I am a Licensed Mental Health Counselor and clinical supervisor in both Florida and Washington, and a telehealth expert. I am also a Core Faculty member of the Clinical Mental Health Counseling Dept at Antioch University Seattle. I practice as a counselor, I supervise post-graduate counselors seeking licensure, and I teach graduate students studying to become counselors. I am the daughter of a Cuban refugee and Navy Veteran and the first woman in my family to earn a PhD. My graduate studies and career have taken me around the country, so I have become familiar with many states' requirements for clinical licensing including Hawaii, Texas, California, and Utah in addition to Florida and Washington. I have worked as a clinician in a variety of settings with clients from many different cultural backgrounds over my fifteen years in the mental health field.

I support HB 2949 and amendments because I believe it is an important step toward diversifying the masters level clinical fields of counseling, marriage and family therapy, and social work by applying principles of equity and social justice in the arduous process of becoming a licensed clinician who can accept medical insurance, which is the only way most people have access to mental healthcare.

With my graduate students I often describe the clinical training, supervision, and licensing process as an on-ramp, with a gradual process for learning foundational concepts, building clinical skills and clinical judgment, with high levels of supervision and guidance at the beginning, which is reduced gradually as competency increases. First students take about two years of graduate coursework in applied psychology, diagnosis, and treatment planning, research, assessments, theories. BIPOC students who work full time and have caregiving responsibilities often take longer to complete this coursework due time and financial constraints.

Next, students complete a clinical practicum, often through an on-campus clinic with peers and supervisors for support, as they see their first clients and accrue around 300 direct hours of clinical experience. Then they complete a longer internship, about 1000 hours, or one year, at a community site, such as a community mental health center or hospital, supervised by an on-site clinician, in addition to weekly consultation/class meetings at school. This clinical internship is unpaid, and is a graduate course, so students are paying tuition to work for free during this part of their clinical training. Students who are marginalized financially often take longer to complete this part of the degree program, paying more in tuition, because they must maintain employment and/or caregiving responsibilities, due to financial and time constraints.

After graduating, the clock starts over and after submitting loads of paperwork and administrative fees to the department of health, and finding a clinical supervisor to meet with weekly, a post-graduate counselor, social worker, or, mft can begin accruing hours toward their independent license. This can take up to three months, and no clinical hours count until the paperwork is complete.Every state has a different number of minimum client contact hours, supervision hours, and minimum amount of time for this period of clinical training. Many post-graduate clinicians pay out of pocket for clinical supervision, which can range from $50-150

per hour, and is required weekly until the direct hours are completed. After these hours are complete, and the clinician passes a proctored exam regulated by their professional body, they can apply for independent licensure.

Oregon has the highest number of direct hours required in the United States with 2400 direct hours, which is defined as face-to-face clinical work with clients, while indirect hours include writing progress notes, administrative tasks, or clinical training. Next door in Washington, only 1200 direct hours are required. In California, only 1750 direct hours are required. A pre-licensed clinician has limited professional options, and a weekly required expense with supervision. Since the pandemic started, telemental health has become normalized, online counseling companies with work at home jobs for licensed clinicians have exploded, and interstate practice comes into question as a clients' geographical location is unimportant. It would be reasonable for any pre-licensed clinician living in Oregon to apply for a license in Washington or California, and practice in Washington or California via telehealth, to increase one's career and financial options. This obviously disincentivizes clinicians from becoming licensed in Oregon, especially BIPOC clinicians who are more likely to be financially disadvantaged and in need of these expanded career options to support their families and communities sustainably.

Finally, A longer pre-licensed training period does not necessarily lead to better clinical outcomes or competency. There is no data to support that longevity of post-graduate supervision alone predicts better treatment outcomes. Mental Health America rated Oregon in 2020 as #21 in access to mental health care, and #51, or the state with the highest prevalence of mental illness, which suggests that having the highest number of required supervised direct hours does not lead to better mental health outcomes for Oregonian. According to HPSO, a large liability insurance provider, the majority of malpractice claims against counselors involve boundary issues with clients and handling of records, not clinical competency. Quality is more essential than quantity in this case, as a clinical supervisor's responsibility is to ensure a pre-licensed counselor is competent, and is aware of their limitations including when to reach out for support and consultation, which is expected to continue even after licensing. When I sign the department of health form endorsing a clinician I have supervised for independent licensure, I am stating I have assessed this clinician's ability to practice independently.

This bill has the potential to make this complex path a little more accessible and less expensive, while maintaining the robust 5-6 year clinical training process for mental health clinicians. Over time, this will allow many more BIPOC and other marginalized people to become mental health clinicians and serve their communities, with the financial stability to maintain working in a stressful and challenging profession.