effect of making it more difficult for consumers to find qualified providers of art-based therapies, because the regulation proposed operates by prohibiting qualified psychiatrists, psychologists, social workers, licensed mental health counselors, psychiatric nurse practitioners, and rostered psychotherapists from advertising art-based therapeutic services. One does not increase access to a professional service by choking its supply.

The Office recommends that the Board of Allied Mental Health Practitioners review its administrative rules to ensure that requirements for degree recognition are developed on the basis of public health and safety rather than private interest or path dependence; that its educational criteria for applicants do not call for undue or irrelevant coursework; and that its policies maximize, to the extent possible, the mobility of qualified therapists into and out of the state. Rigid course requirements in career development, in particular, appear conspicuously problematic to otherwise-qualified practitioners of art therapy and should be carefully reviewed and promptly eliminated if they cannot be justified. If the Board attends carefully to these duties—as we are confident it will—practitioners of art therapy should have no reason to fear exclusion from the diverse range of counseling modalities accommodated and effectively regulated by Vermont's existing regulatory programs.

Respectfully submitted to the House and Senate Committees on Government Operations.

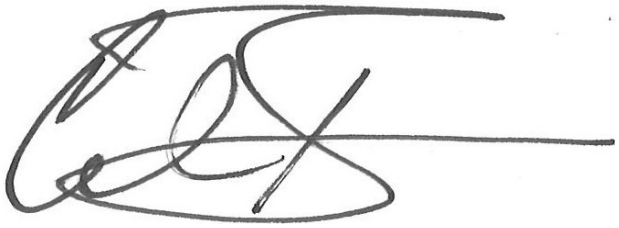
STATE OF VERMONT
SECRETARY OF STATE
OFFICE OF PROFESSIONAL REGULATION

BY:

February 6, 2017

Gabriel M. Gilman — Date
General Counsel

APPROVED:



February 6, 2017

Colin R. Benjamin — Date
Director

SUMMARY

MUSIC THERAPIST PRELIMINARY SUNRISE REVIEW ASSESSMENT

JANUARY 19, 2021

Conclusion: *OPR recommends that the General Assembly establish a creative arts therapy certification that incorporates music therapists, as well as other creative-arts-therapy professionals.*

Law Applied: 3 V.S.A. Chapter 57

Findings:

- The medical and privacy harms alleged in the sunrise preliminary review application do not meet the criteria set forth in 3 V.S.A. § 3105(a) because they are speculative, remote, and can be prevented by other means. This conclusion is supported by complaint data from other states.

- Even if the medical harms alleged were found to meet the statutory criteria, the proposed regulation (licensing music therapists) would not prevent these harms.

- The unregulated practice of music therapy does pose a risk of financial harm to the public that meets the criteria of 26 V.S.A. § 3105(a). Certification is the least restrictive form of regulation to address this financial harm.

- OPR recommends the establishment of a creative arts therapy certification to address the financial harm posed by the unregulated practice of music therapy and potential similar harms in other types of creative art therapies, and to ensure a cost-effective and efficient regulation.

VERMONT SECRETARY OF STATE
OFFICE OF PROFESSIONAL REGULATION

MUSIC THERAPIST PRELIMINARY SUNRISE REVIEW ASSESSMENT

JANUARY 15, 2021

Music therapy is a profession that provides great benefits to many of the most vulnerable in our society. OPR recognizes the tremendous good this profession offers. Based on the evidence provided, OPR finds the unqualified practice of music therapy poses only a speculative risk of mental or physical harm to the public or to the public's privacy. However, OPR finds that there is a non-speculative financial risk to the public. Because of the novelty of the profession and a lack of awareness about qualifications for music therapists, the public is at risk of engaging the services of unqualified individuals claiming to provide music therapy. OPR finds that a state-based certification is the least restrictive regulatory form to address this harm. Costs associated with a music therapist certification would be very high, given the limited number of qualified music therapists in Vermont. However, a creative arts therapy certification would provide the public with the necessary state-based indicators of qualifications for music therapists and other professionals using creative arts therapy modalities. Therefore, OPR recommends that the General Assembly establish a creative arts therapy certification that incorporates music therapists, as well as other creative-arts-therapy professionals.

Music therapists provide a gift to all clients with whom they interact. After an extensive review, it is clear to the Office of Professional Regulation that music therapists are talented individuals using their skills to help others improve their quality of life and achieve therapeutic goals. Scientific study and anecdotal stories support the conclusion that these professionals provide their clients with therapeutic benefits and improve health care experiences.

It is not as clear to OPR, however, that the unqualified practice of music therapy can cause harm. While those who do not hold the qualifications as a board-certified music therapists may not be able to offer clients the same benefits as the trained professionals, OPR has not been able to find any evidence that those subjected to the unqualified practice of music therapy suffer any harm that is not preventable by other means.

That said, the public may be harmed by misrepresentations and deception by individuals claiming to be trained music therapists. If the General Assembly determines that harm of that type warrants a regulatory response, we are mindful that practitioners of similar expressive-arts therapies have sought and will continue to seek state regulation. With that in mind, and because the costs associated with new regulatory programs are not easily borne by very small groups, the Office recommends that a broader

creative arts therapy certification be established that incorporates music therapists, as well as other professionals who use creative arts therapies.

Recommendations

After consideration of comments from the public, review of the application, and study of the available research and other states' sunrise review assessments for music therapist licensure, OPR recommends that the Vermont General Assembly establish a creative arts therapy certification. OPR finds that the unregulated practice of music therapy endangers the health, safety and welfare of the public only in so far as the public lacks access to information necessary to verify that an individual claiming to provide music therapy is, indeed, a music therapist who is qualified to provide this service. This is a harm resulting from a lack of information (at best) and deception (at worst). While there are other means to verify the credentials of an individual claiming to be a music therapist (e.g., searching the national associations' databases), OPR finds based on public comment that the music therapist profession and board certification of these professionals is not well known enough to effectively protect the public from unqualified individuals falsely claiming to provide music therapy.

Per 26 V.S.A. § 3105(b), the form of regulation must be the least restrictive necessary to address the public harm. OPR finds that certification of music therapists will address the harm of public misinformation by providing the public with an additional means of verifying individuals' credentials. At the same time, certification will not prevent musicians from sharing the joy of music with people living in facilities or at schools. If the Legislature opts to establish a certification for music therapists, OPR recommends that the certification include all creative art therapies. This will protect the public by offering a resource to verify the qualifications of other professionals using the creative arts as treatment modalities in therapy.

Background

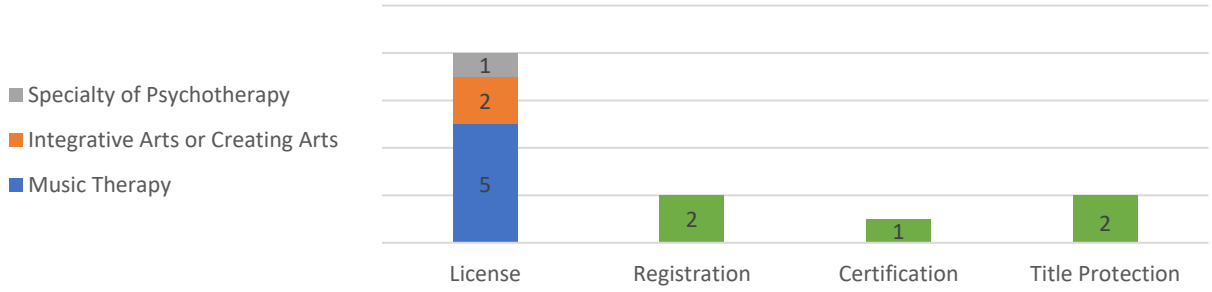
Music therapy is the "clinical and evidence-based use of music interventions to accomplish individualized goals within a therapeutic relationship." American Music Therapist Association website, https://www.musictherapy.org/about/musictherapy (last visited Jan. 4. 2021). To become a board-certified music therapist, one must complete an American Music Therapy Association ("AMTA") approved educational program. These programs can be bachelors-level, masters-level or doctoral-level. These programs include coursework in musical foundations, clinical foundations and music therapy foundations. Additionally, "the entry-level curriculum includes clinical coursework and extended internship requirements in an approved mental health, special education, or health care facility." *Id*. Board-certified music therapists must also pass a national examination administered by the independent Certification Board for Music Therapists ("CBMT").

Board-Certified Music Therapists claim to be distinct from other professionals using music in the health care setting, including therapeutic musicians, music thanatologists, clinical musicians and musical

practitioners, because music therapists intentionally use "music as the therapeutic mechanism" to "attain and/or maintain a maximum level of functioning using interactive music therapy strategies."

Thirteen other states regulate music therapists.[1] (Table 1) Seven of these states offer a license, two offer a registration, one offers a certificate, and two offer title protection (i.e., it is a misdemeanor for an unqualified individual to claim to be a "music therapist"). Of the states that offer a license, two (North Dakota and New Jersey, respectively) offer the license under an integrative health or creative arts therapy credential. Music therapists in New York are eligible for a creative arts therapy license as a specialty addition to an underlying license to practice psychotherapy.

Table 1: Thirteen Other States Regulate Music Therapists



Review Process

Pursuant to 26 V.S.A. § 3107, the Vermont State Music Therapy Task Force ("VMTTF") filed an application with the Office of Professional Regulation ("OPR") for a preliminary sunrise review assessment of regulating and licensing music therapists in Vermont. Their application can be viewed on the OPR website at the following address: https://sos.vermont.gov/opr/regulatory/regulatory-review/music-therapy-sunrise-review. The supporting documentation they provide is also available on the same web page.

The Office of Professional Regulation reviewed this application. OPR also made the VMTTF's application for preliminary sunrise review publicly available on its website, where the dates of the public hearings were also posted. An email address was posted on this website to which the public could send comments and questions. OPR held remote public hearings on October 28, 2020 (at 10:00AM) and on November 10, 2020 (at 6:00PM). Twelve people attended the first meeting and eleven attended the second hearing. Comments offered at both hearings were entirely in support of offering a music therapist credential, except for three comments asking about how current mental health professionals using music treatment modalities would be impacted by the regulation of music therapists. Additionally, OPR independently researched the benefits and harms associated with music therapy and other states' regulation of music therapy. OPR contacted the other states that regulate music therapy regarding complaints against music therapists since the commencement of music therapist regulation in that state.

[1] California, Connecticut, Georgia, New Jersey, New York, Nevada, North Dakota, Oklahoma, Oregon, Rhode Island, Utah, Virginia, and Wisconsin currently regulate music therapists in some form.

OPR received and reviewed 14 comments regarding the music therapy sunrise application. These comments were overwhelming in support of a state-based credential for music therapists. The most notable concern for commenter was that the public is unable to determine whether an individual who claims to provide music therapy is qualified to do so. Notably, the American Speech-Language Pathology Association (ASHA) wrote in opposition to the application for music therapist licensure. ASHA expressed concerns about the music therapists' scope of practice asserted in the VMTF application. Specifically, ASHA asks that any statutes regarding regulation of music therapists include a "prohibition on the diagnosis and treatment of communication disorders."

Legal Standards for Regulatory Review

Vermont law sets clear policies and objective standards for legislative review of proposed professional regulation. 26 V.S.A. Chapter 57 ("Chapter 57"). In sum, the law requires that a profession be regulated only for the purpose of protecting the public and, if a profession must be regulated, the regulations must be the least restrictive form of regulation possible to protect the public from the harm of the unlicensed practice of the profession. 26 V.S.A. § 3101 ("*It is the policy of the state of Vermont that regulation be imposed upon a profession or occupation solely for the purpose of protecting the public. The legislature believes that all individuals should be permitted to enter into a profession or occupation unless there is a demonstrated need for the state to protect the interests of the public by restricting entry into the profession or occupation. If such a need is identified, the form of regulation adopted by the state shall be the least restrictive form of regulation necessary to protect the public interest...*").

Vermont law provides that a profession shall be regulated only when the following three criteria are met:

> *(1) it can be demonstrated that the unregulated practice of the profession or occupation can clearly harm or endanger the health, safety, or welfare of the public, and the potential for the harm is recognizable and not remote or speculative;*
>
> *(2) the public can reasonably be expected to benefit from an assurance of initial and continuing professional ability; and*
>
> *(3) the public cannot be effectively protected by other means.*

26 V.S.A. § 3105(a).

To assist the General Assembly in determining whether regulation of a profession is necessary to protect the public, OPR is charged with conducting a preliminary sunrise review assessment of the above three criteria and providing that assessment to the General Assembly in writing. OPR must base this preliminary assessment report on the "information contained in the request for regulation, oral

comments received at the public meeting, written comments submitted after the public meeting, its own budget analysis, and any other information pertinent to the request." VT ADC 20-4-1:I.

Vermont law further provides that, if, after consideration of the criteria set forth in 26 V.S.A. § 3105(a) and the "governmental and societal costs and benefits," the General Assembly determines that regulation of a profession is necessary, the least restrictive method of regulation must be imposed, consistent with public interest and the following criteria:

> *(1) If existing common law and statutory civil remedies and criminal sanctions are insufficient to reduce or eliminate existing harm, regulation should occur through enactment of stronger civil remedies and criminal sanctions;*
>
> *(2) If a professional or occupational service involves a threat to the public and the service is performed primarily through business entities or facilities that are not regulated, the business entity or the facility should be regulated rather than its employee practitioners;*
>
> *(3) If the threat to the public health, safety, or welfare, including economic welfare, is relatively small, regulation should be through a system of registration;*
>
> *(4) If the consumer may have a substantial interest in relying on the qualifications of the practitioner, regulation should be through a system of certification; or*
>
> *(5) If it is apparent that the public cannot be adequately protected by any other means, a system of licensure should be imposed.*

26 V.S.A. §3105(b).

Pursuant to the above, OPR has reviewed the application submitted by the Vermont Music Therapy Task Force and now submits the following preliminary assessment of the application for regulation and licensure of music therapists. This report also provides recommendations about the least restrictive form of regulation that should be imposed upon music therapists.

Application of 26 V.S.A. § 3105 Criteria

To demonstrate that the unregulated practice of music therapy can "clearly harm or endanger the health, safety, or welfare of the public," the applicants, the Vermont Music Therapy Task Force (VMTTF), provided the examples of both medical and non-medical (privacy and financial) harms that may result from the unregulated practice of music therapy. OPR finds that the medical harms proposed are speculative, and, thus, do not support the regulation of the profession under 26 V.S.A. § 3105(a). Regarding the non-medical harms posited by the applicants, OPR finds that the privacy harm is remote and speculative (and, thus, not sufficient to support regulation), but that the public may be financially

harmed by the unregulated practice of music therapy. The public may suffer a financial harm because of a lack of sufficient information to ensure that the service being paid for is from a qualified music therapist.

Analysis of Medical Harms

(a) *OPR Finding: The medical harms alleged in the application are speculative, remote, and can be prevented by other means.*

VTTF and the AMTA provided the following examples of medical harms to support the need for the regulation of music therapists:

- "A nursing home patient with Lewy body dementia, was engaged in a group music sing-along that utilized songs from the big band era. [Lewy Body dementia is a rare form of dementia, one of the prominent symptoms of which is aggressive outbursts.] At some point the man became progressively upset, and started yelling and threatening other patients and staff. The musician facilitating the sing-along decided to try a different song to engage this man and calm him down. Unfortunately, the song choice only exacerbated the mood and situation. The patient, very distraught and confused, struck another patient and staff member, and in the process stood up and fell. This elderly gentleman was not able to heal, spent his last week in pain, and died in a nursing home in Roanoke, Virginia a few weeks after this incident….The group was facilitated by an entertainer that contracted with small nursing homes and group homes. Part of his brochure included the term music therapy, and although he was not a music therapist, he used many examples of the benefits of music with the elderly. This entertainer did not have the training and a clinical understanding in working with a patient with Lewy body dementia, and to this, did not have the necessary clinical skill set to support the needs of this patient, who became rapidly confused and decompensated into violence…"[2]

- "There was a young teenager who ran his snowmobile into a tree and had a traumatic brain injury. He was in a stage of coma where he was extremely agitated. His parents consulted with someone who claimed to be a music therapist but was not. The person programmed music for them to play at their child's bedside to help him relax. The result of that music was increased agitation, increased heart rate (to dangerous levels), and decreased oxygen saturation rates. This necessitated increased sedation medication, which itself can have negative side effects. The family was playing some beautiful Mozart concerto when the music therapist arrived. The child was in restraints and writhing on his bed. When the music therapist asked the mother if her son liked classical music and would have selected it to relax prior to the accident, she replied, 'oh no. He hates classical music!' The music therapist asked them to turn off the music, but his agitation continued. After explaining the connection between musical preference and relaxation, the family

[2] Example submitted by the American Music Therapy Association.

disclosed their son would relax to gangster rap. After conducting further assessment, the music therapist developed a music listening program specifically for the patient. As soon as she started playing music that would help him relax, he let out a sigh and appeared to visibly relax. His heart rate lowered to normal in less than three minutes and his oxygen saturation rate went from 82% to 96% and remained stable. He was able to relax enough he fell asleep without further sedation medication, allowing his body and brain to focus on healing."[3]

- At least one Vermont hospital has been approached by an individual who wanted to provide "music therapy" services in the neonatal intensive care unit (NICU) and did not have any education or clinical training in music therapy. This is concerning because infants in the NICU have fragile neurological systems that can become overstimulated and cause stress. Stress in NICU patients can be detrimental to their progress and can worsen medical conditions (e.g. increased heart rate in an infant with a congenital heart defect). Stress in an infant can lower oxygen saturation and can have an effect on neural structure, function, and development. Board-certified music therapists have specific training in implementing evidence-based NICU intervention, recognizing infant distress signals, and knowledge of infant neurological development to inform what levels and type of music is most appropriate. Through their specialized training, board certified music therapists know that infant distress signals can be extremely subtle and, therefore, remain acutely aware when providing any type of stimuli in this setting.

- Music therapists often work with individuals with seizure disorders. There is evidence-based research documenting the potential for music and auditory stimulation trigger seizure activity. For individuals where music is not a trigger for seizure activity, there is still a risk if their seizure threshold is low. Thresholds can change based on a multitude of factors. Music therapists have the clinical training to determine when or when not to use music with these individuals.

- Noncompliance with safety protocols and guidelines in the clinical environment, including those related to appropriate sound environments, can result in hearing loss, injury, infection, regression, or even death.

- There are observed instances of music causing increased agitation and emotional distress for veterans with PTSD. For veterans, hearing patriotic music can activate a trauma-based response. MT-BCs are equipped to anticipate potential triggers and thereby avoid causing harm by avoiding certain music. When activating music is not pre-identified, music therapists are highly trained in order to manage and support individuals going through a trauma response.

[3] Example provided by the American Music Therapy Association.

- An intern (who went on to become a board-certified music therapist) worked briefly with an untrained, uncertified individual, who purported to be a music therapist in central Vermont. The individual was observed dispensing psychological advice to an adult male with developmental delays and a background of uncontrolled behavior patterns, including outbursts of uncontrolled anger. This individual directed the client out of the therapy space and into his private bedroom, in order to demonstrate an anger-management technique. Although the client seemed uncertain, he dutifully complied. Once upstairs, the individual picked up a pillow from the client's bed, and proceeded to hurl it upon the mattress, while releasing a loud shout. The client appeared alarmed and ill-at-ease, expressing concern for his pet cat, who had dashed off in obvious distress.

OPR finds that these medical harms asserted by the applicants are remote and speculative and, thus, do not fulfill the first criteria set forth in 26 V.S.A. § 3105(a)(1). With regard to the example of the man with Lewy Body dementia, OPR finds that this harm is remote and speculative because there is no showing that the harm was not due to poor oversight by the nursing home staff or to the man's disease, rather than the unqualified practice of music therapy. In the example given, the applicant states that an investigation into the incident found "there to be a progression of bad decision-making and choices within the environment of the activity setting, [and] placement of the patient" in addition to the "clear and observed effect of music and music activity increasing agitation, confusion, and distress." Nor was there any showing that the man's reaction was due directly to the music or that it would not have occurred otherwise due to a different environmental or internal stimulus. No clinical or scientific studies or empirical data was provided associating music and the instigation of Lewy Body dementia symptoms. OPR has not had the opportunity to speak with any parties involved in the incident to determine whether music instigated the outburst or if there had been any antecedent events that resulted in or led to the accident. Given the limited amount of information provided, OPR finds that it is speculative to conclude that the unqualified practice of music therapy led to this man's outburst, let alone his eventual death. OPR must also conclude, based on conclusions from the summary of the investigation into this incident, that there were environmental and medical ways to prevent this harm from occurring other than requiring the licensure of music therapists.

Similarly, the example about the young boy in the coma is an anecdote of harm that OPR finds to be speculative. The example appears to have originated in 2012 and has been used, with varying elements, in licensing advocacy efforts since then. OPR cannot identify the patient, the parents, or the caregivers to determine whether music was the cause of the agitation or some other stressor. Again, no clinical or scientific studies or empirical data were presented showing an association or causative relationship between the unqualified practice of music therapy, here, and the perceived harm in the patient (agitation). OPR is unable to conclude from just the example provided that the unqualified practice of music therapy caused the harm in this instance.

Further, the harm to this patient is preventable by means other than requiring music therapists to hold a license. Staff is present to monitor the patient's vital signs and observe significant agitation. In such instances, staff may consider stopping all external stimuli, including music, to assess what is causing

the agitation, even if it is found to be caused by the unqualified practice of music therapy. Regarding the more general medical harms proposed (i.e., to NICU patients, to those who suffer from PTSD, and to people with epilepsy), OPR must again conclude that the harms are remote and speculative. In the above examples, the applicants provided no clinical or scientific studies or empirical data showing an association or causative relationship between the unqualified practice of music therapy in these environments and the harms that were presented. No Vermonters claimed that these harms have occurred, nor did the applicants provide examples of these harms actually occurring in Vermont or elsewhere.[4]

The applicant alleges that the unqualified practice of music therapy in the NICU will harm infant patients. However, the applicant did not provide any clinical or scientific data supporting the conclusion that music is the cause of vital sign fluctuations in NICU patients. Nor was OPR able to find any studies or data supporting this conclusion in its independent research. There are many stressors in the NICU environment, and the patients are particularly vulnerable. Even exhaustive studies of stress factors in the NICU have been unable to pinpoint a single cause of stress or attribute health outcomes to certain stressors. See https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4627473/ (last viewed Jan. 4, 2021). OPR, thus, finds it speculative to associate the unqualified practice of music therapy with harm to infant patients in the NICU.

The alleged harm to veterans suffering from PTSD is unique from the other medical harms that the applicants associate with the unqualified practice of music therapy because the patients, here, have the capacity to communicate preferences. In turn, patients can communicate to any musician playing music in a clinical setting that they have PTSD reactions to certain songs and types of songs. In doing so, the risk of harm from the unqualified practice of music therapy seems greatly mitigated and, thus, remote. Similarly, patients suffering from the very rare condition of musicological epilepsy (i.e., epileptic seizures triggered by certain music) can seek out the services of a board-certified music therapist or avoid musical therapy all together. OPR finds that both these purported harms are speculative and remote.

The applicant's last medical claim of harm is that, as therapeutic providers, board-certified music therapists are better trained in COVID-19 prevention measures than the general public, and that board-certified music therapists are trained to comply with the infection-prevention requirements of clinical settings, unlike unqualified music practitioners. This is a speculative harm. No support for the claim that music therapists are more aware of or more qualified to prevent COVID-19 infection than the general public was offered. Nor was there any support offered for the claim that music therapists are better able to prevent infections in clinical settings than unqualified music practitioners. Based on the above, OPR must conclude that the medical harms presented by the applicants are only speculatively associated with

[4] The applicants mention that there are studies supporting these claims. However, only a study summary is provided, and it speaks only about the benefits of music therapy. We have no doubt that such therapy can be helpful. *See* Detmer, Michael R., MME, MT-BC (NICU-MT), Music in the NICU: An Evidence-Based Healthcare Practice with Proven Benefits. The question OPR must answer, though, is whether the unqualified playing of music in these environments is detrimental. Nothing in the one study summary provided indicated any harms from the unqualified practice of music therapy.

the unqualified practice of music therapy, and do not fulfill the first criteria set forth in 26 V.S.A. §3105(a)(1).

Not only are these more general medical harms proposed remote and speculative, but they are also "effectively" preventable "by other means." 26 V.S.A. § 3105(a)(2). Regarding the infection risk, staff in medical facilities are well-trained in and capable of guiding visitors, whether clinical, family, or untrained music practitioners, in standard infection-prevention protocols. In the NICU, nursing staff is present and can attend to a patient whose vital signs fluctuate. As noted above, regarding the inducement of epileptic seizures and PTSD, those suffering from musicological epilepsy and PTSD can choose not to partake in any therapy that involves music, regardless of whether such therapy is provided by a board-certified music therapist or an untrained music practitioner. Alternatively, individuals with these conditions can request that certain types of music be avoided. In turn, the harms presented can be effectively prevented by other means and, thus, further fail to fulfill the criteria set forth in 26 V.S.A. § 3105(a).

(b) OPR Finding: The proposed regulation will not prevent all the medical harms alleged.

Though not a statutory element, it is helpful to note that the regulation sought (i.e., the licensure of qualified music therapists) would not prevent some the purported harms, even if OPR accepted the assertion that the harms are not remote or speculative or effectively prevented by other means. The applicant's proposed definition of music therapy (and the practice thereof), focuses on the therapeutic use of music to achieve goals. ("The clinical and evidence-based use of music interventions to accomplish individualized goals for people of all ages and ability levels within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program."[5]) Licensing requirements, if implemented, would require individuals to obtain a license only if they were intending to use music for these therapeutic purposes. Musicians would still be permitted to offer music for relaxation, enjoyment, comfort and other purposes. Members of these musicians' audiences who are susceptible to music-induced "harms" (e.g., the individual with Lewy Body dementia, if the applicants assertions are accepted; audience members with PTSD or musicological epilepsy) would not be protected by laws requiring music therapists to obtain a license.

Additionally, if the alleged harm is that people may react negatively (sometimes severely so) to music, licensing music therapists will not address the harm. Music is an almost ubiquitous element in life. To use an example from the applicant, an individual with musicological epilepsy will not be protected from a law that requires music therapists to hold a license, when that individual hears a song in the grocery store that induces a seizure. Similarly, veterans who experience PTSD when hearing certain music will not be protected by a law that requires music therapist licensure when that veteran attends a wedding or turns the radio on in the car.

[5] AMTA website, https://www.musictherapy.org/about/musictherapy (last viewed Jan 4, 2021).

Thus, even if OPR found that alleged harms are not remote or speculative, licensing music therapists would not prevent several of the potential harms except in a very limited clinical or therapeutic setting.

(c) *OPR Finding: Complaint data from other states supports the conclusion that the alleged medical harms are speculative.*

The lack of complaints about music therapists in other states that regulate music therapists further supports the conclusion that the harms alleged are remote and speculative. Thirteen states currently regulate the practice of music therapy. See Table 2. Wisconsin was the first state to offer a music therapist license in 1998. OPR contacted ten of the thirteen states to inquire about complaints received about the practice of music therapy and any resulting disciplinary action.[6] OPR received responses from eight states, the results of which are shown in Table 3. The data from these states show that very few complaints have been filed and little to no discipline has been imposed for violation of the music therapy laws or for the unlicensed practice of music therapy in any of these states. This data further supports the conclusion that neither the unlicensed practice of music therapy nor board-certified music therapists endangers the health, safety and welfare of the public.

Table 2
States with Music Therapist Regulation

State	Year of Initial Regulation	Type of Regulation	Number Holding Credential**
California	2019	Title Protection	N/A
Connecticut	2016	Title Protection	N/A
Georgia	2012	License	227
New Jersey	2020	License (Creative Arts Therapy)	N/A
New York	1990	License (Creative Arts Therapist; addition to underlying psychotherapy license)	1,576
Nevada	2011	License	
North Dakota	2011	License (Integrative Health Care)	21
Oklahoma	2016	License	36
Oregon	2015	License	118
Rhode Island	2014	Registration	14
Utah	2014	Certification	89
Virginia	2020	License	N/A
Wisconsin	1998	Registration*	70***

[6] OPR did not contact New York, Virginia or New Jersey. Virginia and New Jersey passed laws regulating music therapists in 2020 and not enough time has passed for those states to establish regulations or receive any complaints. New York regulates music therapists in conjunction with an underlying license permitting psychotherapy. In turn, OPR did not think complaint and disciplinary data from the state would be relevant to the regulation of music therapy as an independent, rehabilitative and mental health therapy profession, not to data specific to music therapists

* Wisconsin law offers an option to obtain a license in music therapy for individuals who wish to provide psychotherapy in conjunction with music therapy.
** Based on data from the states' websites, checked on 1/4/2021.
*** Based on data from the West Virginia Music Therapy State Task Force Sunrise Report (2017).

Table 3
Complaints Against Music Therapists by State

State	Complaint	Reason for Complaints	Discipline
California	N/A*	N/A	N/A
Connecticut	N/A*	N/A	N/A
Georgia	10	Not available	No discipline
New Jersey	Not yet available	N/A	N/A
New York	N/A**	N/A	N/A
Nevada	0	N/A	N/A
North Dakota	3	Unlicensed practice	Letters of Warning
Oklahoma	0	N/A	No Discipline
Oregon	3	1 continuing education; 1 inactive license; 1 billing	Inactive license and billing violation pending; continuing education: no discipline
Rhode Island	No response	N/A	N/A
Utah	1	Practicing beyond scope of license	No discipline
Virginia	Not yet available	N/A	N/A
Wisconsin	1	Complaint was in 1999 and no records remain	No discipline

*In states with title protection as regulation, use of the "music therapist" title without the appropriate qualifications is a criminal offense. There is no qualifications-based regulation and, thus, no system for complaints or regulation based on the practice of music therapy.
**Because New York offers a creative arts therapy licenses as an addition to an underlying mental health psychotherapy license and to therapists who use various forms of creative arts as therapy modalities (e.g., dance/movement, drama, music, poetry, art), OPR was unable to discern whether complaints related to the practice of music therapy.

Analysis of Privacy Harm

The applicants allege that the unlicensed practice of music therapy poses a threat to the privacy of clients seeking music therapy. The alleged privacy harm would arise if a consumer engaged the services of someone who purports to be a music therapist believing that that the individual is a health care provider obligated to keep patient information confidential. The consumer may then make disclosures to the music practitioner that they would not normally share with a non-health care provider, and the musical practitioner, perhaps unaware of a health care provider's obligation under patient confidentiality laws, may improperly disclose the consumer's information.

As with the medical harms discussed above, OPR finds the alleged privacy harm to be speculative. Neither the applicants nor any commenters reported any case of a Vermonter experiencing disclosure of personal health information after falsely believing a music practitioner to be a health care provider. OPR did not find such an instance in its research and other states that regulate music therapists did not share any such instances with OPR when OPR inquired. The applicants provided no evidence of such harms occurring. While it is always possible that such a breach of privacy could occur, there is no evidence that it ever has. Thus, OPR finds this privacy harm to be speculative.

Analysis of Financial Harm

a. *OPR Finding: The unregulated practice of music therapy does pose a risk of financial harm to the public that meets the criteria of 26 V.S.A. § 3105(a).*

OPR does find that the unregulated practice of music therapy endangers the welfare of the public in that such unregulated practice makes the public susceptible to false claims from untrained individuals claiming to provide music therapy. The applicants state that members of the public have been harmed when they have engaged unqualified music practitioners to provide music therapy without knowing that the music practitioners were not qualified to provide music therapy. The harm in this instance is one of deception and misinformation: the consumer has paid for a service that the provider is not qualified to render and that is not, in turn, received.

Commenters supported the applicants' claim about a lack of knowledge about music therapists and board certification. Representative Carol Ode shared that her mother had benefited from board-certified music therapist services engaged by her mother's hospice providers. Prior to her experience with her mother, Rep. Ode was not well informed about music therapy or its use in health treatment, or that there was a way to verify the distinction between a music practitioner and a board-certified music therapist. She stated that, without regulation, the layperson would have no way of knowing the distinctions between a music practitioner and a board-certified music therapist, or the services they provide.

Similarly, Cara Feldman-Hunt, the director of UVM Integrative Health Program, noted that a state music therapist license would help her verify the qualifications and credentials of individuals seeking to provide music therapy. She reported concern that members of the public would not know about the distinction between qualified music therapists and those without training who claim to provide music therapy. Other commenters noted confusion among those in the community (e.g., preschool directors, nursing home administrators), who are hiring unqualified individuals claiming to be providing music therapy and receiving musical entertainment, instead.

Finally, other states reported several complaints of individuals claiming to provide music therapy when not holding a board certification. While no harm to the public appears to have arisen from these false claims, these complaints are evidence that the harm of deception is not speculative. Thus, due to a lack of information about music therapy qualifications, there is a financial risk that the public will unintentionally engage the services of someone who purports to be providing music therapy but is unqualified to do so.

OPR further finds that existing means to address this harm posed by confusion and a lack of information are not well known enough to effectively protect the public from misrepresentations by untrained individuals claiming to provide music therapy. The AMTA and the CBMT offer a database through which members of the public can find board-certified music therapists in each state. However, board certification of music therapists and the profession, itself, are novel and, based on comments received by OPR, few know to search this database prior to engaging the services of an individual claiming to provide music therapy. Thus, the databases are insufficient to effectively protect the public from the financial harm of unqualified individuals falsely claiming to provide music therapy.

Regarding this harm, the public would benefit from OPR offering a license, registration or certification indicating that an individual claiming to provide music therapy has the requisite qualifications. Regulatory oversight by OPR would be familiar to most who are used to engaging professionals for therapeutic services. Additionally, OPR would provide a location where the public could search to see if an individual claiming to provide music therapy has the requisite qualifications, and to seek out providers with such qualifications. Therefore, with regard to the alleged financial harm, all the criteria of 26 V.S.A. § 3105(a) are met and OPR recommends regulation of the music therapy profession to address this financial harm.[7]

(b) <u>OPR Conclusion</u>: Certification is the least restrictive form of regulation to address this financial harm.

If the General Assembly agrees with OPR that regulation of music therapists is necessary to protect the public from the harm of untrained individuals claiming to be music therapists, the law directs the General Assembly to select the least restrictive form of regulation possible. 26 V.S.A. §§ 3101(b) and 3105(b). Per 26 V.S.A. § 3105(b), when neither existing laws nor the regulation of business entities is sufficient to protect the public from the harm caused by the unregulated profession, one of three forms of regulation shall be imposed: licensing, certification, or registration. Licensing is the most restrictive form of regulation. Individuals seeking to practice a licensed profession must be licensed and they must demonstrate achievement of certain qualifications to obtain the license. Certification is less restrictive in that it is voluntary. To obtain a certification, members of the profession must demonstrate that they have achieved certain qualifications. However, individuals may practice the profession without obtaining a certification. Often accompanying the certification form of regulation is a legal protection of the title of the profession or the adjective "certified" modifying the profession (e.g., "certified music therapist"). The third form of regulation is a registration. This form of regulation is mandatory – all who wish to practice the profession must obtain a registration. However, there are minimal, if any, qualifications required to obtain a registration.

[7] It is important to reiterate that OPR has not found that any threat of physical or mental harm to the public from the untrained practice of music therapy. The harm resulting here is one of consumers potentially being deceived into engaging the services of an individual claiming to provide music therapy when the individual is not able or is unqualified to do so. It is a financial harm based on fraud and misinformation.

In the case of music therapists, OPR believes certification is the least restrictive form of regulation possible to address the potential harm to the public of untrained individuals claiming to be music therapists. Requiring a full license is too broad and restrictive given that OPR has found that there is no evidence that the practice of music therapy by untrained individuals causes harm. Licensure would require all musicians in Vermont who wish to provide any form of therapeutic music to meet certain qualifications and obtain a license. This risks preventing musicians who play music in health care settings from sharing music with people in facilities or students in schools. There are several types of Vermont musicians who practice in health care environments (e.g., music thanatologists, certified music practitioners, therapeutic harp musicians, healing harm musicians). These practitioners do claim to offer therapeutic benefits from their music. A law requiring these individuals to become licensed and obtain the same credentials as music therapists, or alternatively to no longer use the word "therapeutic" in association with their music offerings would negatively impact their ability to continue to practice. It is possible that, if music therapy regulations pass, facilities, from nursing homes to schools to hospitals and hospices, will be deterred from seeking the services of non-licensed musical practitioners who use music for therapeutic purposes for fear of liability or the lack of a therapeutic title, as well as, potentially, non-therapeutic musicians who seek only to entertain or provide relaxation.

Additionally, many licensed Vermont professionals (e.g., licensed clinical mental health counselors, licensed marriage and family therapists, licensed alcohol and drug counselors, rostered psychotherapists, psychoanalysts, occupational therapists, speech-language pathologists, social workers, psychologists, massage therapists) use music as a treatment modality in their practice. A licensing law could exempt these professionals from obtaining a music therapy license prior to using music as a treatment modality. However, the proposed licensing legislation would also prohibit these professionals from calling the use of music as a treatment modality, "music therapy". Practically, this requirement may not have much of an impact but it does pose the question of why the government should be prohibiting individuals with extensive training, qualifications and expertise in their field of therapeutic care from calling a therapeutic treatment technique "music therapy."

Finally, a licensing law may prevent many of Vermont's vulnerable populations from accessing music as entertainment or in any therapeutic form. As noted earlier, facilities may be deterred from engaging unlicensed musicians using music therapeutically. Given that there are only 15 board-certified musical therapists in Vermont, however, many facilities and organizations would not be able to find or engage a licensed music therapist. As a result, licensing music therapy to the exclusion of other musical practitioners using music in a health care setting may result in a lack of access for many of Vermont's most vulnerable populations.

Alternatively, a registration form of regulation would not address the issue of having untrained individuals claiming to provide a service they are not qualified to provide. Any person could obtain a registration without any qualifications. Thus, the member of the public seeking a qualified music therapist would not be served by a regulation that indicates only that a person claiming to provide music therapy has registered with the state.

A certification form of regulation is narrowly tailored to address the harm that OPR found (i.e., the risk of the public being deceived or misinformed by untrained individuals claiming to be qualified music therapists) without being so broad as to exclude other music practitioners from providing music in health care settings. Under such a certification law, professionals who wish to claim to be a "certified music therapist" to the public would need to demonstrate to OPR that they had met certain qualifications. The public could then be reassured by the term "certified" preceding "music therapist" that the "certified music therapist" has the qualifications being sought, and could readily determine (either by use of the term or looking at the OPR professional lists) whether an individual who claims to be a qualified music therapist holds the certification. At the same time, music practitioners who offer clinical music or music in a health care setting could continue to offer their services without regulatory impediment or public confusion.

Therefore, based on the finding that there is a financial harm posed to the public from the unregulated practice of music therapists that cannot be effectively prevented by other means, OPR recommends that the state establish a certification program to address this harm.

Creative Arts Therapy Certification

OPR Finding: *OPR recommends the establishment of a creative arts therapy certification.*

OPR is concerned about the costs associated with issuing a separate music therapy certificate. It is the policy of the State of Vermont that "the cost of regulating a profession attached to OPR should be borne by the profession" and that "one profession should not subsidize the cost of regulating another profession." 3 V.S.A. §124(a). The applicants estimate that there are currently 15 board-certified music therapists in Vermont. Even if music therapists are regulated as an advisor profession, which is less expensive to administer than a board profession, there will be significant costs to regulate the profession, including staff, technology and administrative resources. While OPR would be able to implement and manage a separate music therapy credential, it would be an expensive credential and may not be an economically sound decision.

Based on the costs noted above and on knowledge of other creative art therapy professionals interested in state regulation (in Vermont and elsewhere), OPR recommends that, rather than creating a certification specifically for music therapists, the General Assembly establish a more holistic certification, such as creative arts therapy certification. OPR anticipates that, if a music therapist certification is offered, there will be an increasing number of professionals requesting similar certifications for other therapeutic approaches involving the creative arts (e.g., art, writing, drama, dance, etc.).[8] Establishing one

[8] The U.S. Bureau of Labor Statistics recognizes musical therapists as part of the group of Recreational Therapists, defined as those who use recreation-based treatment for people with disabilities, injuries and illnesses. Other forms of recreational therapy may use drama, dance, sports, games, aquatics, and arts and crafts. New Jersey has recently

certification that encompasses the practices of all these professionals will prevent inconsistencies and redundancies and increase efficiency in the laws governing these professions. It will also reduce costs for certification applicants, as there will be more professionals to bear the costs of regulating the professions. Qualifications for each type of therapy could still be specified in the regulations, ensuring that the public can verify that a professional claiming to hold a creative arts therapy certification has the requisite training in that type of therapy.[9] This approach could avoid multiple and duplicative regulatory reviews, statutes, and regulations while ensuring that the public has the information necessary to determine that a professional claiming to provide a form of creative arts therapy has the requisite training. Thus, OPR recommends the establishment of a broad creative arts therapy certification.

Conclusion

OPR finds that regulation of music therapists is necessary to protect the public from the single harm of deception or misrepresentation by untrained individuals claiming to provide music therapy. The least restrictive form of regulation to address this harm is a certification of the profession. OPR recommends that, to address this harm and potential similar harms in other types of creative art therapies and to ensure cost-effective and efficient regulation, the General Assembly establish a holistic, creative arts therapy certification for professionals that use creative art forms as therapeutic treatment modalities, including music therapists.

established a Board of Creative Arts and Activities Therapies to issue licenses to art therapists, drama therapists, dance/movement therapists, and music therapists. (New Jersey requires music therapists and other creative arts therapists to obtain a license, rather than a certification, to practice one of these professions. New Jersey does not have the same professional regulation statutory policy requirements as Vermont, however, and, thus, may establish licenses without determining that there is a public harm caused by the unregulated practice of a profession.) New York also has a creative arts therapy specialty license for applicants who are already trained in psychotherapy.

[9] If there is concern about confusion between the creative art therapy modalities, the General Assembly could permit OPR to create endorsement specialties within the certification program. For example, OPR could establish a music therapy endorsement specialty so a professional would obtain a creative arts therapy certificate with a music therapy specialty.

Respectfully submitted to the House and Senate Committees on Government Relations.

STATE OF VERMONT
SECRETARY OF STATE
OFFICE OF PROFESSIONAL REGULATION

BY: 

January 15, 2020
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APPROVED 

January 15, 2020
S. Lauren Hibbert — Date
Director OPR