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STATE LICENSURE LAWS AND THE MENTAL HEALTH PROFESSIONS: IMPLICATIONS FOR THE RURAL MENTAL HEALTH WORKFORCE
EXECUTIVE SUMMARY

David Hartley, PhD MHA

Erika C. Ziller, MS

David Lambert, PhD

Stephenie L. Loux, MS

Donna C. Bird, PhD

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Maine Rural Health Research Center

Edmund S. Muskie School of Public Service

University of Southern Maine

PO Box 9300

Portland, ME 04104-9300

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EXECUTIVE SUMMARY

BACKGROUND

It is well-established that rural communities suffer disproportionately from a shortage of mental health professionals (Knesper, Wheeler, & Pagnucco, 1984; Lambert & Agger, 1995; Stuve, Beeson, & Hartig, 1989). For example, the supply of psychiatrists is 14.6 per 100,000 in urban areas as compared with 3.9 per 100,000 in rural areas (Hartley, Bird and Dempsey, 1999). Non-physician mental health professionals include psychologists, social workers (SWs), marriage and family therapists (MFTs), and licensed professional counselors (LPCs).[1] This study investigates whether and to what extent licensure laws that determine the permissible scope of practice for each of these professions may affect the availability of mental health services.

Scopes of practice for these professions are thought to have an effect on access to mental health services due to the fact that third party payers often base their decisions about whom they will reimburse for mental health services on these laws. If a specific type of provider is not being reimbursed by Medicare, or by another major insurer, providers of that type cannot practice independently. While such providers may be able to provide services in an institutional setting under the supervision of a provider who is reimbursable, such as a psychiatrist or psychologist, many rural areas do not have such settings. In fact, many rural areas have neither psychiatrists nor psychologists.

Currently, Medicare reimburses psychologists and social workers directly for mental health services, but does not reimburse marriage and family therapists or licensed professional counselors. There is some evidence that professions that have attained reimbursement status will seek to protect this "market" by claiming that other professions do not provide acceptable levels of quality to justify independent practice. This study also investigates whether such "guild" behavior is manifested in licensure laws and rules.

METHODS

This study examines licensure statutes and administrative rules for social workers, psychologists, professional counselors and marriage and family therapists in all states with at least ten percent of the population living in rural areas (total of 40 states). To determine the scope of practice for each of these mental health professions, we examined their legal authority

[1] Advanced Practice Registered Nurses specializing in mental health also provide these services. They are not addressed in this paper, because the laws and rules governing their licensure are significantly different from those of the other professions. Their role in providing mental health services in rural areas will be addressed in a future study.

to provide five core mental health services: assessment, diagnosis, treatment planning, individual and group counseling, and psychotherapy. Since prescriptive authority had not been granted to any of these professions at the time of our study, this function was excluded from our analysis.

FINDINGS

1. Licensure laws authorize psychologists, social workers, marriage and family therapists and licensed professional counselors to practice *assessment, treatment planning*, and *individual and group counseling* independently in most states. Many states do not explicitly grant the authority to social workers, MFTs or LPCs for *diagnosis* (SW: 10, LPC:14, MFT:9) or *psychotherap*y (SW:9, LPC:21, MFT: 8), but none explicitly deny it.

2. While many states offer two levels of licensure to psychologists and social workers, only four allow independent practice for masters level psychologists (Alaska, Kansas, Vermont and West Virginia), and only two allow independent practice for the "lower" level of social work license (North Dakota and West Virginia).

3. While some third party payers (e.g. Medicare) have sought to base payment policies on scope of practice, the intent of state licensure laws is to determine who is qualified to practice, not who is eligible for reimbursement. A few states (e.g. Missouri and North Carolina) explicitly deny the use of scope of practice laws as a mandate for third party reimbursement.

4. Laws that require supervision to be performed exclusively by a member of the profession in a face-to face setting may make it difficult for a new graduate to log the number of required hours within the specified time limit to qualify for independent practice.

5. A few states explicitly allow supervision that is not face-to-face, such as use of tele-health technologies or telephone (Colorado and Kansas for LPC and MFT; Wyoming for Psychologists). Perhaps more importantly, a few states have recognized the negative effect on access to care of professional competition among the mental health professions, and have placed explicit language in statutes or rules encouraging collaboration and cooperation among the professions. Most notable are states that have consolidated the oversight of these professions into a single board (NH), or a single mental health practices act (UT). Other policies that may achieve this end include allowing supervision by members of other professions (ID, KY, NC, NH, SD, TN, UT, and WA) and encouraging collaboration with other professionals as part of the continuing education requirements (NH).

RECOMMENDATIONS

1. States can simplify licensure and clarify clinical roles by combining regulatory functions for several professions into a single office or agency. A first step toward this end is either combining Marriage and Family Therapy and Licensed Professional Counseling into a single board, or creating a mental health professional practice act, as Utah has done, that addresses all mental health professions.

2. State licensure laws do not support payers who choose not to reimburse Marriage and Family Therapists or Licensed Professional Counselors for essential mental health services. For example, the number of states permitting social workers to perform diagnosis and psychotherapy is not significantly different from the number permitting marriage and family therapists to perform those services. Yet Medicare chooses to reimburse SWs but not MFTs. Therefore, Medicare should reconsider its payment policies regarding non-physician mental health practitioners. States that have not done so should consider vendorship laws to bring reimbursement policies into congruency with licensure laws by affirming the right of these professions to practice independently and be reimbursed by third party payers.[2] An interim policy that might address rural access needs would be to authorize direct reimbursement to these professions only in designated shortage areas. A precedent for such a policy can be found in the Federal Employees Health Benefits Program policy that "requires non-HMO FEHB plans to reimburse beneficiaries, subject to their contract terms, for covered services obtained from *any licensed provider* in [underserved areas] (our italics, United States Office of Personnel Management, 2001)

3. Several strategies could be employed to reduce professional competition over the right to practice and be reimbursed. New Hampshire, for example, allows candidates for licensure to be supervised by almost any mental health profession, and requires providers to provide "…proof that they do not work in professional isolation…" by submitting evidence of participation in a minimum of 25 hours of specified collaborative activities with members of other professions. Several other states have begun to address this issue through combined boards or mental health professional practice acts. The professional associations that represent these professions must provide leadership by taking the lead at the state level in working toward consolidated mental health professional practice acts and regulatory functions.

4. New graduates of programs that train mental health professionals can begin to address rural needs soon after graduation, if arrangements can be made for them to receive the supervision required in all states. Supervision may be easier to arrange in states where it is permissible to be supervised by a member of another profession. Another way of facilitating supervision is to explicitly allow telephone and tele-health technologies to be employed in supervision. A few states, such as Colorado, Kansas and Wyoming, explicitly allow electronic supervision, acknowledging its necessity for rural practice sites. In rural states where electronic supervision is not permitted, professional associations, state rural health associations, offices of rural health, and Medicaid programs should work together to effect changes in licensure laws to allow it.

5. The effect of changes in reimbursement, supervision, and regulation of these professions on the geographic distribution of practitioners must be evaluated. Unfortunately, effects cannot be accurately assessed with current workforce data. Few states have accurate data on the practice locations of all mental health professionals in a format that would enable such analysis, and there is no systematic data gathering at the federal level. The dearth of good data has resulted in most states continuing to use psychiatrists as the only profession

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[2] Studies have found no significant increase in costs to insurance carriers resulting from extending reimbursement to new mental health professions through such laws (Frank 1989, Lieberman, Shatkin, & McGuire, 1988). One of these studies found that the number of social workers practicing in rural settings almost doubled following passage of a vendorship law (Lieberman et al., 1988). Had these studies been conducted more recently, the effects of managed care might well have resulted in significant cost decreases, as have been found in several states (Goldman, McCulloch, & Sturm, 1998).

considered in the process of designating mental health professional shortage areas (Bird, Dempsey, & Hartley, 2001). Improvement in the availability of mental health workforce data should be made a priority. The Bureau of Health Professions is the most likely federal agency to lead this effort.

6. On July 1, 2002, New Mexico became the first state to grant prescriptive authority to psychologists. The American Psychological Association, as well as the state affiliate in New Mexico, has argued that New Mexico's rural population and the dearth of psychiatrists outside of Albuquerque and Santa Fe make a compelling argument for prescriptive authority for psychologists. Since the New Mexico law requires extensive additional training for psychologists to qualify for this privilege, including a 400-hour practicum supervised by a physician, it remains to be seen how many psychologists will qualify, and how many of them will practice in rural areas. New Mexico's psychologist prescribing law must be monitored closely, tracking the number of psychologists who qualify, both urban and rural, as well as shifts in practice locations. The availability of lower-cost oversight of psychotropic medications is likely to be of interest to managed behavioral health organizations, who may, in turn, aggressively recruit prescribing psychologists to practice in more populous areas of the state, reducing the likelihood that they will serve rural areas.

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EDMUND S. MUSKIE SCHOOL OF PUBLIC SERVICE
96 Falmouth Street
PO Box 9300
Portland, ME 04101-9300

TELEPHONE (207) 780-4430
TTY (207) 780-5646
FAX (207) 780-4417
www.muskie.usm.maine.edu