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State Licensure Laws and the Mental Health Professions: Implications for the Rural Mental Health Workforce

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Maine Rural Health Research Center
Edmund S. Muskie School of Public Service
University of Southern Maine
PO Pox 9300
Portland, ME 04104-9300
207-780-4430
207-780-4417 (fax)
http://muskie.usm.maine.edu/ihp/ruralhealth

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

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 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.

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 war" behavior is manifested in the language of 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:20, MFT: 8), but none explicitly deny it.

2. The purpose 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.

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 (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 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, while eight states do not explicitly grant MFTs the right to practice psychotherapy, nine do not explicitly grant that privilege to SWs. Yet Medicare chooses to reimburse SWs but not MFTs. This evidence suggests 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.[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; 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 allowing candidates for licensure to be supervised by almost any mental health profession, and by requiring 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 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 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 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 most likely federal agency to lead this effort is the Bureau of Health Professions.

[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

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.

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managed care might well have resulted in significant cost decreases, as have been found in several states (Goldman, McCulloch & Sturm, 1998).

INTRODUCTION

In March 2002, the Governor of New Mexico signed the nation's first law allowing psychologists to prescribe medications, effective July 1, 2002. That same month, the Medicare Payment Advisory Commission (MedPAC) considered a proposal authorizing direct Medicare reimbursement for marriage and family therapists and licensed professional counselors. A central argument in favor of both of these mental health policy options has been the shortage of mental health practitioners in rural areas and the hope that expanding the scope of practice and/or reimbursement will increase the rural mental health workforce, thereby improving access. This paper examines how state licensure laws may potentially affect the mental health workforce distribution, and makes recommendations for state and federal policy to reduce barriers that may have been created by the licensure process.

BACKGROUND

Rural communities suffer disproportionately from a shortage of mental health professionals (Knesper, et al., 1984; Lambert & Agger, 1995; Stuve, et al., 1989). As of September 1999, over 85 percent of the designated Mental Health Professional Shortage Areas in the United States were located in non-metropolitan (rural) counties. These areas are home to roughly 57 percent of the country's rural population (Bird et al. 2001). Variations in the supply of mental health professionals may be an important factor in explaining persistent differences observed in access to and use of mental health services in rural versus urban areas (Lambert & Agger, 1995).

A number of studies have demonstrated that mental health professionals are differentially distributed in rural and urban areas, with psychiatrists and Ph.D. level psychologists tending to practice in urban and suburban areas, leaving mental health professionals with master's level preparation or less as the most readily available mental health providers in most rural areas (Hartley et al., 1999; Holzer, Goldsmith and Ciarlo, 1998; Goldsmith et. al., 1997). 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 et al., 1999).[a]

Distances to colleagues, lack of clinical support and personal preferences may partially explain why few mental health professionals choose to practice in rural areas (Ernst & Yett, 1985). However, state licensure laws that determine the criteria for licensure and the

[a] While national data for urban and rural supply of psychologists are not available, the most rural states have, on average, about 25% fewer psychologists per capita than the national average of 20 per 100,000 (Hartley, Bird and Dempsey 1999).

permissible scope of practice for each profession may further affect the availability of mental health services. Each state, through its legislative process, generates statutes to regulate a broad range of professions and occupations, including core mental health professions. These laws typically specify the nature of the training required to enter the profession, including a specified number of hours of supervised clinical practice. Some statutes fall under the category of "title acts" that are designed to distinguish who can use a professional title such as "psychologist," and can be somewhat vague about the specific functions of a profession. Other statutes, typically referred to as "practice acts," provide a much more comprehensive delineation of the activities that fall within a particular profession's scope of practice.

A recent federal report expressed concern about whether state licensure laws can be used to determine a professional's scope of practice for payment purposes. In a study of Medicare coverage of services provided by non-physician practitioners the authors reported that "…State scopes of practice are broad and as a result provide little guidance that carriers can use to process claims. Most scopes of practice contain only a general statement about the responsibilities, education requirements, and a non-specific list of allowed duties…" (Office of Inspector General, Department of Health and Human Services, 2001, p. ii.). While this may be true for states where the statutes are primarily "title acts," this is not true across all states. In addition, nearly every state has "Administrative Rules," published by professional boards that are authorized by the states' legislatures to clarify the intent of the statutes. These rules often have greater detail on the activities that fall within a professional's domain. Finally, it is important to note that the OIG report primarily considered licensure statutes for physicians' assistants, nurse practitioners, and clinical nurse specialists, and therefore cannot be considered as representing mental health provider statutes.

Within the framework of state scope of practice laws, both public and private insurers have adopted a variety of payment policies for services provided by different types of mental health professionals. For example, Medicare does not recognize marriage and family therapists or professional counselors, but does recognize licensed clinical social workers, Ph.D. psychologists, psychiatrists and psychiatric nurse practitioners. Unfortunately, only a small percentage of mental health practitioners in these latter professions choose to practice in rural areas. Since commercial insurers such as Blue Cross/Blue Shield often follow the lead of Medicare, the net effect is to give some master's-prepared practitioners little incentive to practice in rural areas, even if they are willing. A practitioner who is unable to bill third party payers directly must work in an agency setting or under the auspices of a reimbursable provider and both arrangements are more easily met in more populous areas. In the absence of mental

health workers who are eligible for insurance reimbursement, many rural residents receive mental health services from their primary care practitioners, who may be ill-prepared to provide such services, and lack the time to provide counseling (Rost, Owen, Smith and Smith, 1998; Mechanic, 1990).

While reimbursement policies may have greater effect than licensure laws in determining what kinds of professionals choose to practice in rural areas, some third party payers, such as Medicare, look to licensure laws as an indication of which provider types they will allow to bill them directly. While details of such payment policies are beyond the scope of this paper, a thorough review of licensure laws is a logical starting point in examining differences among the mental health professions. This study examines state licensure laws 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, for a total of 40 states.[a] Where licensure laws and rules have explicit implications for reimbursement for one or more of these professions, this is reported. [b]

To facilitate interpretation of these findings, this study also examines the history and professional culture of each of these professions. How the members of a profession see themselves and their role as providers has, in many respects, evolved in contrast to another profession. For example, psychologists may define their role in terms of psychiatry, while social workers may define their role in terms of psychology. Historically, professional counselors have reacted against each of these professions, viewing them as "disease-oriented," and have preferred to emphasis mental wellness. These cultural factors may be useful in considering policy initiatives designed to improve the distribution of mental health providers. A summary description of each of these professions may be found in the appendix of this paper.

METHODS

We began our analysis by identifying the core set of services that we deemed to be the central functions of a mental health professional: prescribing psychoactive medications, assessment, diagnosis, developing and implementing a treatment plan, providing individual and/or group counseling, and psychotherapy. At the time of our study, none of the professions could prescribe drugs, so this service was eliminated from our analysis. While the distinction

[a] The states excluded from this analysis were: CA, CT, FL, MD, MA, NJ, NY, OH, RI, and VA.

[b] While we also examined licensure laws and rules for advanced practice registered nurses (APRN's) specializing in mental health, this paper does not present data for this group of professionals because we found that licensure laws and rules for nurse practitioners and clinical nurse specialists rarely include information on mental health nursing specialties.

between assessment and diagnosis, and the distinction between counseling and psychotherapy, may not be apparent to the layman, states and payers find substantive differences. Most licensure laws treat these as separate services, and many payers will accept bills for diagnosis and for psychotherapy, but will not pay for assessment or counseling. (Strosnider & Grad, 1993). We decided not to include psychological testing among the services inventoried because this service appears to be the exclusive domain of psychologists, with little variation from state to state.

Data Collection

For each profession, we obtained licensure laws and rules from each state included in the study. As indicated earlier, licensure laws (also called regulations) are part of the statutes set down by the state legislature and are typically found in the "occupations and professions" section of state law. The rules are part of each state's administrative code. States differ on which part of their administrative infrastructure is responsible for collecting and maintaining professional rules. They are typically written by the state board that regulates a profession under authority granted by the state legislature, and usually contain more detail and some interpretation of licensure laws.

Using these documents, we sought to determine whether each of the services targeted in this study could be performed independently by members of a profession, could be performed only with supervision, or are explicitly prohibited for that profession. Because the language used in both licensure laws and rules is not consistent from one state to another, we developed a protocol to guide our interpretation of the wording used by each individual state. Where language was explicit and consistent, we were able to make a determination solely on the basis of document review. However, in many cases there was some ambiguity or seemingly contradictory language in the laws and/or rules, so that we could not be confident in relying exclusively on our own interpretation of these documents. These cases were followed up with telephone calls to the state board for the profession in question, asking for clarification or examples of how the statute or rule is interpreted in practice. By this process, we were able to arrive at a confident summary of the scope of practice for each profession in each state. To assure consistency, all members of the research team were trained by an attorney who is also a clinician, and has extensive experience with interpretation of licensure laws.

Because states may issue more than one type of license within a profession, we developed a protocol for determining what types of license for each profession we would include in our analysis. Simply stated, we eliminated from consideration all levels of licensure that are

reserved for those who do not provide mental health services, or those who are in training. [a] We retained two categories of licensure for psychologists and social workers in our analyses because many states license mental health providers in these professions at two levels, representing different degrees of education and/or training.

In addition to the functional data that we collected for each profession, we used the state laws to gather information on the educational and supervised practice requirements for each type of license studied. In most cases, either the statutes or the rules for a profession specify how many hours of supervision must be completed, who is qualified to serve as supervisor, and what portion of the supervision must be "face-to-face" (as opposed to via telephone, email, or other indirect means). Our summary of education and training requirements includes observations on the extent to which these requirements may have positive or negative effects on the ability of newly trained members of a profession to practice in rural areas.

Because licensing standards for some professions have been implemented or changed in recent years, it is common for there to be some accommodation in educational standards in these statutes for practitioners who were practicing in the profession before the requirements became effective. This practice is known as "grandfathering" or "grandparenting." Because there is tremendous variability in how states implement this practice, we chose not to catalogue variations due to grandparenting. What remains of the grandparented profession is exemplified by the status of master's level psychologists who, in most states, do not have independent practice privileges, and are, in many states, in a transitional profession, on their way to going back to school to get a Ph.D. Table 1 presents the two levels of licensure, corresponding to Ph.D. and master's prepared practitioners. (See also, "Training and Supervision Prior to Licensure" on p. 9)

Definitions

In this section we present a brief description of the definitions used to guide our data collection efforts, in an attempt to assure inter-rater reliability across states, professions and statutes.

- *Assessment:* In general, the term "assessment" applies to those practitioners who are legally permitted to collect information and identify and categorize the patient/client's illness or

[a] For example, school psychologists, psychological examiners, and provisional licenses to professionals in training, (for example, a "professional counselor associate" in some states has completed all licensure requirements except the supervised clinical practice).

injury, as necessary for the determination of the appropriate course of treatment. Practitioners permitted to make diagnoses in accordance with the APA Diagnostic and Statistical Manual IV (DSM IV), are considered to be licensed to both assess and diagnose. This distinction is significant in obtaining reimbursement from some payers, since many will not pay for treatment without a specific DSM-IV diagnosis.

- *Diagnosis*: For this function, we collected data on whether or not a professional is permitted explicitly to assign a mental health diagnosis to patient/client. If state law permitted a profession to use the *DSM IV* classification system this was considered to be explicit permission to diagnose, whether or not the word "diagnosis" was included in that profession's scope of practice.

- *Treatment Plan:* The term "treatment plan" applies to those practitioners who are legally permitted to develop a plan of care/therapy/action for a patient/client to prevent or treat a diagnosed health problem.

- *Individual/group counseling*: Most statutes and/or rules will state whether a practitioner is permitted to provide counseling/therapy services to individuals, families, and/or groups. Counseling is the application of mental health, psychological, or human development principles, through cognitive, affective, behavioral or systemic intervention strategies, that address wellness, personal growth, or career development, as well as pathology (American Counseling Association, no date). A licensure law that permits counseling cannot be construed to permit "psychotherapy" unless explicitly stated. This distinction is significant from a reimbursement perspective, as many third party payers will reimburse for psychotherapy, but not for counseling.

- *Psychotherapy*: The American Medical Association (no date) defines psychotherapy as "The treatment for mental illness and behavioral disturbances in which the clinician establishes a professional contract with the patient and, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development." (AMA, no date) As with diagnosis, we collected data on whether or not the ability to engage in psychotherapy with a patient/client is explicitly granted by state law.

- *Supervised versus Independent Practice:* All practitioners are required to have supervised practice experience as a part of their educational process. In addition, many professions require a specified number of hours of supervised practice after coursework is completed, or after graduation, before a license is granted to practice that profession. Sometimes this is considered part of the degree program; sometimes it is considered part of the "apprenticeship" in a profession. Once the license is granted, some professions continue to require some level of supervision for certain services, while others are permitted to practice independently, either as soon as they are initially licensed, or following the specified period of supervised practice. If licensure laws permit a profession to provide services "autonomously" or "directly to the public," we considered this to be independent practice. Some of these distinctions are summarized in the tables, while others are too complex or subtle to summarize in a table, and are discussed in the next section.

FINDINGS

We present our findings in six areas: 1) scope of practice laws; 2) training and supervision requirements; 3) supervised practice 4) potential effects of licensure laws on reimbursement; 5) evidence and effects of a "guild" environment, or competition among the professions; and, 6) descriptions of initiatives or legal language from specific states that show promise for addressing rural access issues.

Throughout our findings sections, we use a number of professional titles generically although there is actually substantial variation throughout states. For example, in Table 2 we used the title "licensed clinical social worker" to describe those MSW or DSW-level practitioners who have undergone clinical training and typically practice independently. However, in some states these professionals are actually licensed as "independent social workers," "certified social workers," or some other title. Similarly, in Table 3 we use the title "licensed professional counselor" when, in fact, states use many different titles to describe this type of mental health practitioner, including "licensed clinical professional counselor" or "licensed mental health worker." Consequently, the reader should view our use of these generic licensure titles as describing a commonality of function and should not conclude that there is uniformity in the titles used for each profession across the states.

Scope of Practice

Tables 1 through 6 present our findings on the scope of practice for each of the four professions included in this paper. Three mental health services are presented in detail for

each profession in Tables 1-4, assessment, treatment planning, and counseling (individual and group therapy). Because of their direct link to reimbursement, the other two services, diagnosis and psychotherapy, are presented separately in Tables 5 and 6. As stated in the OIG report (2001) discussed in the background section, scope of practice laws, by themselves, are often inconclusive and insufficient to generate conclusions about what level of practice is intended. The rules written by licensing boards were often helpful in clarifying ambiguous language. However, we made liberal use of an entry in our draft tables, "UC" for "unclear", until we were able to follow up our research with telephone calls to appropriate licensing boards. While a few cells in Tables 1-4 remain unclear, we were able to clarify the precise intent in each state, for each profession to a far greater extent than was suggested by the OIG report (2001). However, Tables 5 and 6 indicate that there was far less consistency with respect to diagnosis and psychotherapy.

For all of the mental health professions studied, we found little differentiation among three primary mental health services (assessment, treatment planning, and individual and group counseling). That is, if a professional is allowed to provide assessment, s/he is typically allowed to provide individual and group counseling and treatment planning as well. And if s/he is allowed to provide any of these services independently, s/he can usually provide all of them independently. This pattern is illustrated in Tables 1-4, depicting the scopes of practice for psychologists, social workers, marriage and family therapists, and licensed counselors, respectively.

We found relatively little variation from one state to another in the scope of practice allowed for each profession. For example, both LCSWs and PhD psychologists are allowed to practice each of those three mental health services, independently, in all 40 states. Where variation occurs for these two professions it is in the activities permitted by practitioners licensed at a "lower" level, that is, among those members of the profession with less education and/or training. Of 40 states surveyed, 14 license psychologists at the master's level, but few allow them to practice independently. Kansas, Vermont, West Virginia and Alaska allow independent practice by those licensed at this level, while in Oregon a master's-trained psychologist may petition the psychology board for the right to practice independently after three years of supervised practice.

The two levels of licensure typically offered to social workers are not differentiated on the basis of doctoral education, but on the completion of a supervised clinical practicum (usually two years and/or 3000 hours). As indicated earlier, the title "licensed clinical social worker" is most commonly associated with this level of training, and all social workers who are licensed at this or

a comparable level are allowed to provide each of the core services independently in all states. As with psychologists, there is a lower level of licensure, offered in 32 of the states we surveyed. Only North Dakota and West Virginia allow independent practice at this level.

Tables 5 and 6 offer convincing evidence that scope of practice laws should not be used as a basis for payment policies. Since diagnosis and psychotherapy are the only Medicare reimbursable mental health services of those studied here, one might expect to find the two professions currently eligible for Medicare reimbursement (psychologists and social workers) to be licensed in these areas in all states. While no state explicitly restricts any of the licensed professions from performing these services, many simply do not address them. Three states fail to mention diagnosis, and five fail to mention psychotherapy in the scope of practice for psychologists. For both social workers and MFTs, 10 states fail to mention diagnosis and nine fail to mention psychotherapy, and for LPCs, 14 states fail to mention diagnosis and 21 fail to mention psychotherapy. (See Table 7 for a summary.)

Training and Supervision Prior To Licensure

Although there is some minor variation, the 40 states we studied have generally comparable requirements for the education and supervised practice needed to be licensed for each profession. In all but four states, a Psychologist must have a PhD to practice independently, while the other professions allow independent practice at the Masters level. Typical training and hours of supervised practice for the most independent level of practice for each discipline are as follows:

- Psychologist (PhD): Doctorate in psychology and two years of supervised clinical experience. Typically, one year is completed while earning the doctorate and the second is completed after graduation.

- Psychologist (Masters): (This training is typical only in the four states that allow the Masters level Psychologist to practice independently: Alaska, Kansas, Vermont and West Virginia). Masters in Psychology and two years of supervised clinical experience. (In WV, five years of experience.)

- Licensed Clinical Social Worker: Master's or doctorate in social work and two years of supervised clinical experience. When the requirements for actual face-to-face supervision

are specified, they tend to be approximately one hour per week over the course of the two years of supervised practice.

- Marriage and Family Therapist: Master's in marriage and family therapy or related discipline and two or three years of supervised clinical experience. Supervision is often specified as 200 hours of direct contact for every 1000 hours of practice, of which 100 hours must be face-to-face, or of which 100 hours must be individual supervision as opposed to group supervision. Total hours of required supervised clinical experience may be reduced for those with a Ph.D.

- Licensed Professional Counselor: Master's or doctorate in counseling or related field and two years (2000-3000 hours) of supervised clinical experience. In some cases, one year of experience may be credited for experience prior to earning the degree. Also, hours may be reduced for those with a doctorate.

It is notable that all professions involve supervised clinical experience prior to licensure and that the required amount of time spent in supervised practice was quite similar across the different professions. However there is some variation among states as to who may do the supervision and how much time has to be spent in face-to-face consultation with the supervisor.

Supervision Post-Licensure (Supervised Practice)

As previously noted, supervised practice by practitioners who are not licensed to practice independently (primarily social workers and master's-level psychologists) is allowed in several states. Typically, supervision of such workers must be on site, but unlike the supervised practice required in training, the number of hours of face-to-face supervision is often not specified.

Implications of Licensure Laws for Reimbursement

It is clear that, at least in some states, the authors of licensure laws do not wish these laws to be used as mandates for third party payment. In several states, we found language such as: "Nothing in this article shall be construed to require direct third party reimbursement to persons licensed under this article" (North Carolina Licensed Professional Counselors Act, 24 NC Stat. § 90-344, 1993). Nevertheless, some third party payers would like to have more guidance from licensure laws to allow them to determine more precisely who is qualified to provide the services for which they are billed. For example, a recent report on Medicare

reimbursement found that " State scopes of practice are broad and as a result, provide little guidance that carriers can use to process claims." (OIG, 2001, p.7) As our analysis has revealed, where they are licensed, the four professions detailed in Tables 1-4 are each authorized to deliver the three identified core mental health services independently in most states.

In addition to these three services, we examined the more narrowly defined services of diagnosis and psychotherapy. As mentioned in our definition section, diagnosis involves the assignment of a diagnostic category from the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (third edition revised or fourth edition). Where reimbursement requires that a diagnostic code be submitted with the claim, a clinician legally permitted to diagnose must determine the appropriate diagnosis. We chose to examine diagnosis in greater detail because in the past some insurance companies have used the lack of explicit permission to diagnose as the rationale for denying payment to some master's level professionals (Strosnider & Grad, 1993). Thus, without directly addressing reimbursement, a licensure law may provide a basis on which a carrier may deny payment. Table 5 indicates that, while each of the four practitioner types is authorized to diagnose in some states, many states do not explicitly address this function. And, although there is variability by profession, in some states the permission to diagnose is not explicitly granted to *any* of the core mental health professionals (including psychologists).

Similarly, psychotherapy is not explicitly mentioned in many state licensure laws, although none expressly forbid it to the four practitioner types we studied. Like diagnosis, the lack of explicit statutory authorization to engage in psychotherapy with a patient/client may create barriers to reimbursement for some providers. Typically, the CPT codes used for third party reimbursement of mental health services include psychotherapy, not the more general term "counseling." If a practitioner type is not explicitly authorized to provide psychotherapy, an insurance company may choose not to reimburse that provider type, despite the fact that there may be little or no functional difference between psychotherapy and individual counseling from the patient's or the provider's perspective. Table 6 demonstrates that, as with diagnosis, each of the four provider types we studied is authorized to provide psychotherapy services in some states, and no profession is explicitly prohibited from providing them. Table 7 provides total numbers of states that permit diagnosis and psychotherapy for each profession. There is some variation by profession, with psychologists being the most likely to have explicit statutory permission to engage in psychotherapy, followed by social workers. However, not all state

licensure laws contain language that explicitly authorizes psychotherapy, even for these two older professions, and Pennsylvania does not explicitly permit diagnosis by any non-physician.

Is there A "Guild" Environment?

The American Psychological Association has referred to the subject of prescribing privileges for psychologists as a "guild issue" (Herndon, 1997), because of the consistent opposition to such privileges by psychiatrists. Another facet of the guild environment is the systematic elimination of master's level psychologists from independent practice in nearly all states, helping to better position the profession in its quest for prescriptive authority. Citing similar outcomes of care for different mental health specialists in cross-disciplinary studies, Ivey, and colleagues have identified "role diffusion," the overlapping of roles and functions, as a factor contributing to "turf wars" (Ivey, Scheffler and Zazzali, 1998).

> "A system in which multiple providers perform similar services is unstable, divisive, and potentially inefficient." (Ivey et al., 1998, p. 26)

We frequently found evidence of the guild environment in state licensure laws, where one profession was explicitly prohibited from performing functions that were considered the domain of another profession. Typically, these prohibitions emphasized that psychologists were not authorized to engage in activities that were exclusively reserved for medical providers, and that the other three provider types could not perform functions that were deemed to fall within the purview of psychology. For example, the following excerpt from the Washington State psychology laws exemplifies a common "boundary" statement:

> Nothing in this definition shall be construed as permitting the administration or prescribing of drugs or in any way infringing upon the practice of medicine or surgery as defined in chapter 18.71 RCW (Psychologists, 18 Wash. Rules RCW 18.83.010, 1994).

Similarly, the laws of Tennessee and Kentucky cited below demonstrate some of the ways that non-psychologist professionals have their scopes of practice constrained vis-à-vis the profession of psychology.

> Nothing in this section shall be construed to permit the treatment of any mental emotional or adjustment disorder other than marital problems, parent-child problems, child and adolescent antisocial behavior (General Rules Governing Professional Counselors, Tenn. Rules, Rule 0450-1-.02, 2001);

As these rules suggest, one of the areas where scopes of practice may be limited is the type or severity of mental health problems that a non-psychologist professional can treat. In addition,

many states explicitly prohibit the use of "psychological testing" by any professions except psychology, as seen in the following:

> Nothing in this section shall be construed to authorize any licensed marriage and family therapist … to administer or interpret psychological tests (Marriage and Family Therapists, KY KRS 335.300, 1999).

Promising Practices

Rural Accommodations

State licensing laws, for the most part, fail to make explicit statutory or regulatory accommodations for rural mental health practitioners. However, some states do include explicit rural provisions or rural-friendly provisions within their licensing laws or rules. For example, the Wyoming psychology board may issue a provisional license to an applicant who has completed a Ph.D. program with internship but has not completed supervised post-doctoral practice and/or passed the licensing exam if "a need for psychological services exists in a rural part of Wyoming and the applicant is employed by a state or community mental health center." These applicants have three years to complete the supervision requirements (instead of one) and up to 20 percent of the supervision time may be over the telephone.

Consolidated Regulation

The frustration of policy makers in attempting to assess the adequacy of the mental health workforce to meet current needs is understandable. While there appears to be overlap in scope of services among the various professions, and some substitutability of one profession for another for some services, the language, training requirements, supervision requirements, and clinical approaches of the professions vary and are confusing. We had to examine at least five licensure laws and accompanying sets of rules in each state to determine who is authorized to do what, and we often found different language used for different professions within the same state. To overcome this inefficiency, a few states have consolidated some parts of the regulatory process.

A significant number of states have a single board to oversee two or more professions. The most common board consolidation is between professional counseling and marriage and family therapy as seen in Arkansas, Iowa, Maine, and Oklahoma. Minnesota, on the other hand, combines the board of social work with that of marriage and family therapy. Four states (Arizona, Pennsylvania, Washington, and Wyoming) have a single board for social work, professional counseling, and marriage and family therapy. New Hampshire has one board overseeing four mental health professions: psychology, social work, marriage and family

therapy and counseling. To further break down the barriers among professions, the New Hampshire board requires licensees from each of the professions to obtain 25 hours of collaboration with other professionals per renewal year. Examples of collaboration given included small group meetings, consultation, study groups, and telephone conferences.

Utah's "Mental Health Professional Practice Act" (UT § 58-60-102-112, 2001) covers the activities of all mental health providers including physicians, mental health nurse specialists, psychologists, clinical social workers, certified social workers, marriage and family therapists and professional counselors. This act places professionals on an equal playing field in terms of the scope of their practices. For example, while the rules and regulations for professional counselors and marriage and family therapists in Utah do not explicitly permit diagnosis of mental health problems, these activities are included in the scope of practice for these professions under the overarching "Mental Health" act.

Telehealth and Tele-supervision

State law is typically silent about whether or not some portion or all of a professional's supervised experience can be obtained via electronic communication, including telephone. In this section we report on states that include specific provisions for electronic supervision. In Missouri, professional counselors are explicitly prohibited from obtaining supervision through electronic media. In the same state however, marriage and family therapist rules state: "The use of electronic communication is not acceptable for meeting supervision requirements of this rule unless the communication is verbally and visually interactive between the supervisor and S-MFT."

In Wyoming, a psychologist in a rural area working for a community mental health center may obtain up to 20 percent of his or her supervision over the telephone. In Kansas, rules for marriage and family therapy and professional counseling state that supervision must occur with supervisor and supervisee in the same physical space, "except where not practical due to an emergency or other exigent circumstances, at which time person-to-person contact by interactive video or other telephonic means maintaining confidentiality shall be allowed" (Kansas Counselor Rules, KS Rules 102-3-7a, 1998; Kansas Marriage and Family Therapist Rules, KS Rules 102-5-7a, 1998). In Colorado, licensed professional counselors and marriage and family therapists may use a number of alternative methods to completed their supervised practice requirements based on their treatment setting (with rural specifically mentioned), and the "availability of community resources". The supervisory accommodations include group supervision, audio-visual, process recording and telecommunication. The South Dakota Board

of Social Work allows for non-direct contact supervision as long as the proper telecommunications or technology is available.

Two state boards (both Social Work) allow telecommunications or distance learning as a part of their continuing education programs. The Tennessee Board of Social Worker Certification and Licensure allow for the use of the Internet, closed circuit television, satellite broadcasts, correspondence courses, videotapes, CD-ROM, DVD, teleconferencing, videoconferencing, and distance learning. Not only does Idaho's Board of Social Work Examiners allow some of these forms of continuing education, but it specifically cites rural areas as the reason for allowing them. "Because of our geographic location and sparse population, closed circuit television, videotapes, and correspondence courses may be substituted for face to face contact if coordinated by an approved instructor" (Rules of the State Board of Social Work Examiners, ID Rules 24.14.01-351.02, 1995).

Who may supervise?

Most states require that the supervisor of an applicant for licensure be of the same profession and at or above the licensure level that the applicant is seeking. In some cases, the statutes or rules may make allowances for license applicants who are unable to find a supervisor within their profession. Often this language is vague, stating that when a same profession supervisor cannot be found, an alternate professional may be substituted as approved by the board. Some states do not even specify a profession, like Louisiana where the supervisors for professional counselors simply must be "board approved." However, from our level of review of the licensing laws, there was no way to tell how easy or hard it is to get board approval for a supervisor.

In some states the statutes and rules are more generous in ascribing who can supervise an applicant for license. For example, Wyoming permits a great deal of cross-professional supervision: social workers, MFT's & professional counselors may be supervised by a "qualified clinical supervisor" that includes LPCs, LCSWs, LMFTs, LACs (addictions counselors), licensed psychologists, licensed psychiatrists, licensed physicians with specialty in addictionology or licensed APRNs with psychiatric specialty. Other states have similar practices for certain professions, such as Utah, where approved supervisors for professional counselors include psychiatrists, psychologists, clinical social workers, registered psychiatric mental health nurse specialists and marriage & family therapists. Wyoming is unusual because even the psychology board permits some supervision by other mental health professionals, although a licensed psychologist must provide half of the required supervision. In New Hampshire, candidates for a mental health license may be supervised by almost any licensed mental health professional,

including Licensed Pastoral Counselors. In Kentucky, the supervisors may include nurses with a master's and psychiatric certification and Certified Professional Art Therapists.

DISCUSSION

Core Mental Health Services and Reimbursement

Most state licensure laws permit psychologists, social workers, marriage and family therapists and licensed professional counselors to practice assessment, treatment planning, and individual and group counseling. We found that psychologists and social workers are licensed in every state we studied, and that each of these professions has a level of licensure that permits that these core services be delivered independently. Similarly, every state that licenses marriage and family therapists and professional counselors permits these professionals to engage in at least some, and usually all, of these core functions independently. Consequently, we conclude that state licensure laws create little functional difference between these four professions in their ability to obtain an independent level of licensure and provide core mental health services.

Despite the fact that there is limited variation in the ability of the four professions studied to perform core mental health services, we found that the explicit authority to diagnose and provide psychotherapy to patents/clients was not consistent across states. Psychologists were the most likely profession to have diagnosis and psychotherapy included in their scopes of practice. However, in some states even psychologists were not explicitly permitted to perform these functions. In many states the explicit right to diagnose or to perform psychotherapy was not included in the scopes of practice for social workers, MFTs or LPCs, however no state explicitly prohibits these professions from providing these services. Consequently, we deem it unreasonable to use the absence of explicit language around diagnosis or psychotherapy as rationale for refusing to reimburse a specific profession for performing the core mental health services that fall within its scope of practice. In fact, our findings would seem to provide support for increasing the number of practitioners eligible for reimbursement, rather than for limiting it to one or two professions.

A handful of states have included language in their scope of practice laws to avoid the interpretation of these laws as a mandate for third party reimbursement. Thus, while state licensure laws may not have created explicit barriers to entry into independent mental health practice, they have often avoided language that might be used to break down barriers. Payers who seek guidance from scope of practice laws as to whom they should be paying for specific services may be disappointed. States that wish to dictate to third party payers that a specific

profession is not only authorized to provide a service, but also should be reimbursed for that service, have done so through separate legislation such as “vendorship” or “freedom of choice” laws (Frank, 1989; Fairbank, 1989; Lieberman et al., 1989). The lack of an explicit reimbursement mandate may differentially affect providers trying to locate in rural areas because independent third-party billing is particularly critical for these providers. Without an agency to provide a salary or another professional under whose authority a rural practitioner can provide reimbursable services, barriers to direct reimbursement are also barriers to rural mental health practice.

Supervision and Rural Practice

The language that licensure laws use to describe the clinical supervision required to qualify for independent practice may create barriers to entry into a profession, or barriers to practice, that differentially affect rural areas. States (and even professions within states) vary in the degree to which they require supervision to be performed exclusively by a member of the profession being entered, and the extent to which this supervision must be obtained on a one-to-one, face-to-face basis. These variations are relevant in that they can make it easier or more difficult for a newly trained practitioner to move quickly into independent practice, thereby meeting the need for mental health practitioners in many rural areas. In cases where independent practice is not the immediate goal, as with a practitioner working in a community mental health center, limitations on who may supervise may also be relevant, as many rural CMHCs may not have a full complement of experienced practitioners in all professions.

In practice, if a non-independent practitioner works in a clinical setting with his or her independently licensed counterpart, weekly or bi-weekly clinical supervision sessions are easy to arrange and meet the supervision requirement. Moreover, the non-independently licensed worker is typically salaried, not able to bill directly for services, and has the support of the agency or institution. In a rural area, where a mental health center may be operating outreach services or satellite clinics staffed by a social worker, psychologist or counselor who is not licensed to practice independently, licensure laws do not specifically address the interpretation of supervised practice. Thus, state licensing boards have delegated the oversight of these practitioners to the agencies that employ them.

In general, a more restrictive approach to the question of who may supervise may affect the ability of new professionals to move into rural areas. However, further research is needed to determine the extent of that effect.

A few states have made meaningful efforts to lower the barriers to entry or to practice by explicitly allowing supervision that is not face-to-face, such as use of tele-health technologies or telephone. In some states, for some professions, a portion of the required supervision time can be obtained in a group format so that the time demand upon the supervisor is reduced. These efforts, in addition to the laws that permit "cross-discipline" supervision, could be particularly important accommodations for ensuring that practitioners who desire to practice in a rural area do not face sizeable barriers to obtaining necessary supervision.

Reducing Professional Competition

As indicated in our findings, evidence of the "guild environment" exists in current licensure laws. Licensed professions continue to seek limitations on the scopes of practice for other professions to protect their professional niche. When a profession seeks to secure exclusive rights to a specific practice, they must argue that other professions are not qualified in this area – an argument based on quality, often expressed as years of education. A profession may set extensive requirements for entry into the profession, such as many hours of supervised practice, or requiring a doctorate. Requiring that only members of the profession can supervise, or that a certain number of hours of supervision must be face-to-face, further establishes an explicit "gateway" into the profession, similar to an apprenticeship in a traditional guild. These strategies are rational means of protecting the market for a profession's services in an environment where there are ample members of multiple professions competing for market share.

Guild behavior can help to define the philosophy and techniques of a profession in ways that are helpful to consumers in choosing a provider. Our brief histories of the professions and their historical approaches to mental health treatment (see Appendices) illustrate that there are some meaningful differences between them, differences that might be significant to both the practitioner and the consumer. If competition between the professions were solely on the basis of these philosophical differences, and if consumers were free to choose among the professions based on complete information, we would be less concerned about the potential impact of guild behavior on the supply of rural mental health workers.

From an access perspective the "guild environment," or any other effort to limit professional supply, is of concern. These competitive behaviors have the unintended consequence of making it even more difficult to enter the profession in non-competitive markets where there are few or no practitioners. For example, it is more difficult to complete the required number of hours of supervised practice in a geographic area where there are fewer

senior practitioners, particularly when a specified number of those hours must be face-to-face. Another example is the barrier posed by requiring a PhD to practice independently. As with medical training, additional years of university training may predispose practitioners to practice in urban areas where, like medical specialists, they can expect higher incomes and access to colleagues. Whether for these or other reasons, few PhD Psychologists choose to practice in rural areas.

Some states have recognized the potentially negative effect of this competition between the mental health professions on access to mental health services as evidenced by the number of states that have promulgated legislation that would reduce competition. For example, states like New Hampshire have placed explicit language in licensing statutes and/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 Practice" 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

Based on our findings and the discussion presented above, we present six recommendations that we believe could help address potential barriers to increasing the supply of rural mental health professionals. These are:

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. 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).

Another option for consideration by Medicare is a program currently authorized for CHAMPUS/Tricare beneficiaries as a two-year demonstration. Prior to this demonstration, Tricare has required a physician referral before they would reimburse a "licensed mental health counselor" for services to beneficiaries. The demonstration is allowing beneficiaries direct access to counselors without the referral. It proposes to assess whether extending independent practice to counselors will alter expenditures or utilization. (National Defense Authorization, Fiscal Year 2001, Appendix, 7 U.S.C. § 731, 2000). It should be noted that the effect of extending reimbursement to new mental health professions through vendorship laws has been studied, and findings consistently show that there is no significant increase in costs to insurance carriers (Frank, 1989, Lieberman, 1988). In fact, one study found that the increased competition resulted in a drop in psychiatrist's fees (Frank, 1982).

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 allowing candidates for licensure to be supervised by almost any mental health profession, and by requiring 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 (New Hampshire Board of Mental Health Practice, NH Rules 404.01, 1993). 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 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 supervision,

as required by most states for most professions. 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 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 considered in the process of designating mental health professional shortage areas (Bird et al. 2001). To address the inability of policymakers to accurately estimate the supply of mental health professionals at a level of geography that allows rural shortages to be clearly documented, the National Rural Health Association has recommended:

   > The Health Resources and Services Administration (HRSA), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the National Institute of Mental Health (NIMH), should form a joint task force to address issue of access to mental health in rural areas. This group should be charged with addressing the collection of current, accurate data on the rural mental health workforce, revising the criteria for mental health professional shortage area designation, and addressing access to mental health services for the rural uninsured and underinsured (NRHA, 2002).

   This recommendation has been on NRHA's agenda for two years, but none of these agencies has taken the initiative to act on it, or to suggest an alternative means for addressing our inability to measuring workforce supply.

7. 6. On July 1, 2002, New Mexico will become the first state to grant prescriptive authority to psychologists ("New Mexico adopts", 2002). 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, reducing the likelihood that they will serve rural areas.

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LIMITATIONS

This study has investigated scope of practice, and has focused on a short list of specific services that each profession is permitted to provide. This approach has not allowed us to comment on the differential needs of the clients receiving these services, which may be better addressed by one profession than another. For example, while a practitioner may be licensed to provide all of the core mental health services, he or she may not be trained to intervene in a psychiatric crisis involving a patient with a severe mental illness. Some professions may, in fact, be better prepared to care for specific populations of clients defined by diagnosis, need, or cultural factors. In the struggle for independent practice and reimbursement, such issues are likely to be presented as "quality" issues. If reimbursement were not a contentious issue for some of these professions, perhaps the guild behavior we have identified could be redirected toward informing consumers and payers of the strengths of each profession.

Table 1: Psychology Scope of Practice, by State

	Licensed Psychologist (PhD)			Licensed Psychologist (MA)		
State	**Assessment**	**Treatment plan**	**Counseling**	**Assessment**	**Treatment Plan**	**Counseling**
Alabama	I	I	I	S/I[a]	S	S
Alaska	I	I	I	I	I	I
Arizona	I	I	I	N	N	N
Arkansas[b]	I	I	I	S	S	S
Colorado	I	I	I	N	N	N
Delaware	I	UC	I	S	S	S
Georgia	I	I	I	N	N	N
Hawaii	I	I	I	N	N	N
Idaho	I	I	I	N	N	N
Illinois	I	I	I	N	N	N
Indiana[c]	I	I	I	N	N	N
Iowa	I	I	I	N	N	N
Kansas	I	I	I	S/I[d]	S/I	S/I
Kentucky	I	I	I	S	S	S
Louisiana	I	I	I	N	N	N
Maine	I	I	I	N	N	N
Michigan	I	I	I	S[e]	S	S
Minnesota	I	I	I	N	N	N
Mississippi	I	I	I	N	N	N
Missouri	I	I	I	N	N	N
Montana	I	I	I	N	N	N
Nebraska	I	I	I	N	N	N
Nevada	I	I	I	N	N	N
New Hampshire	I	I	I	N	N	N
New Mexico	I	I	I	N	N	N
North Carolina[f]	I	I	I	S	S	S
North Dakota	I	I	I	N	N	N
Oklahoma	I	I	I	N	N	N
Oregon	I	I	I	S/I[g]	S/I	S/I
Pennsylvania	I	I	I	N	N	N
South Carolina	I	I	I	N	N	N
South Dakota	I	I	I	N	N	N
Tennessee	I	I	I	S	S	S
Texas	I	I	I	S	S	S
Utah	I	I	I	N	N	N
Vermont	I	I	I	I	I	I
Washington	I	I	I	N	N	N
West Virginia	I	UC	I	I	UC	I
Wisconsin	I	I	I	N	N	N
Wyoming	I	I	I	S	S	S

I	Can be performed independently	∅	Cannot perform this function
S	Can be performed with supervision	N	State does not license at this level

[a] In AL a Master's level psychologist (psychologist technician) may complete some assessments independently but for more clinical/diagnostic assessments they must be supervised.
[b] In AR and TN, a master's level psychologist may be licensed as a Psychological Examiner to administer psychological tests independently, but must be supervised by an independent psychologist to engage in assessment and counseling activities.
[c] IN permits psychologists to be licensed before completing supervised practice. However, in order to practice independently, the psychologist must complete supervised practice and obtain endorsement as a "health service provider."
[d] KS has two licenses for Master's level psychologists: Master's Level Psychologist who must be supervised and Licensed Clinical Psychotherapists who may practice independently.
[e] In MI, a Master's level psychologist may obtain "Limited License" that allows practice under the supervision of a psychologist.
[f] In NC, a Master's level psychologist may practice if supervised four hours per week by a licensed psychologist.
[g] In OR, a Master's level psychologist usually may practice only under the supervision of a psychologist, however, after three years of practice s/he may petition the board for the right to practice independently, pending successful completion of oral exam.

Table 2: Social Work Scope of Practice, by State

	Licensed Clinical Social Worker (MSW or DSW—"Clinical")			Licensed Social Worker (MSW—Non-clinical or Without Supervised Clinical Practice)		
State	**Assessment**	**Treatment plan**	**Counseling**	**Assessment**	**Treatment Plan**	**Counseling**
Alabama	I	I	I	S	S	S
Alaska	I	I	I	S	∅	S
Arizona	I	I	I	S	S	S
Arkansas	I	I	I	S	S	S
Colorado	I	I	I	S	S	S
Delaware	I	I	I	N	N	N
Georgia	I	I	I	S	S	S
Hawaii[a]	I	I	I	N	N	N
Idaho[b]	I	I	I	S	S	S
Illinois	I	I	I	S	S	S
Indiana	I	I	I	S	S	S
Iowa	I	I	I	S	S	S
Kansas	I	I	I	S	S	S
Kentucky	I	I	I	S	S	S
Louisiana[c]	I	I	I	S	S	S
Maine	I	I	I	∅	I	∅
Michigan	I	I	I	S	S	S
Minnesota	I	I	I	S	S	S
Mississippi	I	I	I	S	S	S
Missouri	I	I	I	N	N	N
Montana[d]	I	I	I	N	N	N
Nebraska[e]	I	I	I	S	S	S
Nevada	I	I	I	S	S	S
New Hampshire	I	I	I	N	N	N
New Mexico	I	I	I	I	I	I
North Carolina	I	I	I	S	S	S
North Dakota	I	I	I	I	I	I
Oklahoma	I	I	I	S	S	S
Oregon	I	I	I	S	S	S
Pennsylvania[f]	I	I	I	S	S	S
South Carolina	I	I	I	S	S	S
South Dakota[g]	I	I	I	S	S	S
Tennessee	I	I	I	S	S	S
Texas	I	I	I	S	S	S
Utah	I	I	I	S	S	S
Vermont	I	I	I	N	N	N
Washington	I	I	I	S	S	S
West Virginia	I	I	I	I	I	I
Wisconsin	I	I	I	S	S	S
Wyoming	I	I	I	N	N	N

I	Can be performed independently	∅	Cannot perform this function
S	Can be performed with supervision	N	State does not license at this level

[a] HI has one social work license, although social workers may also obtain a "clinical" designation that permits insurance billing.
[b] In ID, there is only one level of licensure for Master's level professionals, the Certified Social Worker license. However, to practice independently, a Certified Social Worker must complete the additional requirement of 2 years supervised clinical experience.
[c] LA Statutes state that MSW-level social workers without LCSW license must work for an agency and paid direct compensation.
[d] MN has only one level of licensing for social work, the Licensed Social Worker, which is required for independent clinical practice.
[e] In addition to being certified as a "Master Social Worker," in order to practice psychotherapy independently in NE, a social worker must obtain a "Mental Health Practitioner License."
[f] In PA, social workers must refer for mental health problems that are biologically based, and all clients who are suicidal /psychotic.
[g] In SD, there is only one level of licensure for Master's level professionals, the Certified Social Worker license. However, to practice independently, a Certified Social Worker must complete the additional requirement of 2 years supervised clinical experience.

Table 3: Marriage and Family Therapy Scope of Practice, by State

State	Marriage and Family Therapist		
	Assess	Treatment Plan	Individual & Group Counseling
Alabama	I	I	I
Alaska	I	I	I
Arizona	I	I	I
Arkansas	I	I	I
Colorado	I	I	I
Delaware	N	N	N
Georgia	I	I	I
Hawaii	I	I	I
Idaho	N	N	N
Illinois	I	I	I
Indiana	I	I	I
Iowa	I	I	I
Kansas	I	I	I
Kentucky	I	I	I
Louisiana	N	N	N
Maine	I	I	I
Michigan	I	UC	I
Minnesota	I	I	I
Mississippi	UC	UC	I
Missouri	I	I	I
Montana	N	N	N
Nebraska[a]	I	I	I
Nevada[b]	I	I	I
New Hampshire	I	I	I
New Mexico	I	I	I
North Carolina	I	I	I
North Dakota	N	N	N
Oklahoma	I	I	I
Oregon	I	UC[c]	I
Pennsylvania	I	I	I
South Carolina	I	I	I
South Dakota	I	I	I
Tennessee	I	I	I
Texas	I	I	I
Utah	I	I	I
Vermont	I	I	I
Washington	I	I	I
West Virginia	N	N	N
Wisconsin	I	I	I
Wyoming	I	I	I

Key:

I	Can be performed independently	∅	Cannot perform this function
S	Can be performed with supervision	N	State does not license at this level

[a] NE "certifies" each mental health profession, but has one license for every professional who performs clinical mental health tasks, the "Mental Health Practitioner License."
[b] In NV, Marriage and Family Therapists cannot diagnosis or treat psychotic disorders.
[c] According to interview, the ability for MFT's to develop treatment plans is open to interpretation in Oregon.

Table 4: Professional Counseling Scope of Practice, by State

State	Licensed Professional Counselor (MA/MS)		
	Assess	Treatment Plan	Individual & Group Counseling
Alabama	I	I	I
Alaska	I	I	I
Arizona	I	I	I
Arkansas	I	I	I
Colorado	I	I	I
Delaware	I	UC	I
Georgia	I	I	I
Hawaii	N	N	N
Idaho	I	I	I
Illinois	I	I	I
Indiana	I	I	I
Iowa	I	I	I
Kansas	I	I	I
Kentucky	I	I	I
Louisiana	I	I	I
Maine	I	I	I
Michigan	I	I	I
Minnesota	N	N	N
Mississippi	I	UC	I
Missouri	I	∅	I
Montana	I	I	I
Nebraska[a]	I	I	I
Nevada	N	N	N
New Hampshire	I	I	I
New Mexico	I	I	I
North Carolina	I	I	I
North Dakota[b]	I	I	I
Oklahoma	I	I	I
Oregon	I	I	I
Pennsylvania	I	I	I
South Carolina	I	I	I
South Dakota	I	I	I
Tennessee	I	I	I
Texas	I	I	I
Utah	I	I	I
Vermont	I	I	I
Washington	I	I	I
West Virginia	I[c]	I[c]	I
Wisconsin	I	I	I
Wyoming	I	I	I

Key:

I	Can be performed independently	∅	Cannot perform this function
S	Can be performed with supervision	N	State does not license at this level

[a]NE "certifies" each mental health profession, but has one license for every professional who performs clinical mental health tasks, the "Mental Health Practitioner License."
[b] In ND, Licensed Professional Counselors can practice independently but only in a non-clinical setting.
[c] Permitted within the scope of practice for professional counseling, based on individual counselors' experience and training

Table 5: Legal Authority to Diagnose, by State and Profession

State	PSY	SW	LPC	MFT
Alabama	+	?[a]	?	?
Alaska	+	+[b]	+	+
Arizona	+	+	?	+
Arkansas	?	?	+	+
Colorado	+	+	+[c]	+
Delaware	+	+[c]	?	N
Georgia	+	?	?	?
Hawaii	+	+	N	+
Idaho	+	?	?	N
Illinois	+	?	?	+
Indiana	+	+[d]	+[d]	+[d]
Iowa	+	+[b]	?	?
Kansas	+	+[b]	+	+
Kentucky	+	+[c]	+	+
Louisiana	+	+[b]	+	N
Maine	+	+[e]	?	?
Michigan	+	+	+	?
Minnesota	+	+[b]	N	?
Mississippi	+	+[ce]	?	?
Missouri	+	+[c]	?	?
Montana	+	?	+	N
Nebraska	+	+[f]	+[f]	+[f]
Nevada	+	+[c]	N	+[g]
New Hampshire	+	+[c]	+[c]	+
New Mexico	+	+[b]	+[c]	+
North Carolina	+	+[c]	+	+
North Dakota	+	?	?	N
Oklahoma	+	+[c]	+	+
Oregon	+	+[c]	+	?
Pennsylvania	?	?	?	?
South Carolina	+	?	+	+
South Dakota	+	+[c]	+	+
Tennessee	+	+[b]	+[h]	+[i]
Texas	+	+[ce]	+	+
Utah	+	+[j]	+[j]	+
Vermont	+	+	+	+
Washington	+	?	?	+
West Virginia	?	+[c]	+	N
Wisconsin	+	+	?	+[k]
Wyoming	+	+[c]	+	+

+	Diagnosis explicitly permitted by statute or administrative code
-	Diagnosis explicitly prohibited by statute or administrative code
∅	Statute and administrative code do not discuss diagnosis
N	State does not license at this level

[a] Definition of clinical social work includes "diagnostic impression."
[b] LCSW-level social workers may diagnose independently, MSW-levels with supervision.
[c] Permitted only for providers licensed as "clinical" professionals
[d] Prohibited from making medical "diagnosis", but able to classify according Diagnostic and Statistical Manual
[e] Permitted only for practitioners licensed at an independent level
[f] Excludes diagnose of major mental illness unless consulting with a physician or Licensed Clinical Psychologist
[g] Excludes diagnosis and treatment of "psychotic disorder"
[h] Must be licensed professional counselor and designated as a mental health service provider
[i] MFTs prohibited from "psychological testing intended to measure and/or diagnose mental illness."
[j] Not included in statute for profession, but permitted through broader "Mental Health Professional Practice Act"
[k] "Marital or family diagnosis"

Table 6: Legal Authority to Practice Psychotherapy, by State and Profession

State	PSY	SW	LPC	MFT
Alabama	+	+[a]	∅	∅
Alaska	+[b]	+[c]	∅	+
Arizona	∅	+	∅	∅
Arkansas	+	∅	+	+
Colorado	+	+	+	+
Delaware	+	+[c]	∅	N
Georgia	+	+[c]	+	+
Hawaii	+	∅	N	+
Idaho	+	+[c d]	∅	N
Illinois	+	+[c]	+[c d]	+
Indiana	+	+[c]	+	+
Iowa	∅	∅	∅	∅
Kansas	+	+[a]	+[a]	+[a]
Kentucky	+[b]	+	∅	+
Louisiana	+	+[a]	∅	N
Maine	+	∅	∅	∅
Michigan	+	∅[e]	+	∅
Minnesota	+	+[f]	N	+
Mississippi	+	∅	∅	+
Missouri	+	+[c]	∅	+
Montana	+	+	∅	N
Nebraska	+	∅	∅	+
Nevada	+	+[c]	N	+
New Hampshire	+	+[c]	+[c]	+
New Mexico	+	+[c]	∅	+
North Carolina	+	+[c]	+	+
North Dakota	+	+	∅	N
Oklahoma	+	∅	∅	∅
Oregon	∅	+[c]	∅	+
Pennsylvania	∅	∅	+	+
South Carolina	+	+	∅	∅
South Dakota	+	+[c]	+	∅
Tennessee	+	+	∅	+
Texas	+	+	+	+
Utah	+	+[a]	+	+
Vermont	∅[g]	+[c]	∅	∅
Washington	+	+[h]	+	+
West Virginia	+	+[c]	∅	N
Wisconsin	+	+	+	+
Wyoming	+	+[c]	+	+

Key:

+	Psychotherapy explicitly permitted by statute or administrative code
-	Psychotherapy explicitly prohibited by statute or administrative code
∅	Statute and administrative code do not discuss psychotherapy
N	State does not license at this level

[a] May be performed independently only at the clinical level
[b] Only for Licensed Psychologists
[c] Permitted only for providers licensed as "clinical" professionals
[d] Permitted only for practitioners licensed at an independent level
[e] Qualifying experience for an applicant for registration as certified social worker includes "psychotherapy."
[f] Independent clinical social workers may perform pscyhotherapy independently, other Master's level professionals with supervision.
[g] Psychotherapy is an educational requirement, however, is not explicitly permitted under scope of practice.
[h] Only LICSWs can perform psychotherapy independently.

Table 7: Summary of State Statutes and Administrative Code With Respect to Diagnosis and Psychotherapy
(n=40 states)

	Permitted	Permitted as % of states that license	Prohibited	Not addressed in statute or code
	Diagnosis			
Psychologist	37	92.5	0	3
Social Worker	30	75	0	10
Marriage and Family Therapist[a]	24	70.6	0	10
Licensed Professional Counselor[b]	23	62.2	0	14
	Psychotherapy			
Psychologist	35	87.5	0	5
Social Worker	31	77.5	0	9
Marriage and Family Therapist[1]	25	73.5	0	9
Licensed Professional Counselor[2]	16	43.2	0	21

[a] Total number of states that license MFTs is 34 of the 40 states surveyed.
[b] Total number of states that license LCPs is 37 of the 40 states surveyed.

APPENDIX A: THE NON-PHYSICIAN MENTAL HEALTH PROFESSIONS

Clinical Psychologists

Origins of the Profession

The modern science of psychology can be traced to the ideas and writings of such late nineteenth century intellectual luminaries as Wilhelm Wundt, Sigmund Freud and William James. According to Leahey (1991), each of these individuals contributed to a different aspect of the emerging discipline. Wundt is considered the founder of experimental psychology, making traditional philosophical psychology more rigorous as an approach to the study of human consciousness. As the founder of psychoanalysis, Freud began to define the practice of psychology as a clinical intervention. James contributed the psychology of adaptation, which seeks to explain the evolutionary value of mind and behavior, and is primarily the province of so-called academic psychology.

Prior to World War II, academic psychologists dominated the profession (Grob, 1991). Most clinical psychologists spent their time administering intelligence and aptitude tests to various populations, including soldiers, workers and mental patients (Leahey, 1991). The war created an unprecedented demand for clinical psychologists. A critical shortage of psychiatrists, coupled with concerns about the combat-related onset or aggravation of psychological disorders, prompted General William Menninger (himself a psychiatrist) to refer recruits with backgrounds or interests in psychotherapy to the School of Military Neuropsychiatry for formal training and subsequent posting as combat therapists (Cummings, 1992). With support from the Veterans Administration and the National Institute of Mental Health, many of these individuals pursued comprehensive training as clinical psychologists after the War. These federal agencies also provided employment opportunities to the psychology graduates and, in many respects, shaped the profession as it is known today.

Fundamental Approach to Treating Mental Health Problems

Clinical psychologists take an approach to treating mental health problems that is based on the discipline's foundation in the scientific study of individual human cognition and behavior and on its moral imperative to foster growth (Leahey, 1991). They typically use methods such as interviews and behavioral assessments to determine the causes and potential effects of personal distress (Society of Clinical Psychology, 2001). Relying on their findings, they provide non-medical interventions in an effort to promote client adaptation and satisfaction. In many regards, their approach is comparable to that of the other non-physician mental health

professions (clinical social workers, professional counselors, and marriage and family therapists) although their education and training requirements are far more stringent.

According to a 1980's national survey, psychologists are less likely than psychiatrists to treat patients with severe conditions, such as major depressive, manic or schizophrenic disorders and that persons with more significant impairments are more likely to seek care from psychiatrists in the first place (Knesper, Belcher, & Cross, 1989). The authors conclude that, for patients with less severe mental health conditions, psychologists present a more cost-effective therapeutic alternative. They note that expansions in reimbursement and scope of practice for psychologists may make them even more attractive for these consumers.

Credentialing

State licensure of clinical psychologists did not begin until after World War II. By the late 1970s, all states had adopted such laws (Hogan, 1979). The American Psychological Association played an active role in this process, developing and promoting a model licensing law aimed at ensuring high professional standards and the right of psychologists to practice independently.

In order to obtain licensure as a psychologist in most states, a person is required to have completed a doctorate in psychology (either a PhD or a PsyD) from a program accredited by the American Psychological Association (APA). In addition, s/he must have completed a pre-doctoral internship (typically one year long) and a postdoctoral residency (also one year long). Many of these highly structured clinical training programs are also accredited by the APA. Some (but not all) state psychology boards consider the APA accreditation status of internships and residencies when making licensure decisions (Keilin et al., 2000).

During doctoral studies, the psychology graduate student is expected to gain mastery of subject areas including but not limited to: biological, cognitive, affective and social aspects of behavior; history and systems of psychology; research methods and techniques of data analysis; human development; psychopathology; professional standards and ethics; problem assessment and implementation of appropriate intervention strategies. S/he is expected to spend a minimum of three years in full-time coursework (American Psychological Association, 2002). The PhD includes the requirement of a dissertation, as well.

As of October 2000, the APA had accredited over 200 doctoral programs in professional psychology (American Psychological Association, 2000). They are located in virtually every state, as well as the District of Columbia, Puerto Rico, and every Canadian province. While most are university-based, some are freestanding institutes, while others are affiliated with theological seminaries.

Number and Distribution of Professionals

A 1995 survey of state psychology boards found 89,514 licensed psychologists in the U.S. (Robiner & Crew, 2000). An increase in excess of 40 percent from 1988, this number yields an average ratio of 33.6 licensed psychologists per 100,000 population nationwide. At the state level, uneven distribution of these professionals becomes evident. In Louisiana, for example, there were only 10.32 psychologists per 100,000 population in 1995, while the comparable ratio for Vermont was 85.15. In part, these variations may reflect cultural differences that influence overall demand for mental health services. They may also reflect differences in scope of practice laws, reimbursement policies, or availability of training programs.

Data on distribution of psychologists and other non-physician mental health professionals within states is difficult to obtain. Studies now two decades old suggest that psychologists are no more likely than other mental health professionals to practice in geographically isolated or sparsely populated rural areas. A county-level analysis for the Northeastern United States using 1978 data, for example, found a significant and positive correlation between population density and the rate of psychologists per 100,000 persons (Keller, Zimbelman, Murray, & Feil, 1980). A national study using slightly more recent data found that psychiatrists, psychologists and social workers all tended to practice in relatively affluent, urbanized counties whose residents enjoyed high educational status, an adequate supply of primary care physicians and relatively liberal mental health insurance benefits (Knesper et al., 1984).

Professional Associations

The APA is the principal national association for this profession. A 501(c)(3) non-profit corporation, the APA has as its mission the advancement of psychology as a science, a profession and a means of promoting human welfare (American Psychological Association, Inc., 2001c). Out of offices in Washington, DC, the APA provides a variety of services to the profession and broader publics, including publication of the *American Psychologist* journal and the highly-regarded *Publication Manual of the American Psychological Association*. As noted above, the APA is also responsible for accreditation of programs in professional psychology. Its annual operating budget of more than $75 million is derived from member dues, investments, publication sales and real estate.

Special Efforts to Serve Rural Populations

Experts have long argued that quality of life differences, isolation from professional colleagues, and the need to balance multiple roles make the practice of psychology in rural

areas uniquely challenging (Murray & Keller, 1991). By the mid-1960s, rural and community psychology was already gaining recognition as a separate and important sub-discipline. In 1965, the APA established a Division of Community Psychology (Resnick & Morris, 1997). Clinical psychologists assumed strong leadership roles in the community mental health centers that began to form following passage of the Community Mental Health Centers Act of 1963 (Grob, 1991). Many of these centers were located in rural areas or served significant rural populations. By the early 1970s, at least three journals covering issues related to rural and community psychology were in publication. At least one of these, the *Journal of Rural Community Psychology*, is currently published in electronic format.

APA's continued commitment to rural health is evidenced in the presence of a professionally-staffed Office of Rural Health that works closely with a Committee on Rural Health comprised of APA members with special interests in rural health issues (American Psychological Association, 1999, 2001a). The APA Office of Rural Health engages in liaison work with a number of key federal agencies, including the Office of Rural Health Policy, the National Institute of Mental Health, the National Health Service Corps and the Bureau of Health Professions. The Office also works closely with the state Offices of Rural Health and with other professional organizations including the American Academy of Family Physicians, the National Rural Health Association and the Capitol Area Rural Health Roundtable at George Mason University.

Advocates for a uniquely rural approach to psychology training suffered a serious moral defeat when the masters' degree program in community-clinical psychology at Mansfield University closed in 2001 after 25 years of operation (Keller, 2000). In part, the closure came as a consequence of changes in Pennsylvania state licensure requirements regarding psychology practice at the masters' level. Nonetheless, an APA survey conducted in 1997 found over 100 accredited pre-doctoral internship programs in the U.S. that deal with rural issues (American Psychological Association, 2001b). In many instances, the rural experiences offered to students are a consequence of the geographic location of internship sites. However, some programs build specific goals around rural training. For example, the Southwest Consortium, part of the New Mexico VA Health System, offers its psychology interns opportunities to work with patients from American Indian, Hispanic and Anglo cultures in both urban and geographically isolated rural environments (Southwest Consortium, 2001). Interns in the Division of Behavioral Medicine at West Virginia University's Charleston campus can spend a rotation working on a rural schools resiliency project in a rural county southwest of Charleston (West Virginia University, 2000). Prompted by disaster service needs emerging in the wake of Hurricane

Andrew, the University of Florida Department of Clinical and Health Psychology established a rural health psychology internship track in 1995 (Rural health psychology specialty, University of Florida, 2000). Faculty and interns from this program have helped train cooperative extension agents in rural areas outside of Florida to deal with provision of mental health services following natural disasters.

Current Issues

Three issues concerning the scope of practice of clinical psychologists have surfaced in the states in recent years. Psychologists have attempted (thus far in vain) to obtain independent rights to prescribe medications related to the treatment of mental health problems. In part, the argument in favor of this development is based on the higher penetration of psychologists in rural areas where their ability to prescribe medication would enhance overall access to mental health services. This is particularly the case in those rural communities where the only clinicians with prescriptive rights are family practice physicians who lack comprehensive training in psychopharmacology. The psychiatric profession, arguing that psychologists lack the necessary training in human physiology and pharmacology, has actively opposed this effort (American Psychiatric Association, 2000b). In spite of the fact that the APA's Council of Representatives voted to support prescriptive rights in 1995, some members of the profession of psychology have also not favored this development. They are especially concerned that such a move would undermine the fundamental distinction between the approaches to treating mental illness taken by psychology and psychiatry (Ax, Forbes, & Thompson, 1997).

Another scope of practice issue of concern is the right of psychologists to admit persons with severe mental illness to inpatient hospital care and to attend those patients while they are hospitalized. As of 1996, 16 states and the District of Columbia had enacted laws allowing psychologists to exercise hospital admitting and attending privileges (Resnick & Morris, 1997). The American Psychiatric Association has opposed this effort, as well (American Psychiatric Association, 2000a).

A third issue of particular concern to rural states is the continued licensing of masters' level psychologists. Hogan (1979) asserts that the APA has maintained and promulgated a strong commitment to the doctoral degree as the minimum requirement for licensed clinical psychologists as a strategy for assuring the credibility of the profession. Nevertheless, roughly 6.5 percent of the licensed psychologists identified in the psychology board survey mentioned above were trained only at the masters' level (Robiner & Crew, 2000). This survey identified eight state boards that licensed masters'-level psychologists with some title that included the

word “psychologist,” although the license was often limited or the title qualified. Another thirteen boards licensed people with masters'-level training in psychology under another title.

The profession scored a major coup with the passage of the Omnibus Budget Reconciliation Act of 1987, which included a provision allowing for direct Medicaid and Medicare reimbursement of the services of clinical psychologists furnished at rural health clinics and community mental health centers (Omnibus Budget Reconciliation Act, 1987).

Social Workers

Origins of the Profession

In the United States social work developed in two directions: (1) the expanding involvement of social workers in service programs supported by governmental and non-profit agencies to address the needs of individuals and families and (2) the organization of social work as a profession (Austin, 1984). Participation of social workers in service agencies started in the 19th Century and expanded through the mid - 20th Century to meet the social welfare needs of immigrants, poor persons, and persons with psychiatric needs. Organization of social work as a profession included development of professional schools, journals, conferences, and membership associations. The professionalization of social work helped to meld together social workers working in diverse settings, including settlements, hospitals, schools, charity agencies, and psychiatric clinics (Austin, 1984). Social work also provided career opportunities for educated women.

The search for a single underlying framework for social work has been elusive throughout the last century. As Austin observes, social work is a blend of professional practice activities clustered in three areas, dealing with problems of (1) poverty, (2) social care, and (3) acute mental health treatment. Most social workers identify with one of these three traditions, each with its own history and conceptual framework. Social work practice dealing with problems of poverty began with charity societies and settlement houses tracing back to the late 19th Century. Social work practice taking up social care began with institutional reforms of Dorothea Dix in Massachusetts in the mid 19th century; the development of children's homes and foster homes; and early forms of psychiatric hospitals, schools for persons with retardation, and juvenile correction institutions (Austin, 1984). Social work practice in acute mental health treatment emerged early in the 20th Century, spurred by the development if outpatient clinics attached to psychopathic hospitals, treatment of shell-shocked World War I veterans, and the growth of child guidance clinics around 1920. Social work was taught at the psychiatric social work training program at Smith College, funded by the Red Cross.

In the 1920s charity organizations and societies changed their mission and role from charity administration to mental health oriented family and individual counseling, re-naming themselves family service agencies (Austin, 1984). This transition had a profound effect on the growth of social practice in mental health and was further fueled by the replacement of many charity agencies by Federal assistance to low-income families through the AFDC program. This greatly diminished the involvement of social work practice in poverty, serving to further direct practice to mental health issues.

Approach to Treating Mental Health Problems

The core of social work practice in acute mental health settings is individual and group practice and involves psychological counseling or psychotherapy. The psychotherapeutic practice includes ego-psychology, behavioral, cognitive, and ecological theoretical frameworks. While using these approaches, social work practice is usually based on a medical model that includes diagnosis, treatment (intervention) and the notion of cure as an outcome (Austin, 1984).

In contrast to psychology, social work has generally enjoyed cordial relations with psychiatry – the dominant mental health profession (Grob, 1991). During World War II, psychiatric social workers were afforded the opportunity to do psychiatric assessments - a function they continued to perform after the war in psychiatric hospitals and, increasingly, in outpatient settings as the locus of mental health care shifted to the community. Because psychiatry and social work viewed each other largely as complementary to (rather than substitutable for) each other, demand and opportunity for psychiatrically trained social workers has increased steadily with the growth of mental health care and services. In addition to assessment (including diagnosis) and individual and group treatment, social workers are potentially well-suited to address issues involving families and other social and community services that are central to community-based mental health care.

The relations between psychiatry and social work have remained cordial, even as social workers have achieved a greater role as direct service providers. Perhaps this is because social work does not contest the medical sovereignty of psychiatry in delivering mental health care. In contrast, both nursing and psychology are increasingly pressing for the right to prescribe psychotropic medications. There is a potential and sometimes realized conflict between social work and psychology. This conflict arises primarily in the areas of the right of direct practice and direct reimbursement for services. In larger, organized work settings such as community mental health centers, psychologists and social workers tend to work relatively harmoniously with each

other. Social workers and counselors may also compete with each other in the area of providing supportive services.

Current Structure of the Profession

The National Association of Social Work (NASW) is the governing professional Association and the Council on Social Work Education accredits educational programs in social work. In 1998 the NASW surveyed its membership about the perceived need and interest for additional certification and training. "To help NASW members in today's competitive workplace" the NASW has established a national certification program creating specialty certification in three areas": case management, ATOD (alcohol, tobacco, and other drugs), and school social work (NASW, no date).

As of 2000, the Council on Social Work Education accredited 421 BSW programs and 139 MSW programs. There were 71 doctoral programs for Ph.D.s in social work (Bureau of Labor Statistics, 2002). Acute mental health treatment has been the major focus of graduate education for direct practice in social work since the 1950s. Approximately 85 percent of students entering social work programs expect to practice in mental health.

Number and Types of Social Workers

Licensed clinical social workers (LCSWs) are a component of mental health delivery systems and generally have received master's level training in programs teaching family dynamics, psychotherapy, cultural milieu, and crisis intervention (Ivey et al., 1998). Estimates of the number of clinically trained social workers in mental health vary, but generally show a lower bound of around 84,000 (active) and a upper bound of 94,000 - 100,000 (active and inactive) (Ivey et al., 1998; BLS, 2002).

Licensure, Scope of Practice, and Reimbursement

All states and the District of Columbia have licensing, certification, or registration requirements. While standards vary, communication skills and training in cultural diversity are increasingly being emphasized. The NASW offers voluntary certification and (as described above) is offering its membership increased options for specialty certification to enhance competitive position (employment and reimbursement) in the market place.

The Bachelor's degree is the most common and minimum requirement to qualify for a job as a social worker in mental health. However, the master's or doctoral level clinical social work degree is generally (almost always) required for independent practice and reimbursement by Medicare, Medicaid, and most private payers. Medicare pays licensed clinical social workers seventy-five percent of a physician's fee and allows for direct billing.

Issues in Serving Rural Populations

Social workers are the backbone of rural mental health delivery systems -- the bachelor's level social worker is the most common rural mental health worker (Geller, Beeson, & Rodenhiser, 1997). Because social work programs are found in rural as well as urban states there is a relatively steady flow of new social workers into rural mental health practice who are well suited to understanding the cultural requirements and nuances of rural communities. Social workers may be one of the few bright spots within the ongoing effort to address the chronic shortage of mental health professionals in rural areas. However, the profession faces ongoing and emerging challenges with respect to rural practice. Rural areas need more master's level clinical social workers. It is not certain that rural areas can successfully compete for these workers, particularly in light of increased specialty certification, which may induce even more clinical social workers to work in more lucrative urban markets. The Bureau of Labor Statistics (2002) forecasts growing demand for social workers, portending that rural areas are likely to experience increased market competition from urban areas. The growing ethnic diversity of many rural areas (particularly Hispanic and Asian) poses a fundamental challenge to the cultural competence of the current supply of social workers practicing in rural areas. Finally, there are efforts to bolster the ability of other non-physician providers, including counselors and marriage and family therapists (e.g. Medicare reimbursement) to provide mental health care in rural and other under-served areas. This would increase the competition faced by social workers who might respond by increasing their own practice requirements to differentiate themselves from these other professions. This could result in a "credentialing race" that might ultimately further constrain, rather than increase, the number of mental health social workers in rural areas.

Professional Counseling

Origins of the Profession

The field of professional counseling encompasses a broad array of activities, services, and professional settings. Counseling as a profession is rooted in school guidance counseling and vocational rehabilitation counseling, professions that emerged during the 1950's partly in response to federal legislation and funding (Remley & Herlihy, 2001). At the same time, professional counselors share much of the same history and practice philosophy with counseling psychology, a branch of psychology that developed during roughly the same time period as professional counseling (Remley & Herlihy, 2001; Goodyear, 2000).

The American Counseling Association (ACA), the primary professional association that represents professional counselors, is comprised of separate divisions, or "specialties," that strive to reflect the interests of different segments of the professional counseling community (ACA, no date). Originally named the American Personnel and Guidance Association, the American Counseling Association was established in 1952 when three of the current "divisions" joined together as one organization. These were the Association for Counselor Education and Supervision, the Counseling Association for Humanistic Education and Development, and the National Career Development Association. Over time the ACA grew to encompass 17 different divisions, with professional focuses that include serving aging populations, working in educational settings, multicultural approaches to counseling, social justice, and mental health employment, and rehabilitation counseling. (ACA, no date). Being comprised of many different factions has led to a unique professional identity dynamic for professional counselors, permitting many different perspectives to coexist under the same umbrella but at the same time potentially weakening the profession's ability to coalesce around a common vision. According to one source, "Our specialties are at once a rich heritage and a strong force for fragmentation" (Myers & Sweeney, 2001).

Fundamental Approach to Treating Mental Health Problems

Historically, one of the central tenets of professional counseling has been that, unlike other mental health disciplines, the paradigmatic focus has been on wellness and positive developmental health, not psychopathology (Remley & Herlihy, 2001; Ivey & Ivey, 1998). According to the ACA, "What makes professional counselors unique from their peers in other mental health disciplines is their "wellness" orientation. While trained to understand pathology and mental illness, professional counselors take a preventive approach to helping people" (ACA, no date). In adopting the "wellness model" as its primary paradigm for understanding mental health issues, professional counseling reacted against what some professional counselors call the "illness model" used by other professionals including psychologists, clinical social workers and psychiatric nurse specialists (Remley & Herlihy, 2001). Instead of focusing on treating mental health problems, a segment of professional counseling believes their practice should be aimed at helping individuals achieve the best level of mental health and functioning possible for them (Remley & Herlihy, 2001; Briddick, 1997).

This focus on wellness stems in part from the profession being rooted in the field of "guidance" which was centered around developmental models that focused on optimizing human performance (Myers, 1991). The "developmental perspective" of professional counseling means that, for the most part, mental health problems are viewed as normal

responses to adverse life experiences (Remley & Herlihy, 2001). Juxtaposing the "illness" and developmental models, Ivey and Ivey (1998) report that the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association "describes pathology as located 'in an individual'" while developmental counseling and therapy "considers distress (rather than 'pathology') as the logical result of biological and developmental insult. The stressor may be located within the individual, in broader systemic and historical factors, or in both." (p.335) Consequently, assessments in professional counseling include the individual and his or personal and family history, as well as their environment and cultural factors (Ivey & Ivey, 1998; Myers, 1991).

In recent years, however, the emphasis on wellness and prevention has been at odds with efforts to bring the profession of counseling to an equal footing with other master's level mental health professionals such as clinical social workers or clinical nurse specialists. As professional counselors increasingly became employed in community agencies or private practice, some have sought to add training in "pathology" to counselor education programs in order to be better equipped to gain third-party reimbursement (Myers, 1991). The American Mental Health Counselors Association, a division of ACA that was founded in 1976, has represented those professional counselors whose practice encompasses "the developmental, preventive, and educational as well as the traditional remedial aspects of mental health care" (Smith & Robinson, 1995).

There is evidence that, despite these seeming contradictions in approach to mental health practice by different segments of the professional counseling field, members of the profession have resolved their differences sufficiently to maintain a united front. In 1997, the ACA adopted a definition of professional counseling that incorporates both the historical roots of the profession and the more recent emphasis on conventional mental health assessment and treatment modalities. According to the ACA (no date), the definition of professional counseling practice is "The application of mental heath, psychological or human development principles, through cognitive, affective, behavioral or systemic intervention strategies that address wellness, personal growth, or career development, as well as pathology."

Credentialing

The first certification of counselors occurred during the 1940s and 1950s when school counselors' certification was tied to the certification of teachers (Forest & Stone, 1991). Virginia became the first state to license professional counselors in 1975 and since then, 45 states and the District of Columbia have established legislation to certify or license professional counselors (ACA, no date; Bradley, 1995). One of the defining characteristics of professional counselor

credentialing has been the lack of uniformity between states, especially in terms of training, supervised experience, and examinations (Bradley, 1995; Anderson & Swanson, 1994). Through licensing legislation, states have given a broad range of titles to those in the counseling profession. The most commonly used title is "professional counselor," however states may license counseling professionals as mental health counselors, clinical counselors or some other professional title (Remley & Herlihy, 2001; Bradley, 1995). According to one source, there are as many as 16 different titles used in counselor licensing laws throughout the country (Smith & Robinson, 1995).

The National Board for Certified Counselors (NBCC) is a professional association that was established in 1982 to provide professional counselors with the opportunity to obtain voluntary national certification. As of 2001, more than 31,000 professionals had been certified by NBCC (NBCC, 2001). According to the organization, although not a substitute for state licensing requirements, credentialing through the NBCC allows professional counselors to demonstrate to the public that they have undergone a certification process that meets professional standards designed by counselors, not legislators (NBCC, 2001). States typically require that professional counselors pass a national exam prior to certification, and 38 of the 46 states (including the District of Columbia) that license counselors require or accept the National Counselors Exam for Licensure and Certification (NCE) administered by NBCC (NBCC, 2001).

Number and Distribution of Professionals

According to the Occupational Outlook Handbook, there were approximately 465,000 counselors employed during 2000 (BLS, 2002). The same source reported that nearly half of these professionals (205,000) were identified as education, vocational or school counselors and another 110,000 as rehabilitation counselors. The remainder (approximately 150,000 counselors) are reportedly engaged in more traditional mental health practice as mental health counselors, substance abuse or behavioral disorder counselors, and marriage and family therapists (BLS, 2002).

In addition to having a range of specialization within the professional counseling field, counselors may work in a number of different settings. As one would expect, the primary settings for education, vocational and school counselors are public and private schools, colleges and universities (BLS, 2002). In recent years, however, many more counselors have become employed in agency settings or in private practice. One professor in a counseling education program estimated that only 15 percent of graduates from his program now enter school settings, with about two-thirds entering agency settings (Briddick, 1997). According to this source, another 15 percent work for the Employee Assistance Programs (EAP's) of public or

private employers and perform functions similar to those in agency settings. The number of ACA members who identified themselves as working in a school setting declined between 1990 and 2000, from 30 to 23 percent while the number of members who reported themselves to be in private practice increased from 25 to 31 percent over the same time span (Locke, Myers & Herr, 2001).

Current Issues

License Portability

Although an important issue for all mental health professionals, portability of licensure between states is a particular concern for professional counselors. By portability, we mean the degree to which a professional licensed in one state can move to another state and be eligible for licensure in their new place of residence. According to one source, "credentialing and occupational mobility in the counseling profession are among the most pressing national and international issues facing the growing profession" (Anderson & Swanson, 1994). Counselors face unique challenges to license portability compared to other mental health professionals because of the differences in state certification and licensure requirements across the country (Anderson & Swanson, 1994). As noted above, even the titles that states use to identify professional counselors through the licensing process may differ dramatically between states.

Insurance Reimbursement

For professional counselors working in mental health agency settings or in private practice, the ability to secure third-party reimbursement for services is critical. A number of states require that insurance companies must reimburse professional counselors for services that they cover when rendered by other professionals (Remley & Herlihy, 2001; Strosnider & Grad, 1993). However, while these "vendorship" or "freedom of choice" laws are beneficial for professional counselors, their effectiveness can be limited if the plans that cover state residents are from out-of-state or come from self-insured employers (Strosnider & Grad, 1993). In most states insurance companies can decide themselves whether or not they will reimburse professional counselors and, although many choose to cover their services, this is by no means uniform (Remley & Herlihy, 2001).

Scope of practice legislation can affect the ability of professional counselors to gain reimbursement for third party payers. In order to be able to bill an insurance company, a professional counselor needs to be able to submit a diagnosis on the insurance forms (Anderson & Swanson, 1994). As Table 5 indicates, diagnosis is only explicitly defined to fall within the scope of practice for professional counselors in 19 of the 36 states that we reviewed that license them. In some states where diagnosis is not explicitly permitted, professional

counselors have faced legal challenges when they have diagnosed mental health problems (Remley & Herlihy, 2001). Consequently, professional counselors in some states have tried to amend their licensing regulations to include diagnosis as one of the explicit functions of their profession. For example, in February 2002, the Missouri Legislature introduced a bill (House Bill 1843) that would change the professional counseling statutes to include diagnosis, among other counseling functions (Missouri Legislature, 2002).

In addition to the challenges that professional counselors can face in obtaining reimbursement from private insurance companies, securing public reimbursement through Medicaid and Medicare is a significant issue. Currently professional counselors are not considered eligible providers under Medicare and cannot be reimbursed for their services (ACA, 2001). Reimbursement by state Medicaid programs is not uniform, and many states do not include professional counselors as Medicaid providers. Efforts to increase the number of states that reimburse professional counselors are an on-going political struggle. For example, in 2001 the Mississippi legislature introduced a bill to amend Medicaid regulations to permit mental health services provided by licensed professional counselors to be reimbursable, however this bill (House Bill 198) died in committee in January of 2001 (Mississippi Legislature, 2001).

Marriage and Family Counselors

Origins of the Profession

Marriage and family therapy began as preventative classes and courses to meet the normal needs of people, especially women, who wanted to know more about marriage, parenting and family life (Thomas, 1992). As colleges and universities began to admit their first female students, in the early 1900's, these students requested courses on the family. In 1908, 20 colleges offered such courses, with a focus on prevention and promoting the physical and emotional health of the family. In 1924, Ernest R. Groves taught the first parenthood course for credit at Boston University (Thomas, 1992). Groves' subsequent work pulled together the biological, psychological, and social elements of marriage in a practical manner and began a trend of looking at marriage and family life from a holistic perspective. In 1942, The American Association of Marriage Counselors (AAMC) was formed and Ernest R. Groves became the first president. From the very beginning, AAMC emphasized the marital relationship and the value of conjoint marital therapy, marking the beginning of unique profession (Thomas, 1992). In 1963, California was the first state to legally recognize marriage, family and child counselors (Levison, 1995). In 1970 AAMC changed its name to the American Association of Marriage and

Family Counselors (AAMFC), the number of schools for training in family therapy grew and licensure/certification bills passed in more state legislatures.

Fundamental Approach to Treating Mental Health Problems

The marriage and family therapist takes a systematic, holistic approach regarding environments and relationships that affect the emotional well being of the patient. The profession sees itself as offering a broader perspective than the other professionals, although among the other mental health professions, it is perhaps most like Licensed Clinical Counseling in its approach to mental heath issues.

Credentialing

In 1978, AAMFC changed its name to the American Association for Marriage and Family Therapists (AAMFT) (Levison, 1995). Initially, AAMFT set the credentialing/licensing standards to ensure the public's needs were met by trained practitioners. In 1979, the Department of Education formally recognized the commission of Accreditation for Marriage and Family Therapy Education. This meant graduate schools were now accredited and Marriage and Family Therapists officially became a unique profession, now formally separate from social work, psychology, and/or psychiatry.

In the 1990's, AAMFT deferred the licensure/credentialing process to the individual states. However, most states used the AAMFT rules as their credentialing model. The licensure criteria for marriage and family therapists tend to be more uniform than the other mental health professions. Typically, there is one level of marriage and family therapy licensure per state, and since most of the 44 states modeled their licensing criteria upon the original AAMFT rules, there's more credentialing uniformity in this profession than among some others. Typically, most states require a Master's degree and 3 years supervised experience prior to licensure.

Number and Distribution of Professionals

According to AAMFT, there are now 93 nationwide accredited marriage and family therapy training programs (Master's and Doctoral level), 44 states license marriage and family therapists, and there are now 47,111 nationwide clinical Marriage and Family Therapists, of whom 45,176 are licensed.

Current Issues

<u>Perception of the profession</u>

According to a spokesperson for the AAMFT, a major obstacle to expanding the profession is a misperception among policy makers and the public, regarding the title. Many perceive these professionals to be exclusively marriage counselors. Perhaps due to this

misperception, federal law does not recognize marriage and family therapists as qualified professionals for employment in schools (D. M. Bergman, personal communication, March 1, 2001). This perception has implications for reimbursement as well.

Reimbursement

According to 42 USC §1395 x (aa)(1), neither Medicare nor Medicaid will reimburse marriage and family therapists in rural health clinics. This federal law, which provides Medicaid and Medicare reimbursement to mental health services in rural health clinics and federally qualified health centers, has a very specific roster as to who will be reimbursed. This exclusion may be a major access barrier for rural residents who are beneficiaries of these public insurance programs. This exclusion also applies to Licensed Counselors. Medicare, in fact, will not directly reimburse these two professions in any setting. This potential access barrier is directly addressed by a bill currently being considered in the U.S. Congress, known as the Seniors Mental Health Access Improvement Act (H.R. 3899, 2002).

In addition to Medicare/Medicaid and the rural health clinic provision, reimbursement from third parties is as a major obstacle for the marriage and family therapist according to Patricia Stevens-Smith. Dr. Smith claims that the majority of third party payment sources base their payment criteria upon the Diagnostic and Statistical Manual of Mental Disorders (DSMIII-R, or DSM IV). Although marriage and family therapists treat many individuals, Dr. Smith explains that this assessment and diagnosis model is individually oriented, and is therefore contrary to the holistic wellness philosophy of the marriage and family theory and a disadvantage for reimbursement for any family therapy (Stevens-Smith, 1993).

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Muskie School of Public Service

Muskie School of Public Service
96 Falmouth Street
PO Box 9300
Portland, ME 04104-9300

telephone (207) 780-4430
tty (207) 780-5646
fax (207) 780-4417
www.muskie.usm.maine.edu

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