EFFECTS OF LICENSURE LAWS AND RULES ON ACCESS TO MENTAL HEALTH SERVICES IN RURAL AREAS
PRELIMINARY EXECUTIVE SUMMARY

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BACKGROUND

It is well-established that rural communities suffer disproportionately from a shortage of mental health professionals (Knesper, et al., 1984; Lambert & Agger, 1995; Stuve, et al., 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, marriage and family therapists, licensed professional counselors and advanced practice nurses. This study investigates whether and the extent to which licensure laws that determine the permissible scope of practice for each of these professions may affect the availability of mental health services. These effects may be direct, by establishing barriers that are difficult to overcome for those seeking to practice in rural areas, or indirect, by making it difficult for members of some professions to practice independently and be reimbursed, thereby necessitating that they practice in institutional settings more common in more populated areas.

METHODS

This study examines licensure laws and accompanying 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). Where licensure laws and rules have explicit implications for reimbursement for one or more of these professions, this is also

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reported. Because licensure laws for advanced practice nurses do not address specific mental health services in most states, our analysis for that profession was inconclusive, and will be addressed in a future report. For the remaining four mental health professions, we identified core mental health services: assessment, diagnosis, treatment planning, individual and group counseling, and psychotherapy. Prescriptive authority had not been granted to any of these professions at the time of our analysis. Our examination of scope of practice began with analysis of licensure laws, was followed with analysis of licensure rules (administrative codes) issued by the state boards that oversee each profession, and, in many cases, was followed with calls to state board staff to determine precise meaning of terms that we found varied considerably from one state to another. The research team was trained and advised by an attorney who is also a clinician and has extensive experience with interpretation of licensure laws.

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 for *diagnosis* or *psychotherapy* to social workers, MFTs or LPCs, but only one state explicitly denies it. Payers may choose to interpret failure to mention these two practices as denial of such authority. Thus, while states have not created explicit barriers to practice, they have often avoided language that might be used to break down barriers**.**
2. **The purpose of state licensure laws is to determine who is qualified to practice, not who is eligible for reimbursement. A few states explicitly deny the use of scope of practice laws as a mandate for third party reimbursement.** Payers who seek guidance from scope of practice laws as to whom they should be paying for specific services will be disappointed. States that wish to make it clear that a specific profession is authorized to provide a service and be paid for it have done so through a separate piece of legislation, such as "vendorship" or "freedom of choice" laws. 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, 1988). In fact, one study found that the increased competition resulted in a drop in psychiatrist's fees (Frank, 1982), while another found that the number of social

workers practicing in rural settings almost doubled following a vendorship law (Lieberman, Shatkin and McGuire 1988).

3. **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.**
4. **A few states explicitly allow supervision that is not face-to-face, such as use of tele-health technologies or telephone**. Perhaps more importantly, a few states have recognized the negative effect on access to care of 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, or a single mental health practices act. Other policies that may achieve this end include allowing supervision by members of other professions and encouraging collaboration with other professionals as part of the continuing education requirements.

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. **Since we found no evidence in state licensure laws to support payers who choose not to reimburse Marriage and Family Therapists or Licensed Professional Counselors for essential mental health services, Medicare should reconsider its position on these professions.** 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. 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, Federal Register, 2001)

3. Several strategies could be employed to **reduce professional competition over the right to practice and be reimbursed**. New Hampshire has addressed this issue by encouraging collaboration among the professions, while several other states have begun to address it 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 mental health professional practice acts and consolidated 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 Idaho, Wyoming and Colorado, 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 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 considered in the process of designating mental health professional shortage areas (Bird et al. 2001). Improvement in the availability of mental health workforce data should be made a higher priority, and assigned explicitly to a federal agency.
6. On July 1, 2002, New Mexico will become 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 will require 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, create increased incentives for prescribing psychologists to practice in more populous areas of the state.

7. **The growing profession of advanced practice registered nurses specializing in mental health holds great promise for rural areas**, combining medical training that is more extensive than that proposed for prescribing psychologists in New Mexico, with a tradition of both collaboration and independent practice. We regret that we were not able to include data for this profession in this study. Our methodology did not discover sufficient information on which to base conclusions. We hope to address this profession in a future project.

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