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Health Workforce Policy Brief

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A Preliminary Analysis of State Scopes of Practice for Behavioral Health Professions

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BACKGROUND

Scopes of practice (SOPs) can limit or promote specific services and functions a health provider is permitted to perform, depending upon how they are written. The Affordable Care Act and the Mental Health Parity and Addiction Equity Act have increased the need for additional behavioral health care workers and challenged policy makers to regulate behavioral healthcare practice in such a way that maximizes the use of practitioners to deliver care to patients.

As demand for greater and more diverse behavioral health care services increases, expansion of occupational SOPs has been suggested as one mechanism for enhancing workforce capacity. SOPs that are uniform for a given occupation across states, and complementary across behavioral health occupations, may help ensure that a full range of mental health and substance use disorder services are authorized and easily accessible for patients. This study collected SOPs for nine behavioral health occupations in order to compare similarities, variations and gaps in provider authority.

METHODS

The Behavioral Health Workforce Research Center's research team conducted a comprehensive analysis of state statutes and administrative rules for nine types of behavioral health professionals and paraprofessionals from all 50 states and the District of Columbia (D.C.). Our list of professionals included: psychiatrists, psychologists, advanced practice registered nurses (APRNs), mental health counselors, marriage and family therapists (MFTs), and addiction counselors. Our list of paraprofessionals included: prevention specialists, psychiatric rehabilitation specialists, and psychiatric aides. Social worker SOPs were also collected and underwent more in-depth analysis; these findings will be released in an accompanying report. Data gathering was restricted to online sources; therefore, some states did not provide SOP information.

Spreadsheets were developed to summarize information from statutes, administrative rules, and candidate guides and inform three sub-analyses:

- "Macro state" analysis consisted of broad information about SOP laws/rules, such as dates enacted and updated, web location, and language.
- "Licensure requirements" analysis consisted of the educational, practice hour, supervision hour, renewal, and continuing education requirements necessary for licensure/certification, as well as any language about licensure through reciprocity or endorsement.
- "Services available" analysis assessed which of the following services were legally authorized by the SOP: assessment, diagnosis, psychotherapy, crisis intervention, and telehealth.

CONCLUSIONS AND POLICY IMPLICATIONS

The findings of this study show:

- A need for better defined SOPs for paraprofessional and peer professional occupations.
- Variation in diagnosis, treatment, and prescribing authorities for licensed behavioral health professionals across states.
- Variability in state examination requirements for paraprofessional licensure and certification.
- A need for telehealth authority to be addressed in occupational SOPs.
- Behavioral health occupations have vested interests in protecting their scope of practice.

Although changes in SOP authority may strengthen overall behavioral health workforce capacity, potential barriers to SOP changes may include:

- A need to ensure appropriate training of behavioral health workers if authorities are expanded
- Resistance to change by professional groups desiring to protect their discipline's SOP authority
- A lack of empirical literature detailing the types of SOP changes leading to high quality and effective care delivery.

KEY FINDINGS

SOP accessibility varied across professions and states (Figure 1).

Macro State Analysis

- SOP language was identified for licensed behavioral health professionals in all states and D.C.; however, data for paraprofessional occupations varied. Psychiatric aides were the least common paraprofessional group to have an SOP (36 states); prevention specialists were the most common (43 states).
- Five states had licensed positions for psychiatric aides: Alabama, Arkansas, California, Colorado, and Kansas.

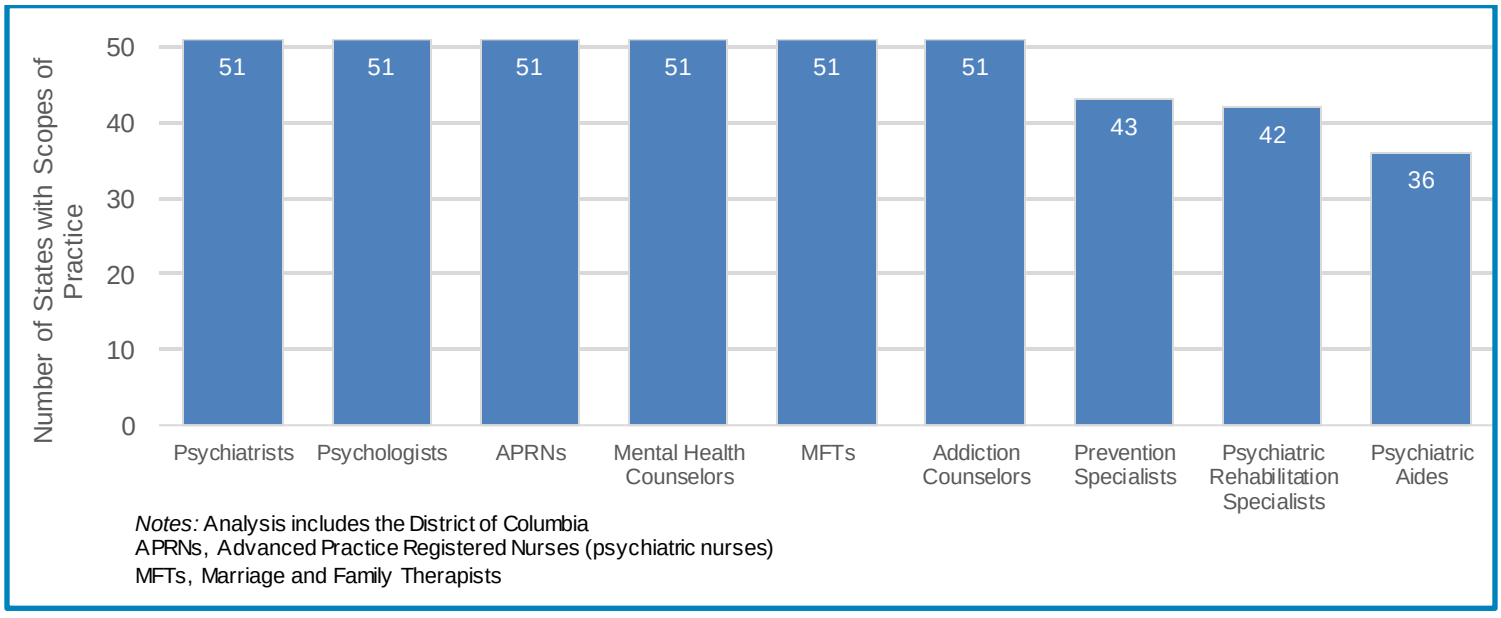
Licensure Requirement Analysis

- MFTs were most likely to have education core requirements outlined in their SOPs (49 states), followed by mental health counselors (48 states) and addiction counselors (48 states).
- Paraprofessional licensure/certification required passing state-specific examinations in 11 instances. Professional licensure/certification always required passing national examinations.
- Of continuing education requirements for all professionals and paraprofessionals, 75% had an ethics component and 14% had a knowledge of state laws/regulations component.
- Licenses/certifications typically were valid for either 12 or 24 months, with rare exceptions. Psychiatrist licenses were more likely to be valid longer than 24 months compared with other license types.

Services Available Analysis

- Telehealth authority was most often granted to psychiatrists (31 states), followed by psychologists (21 states), and APRNs (17 states). Telehealth was not explicitly authorized in SOPs for paraprofessional occupations.
- Diagnosis was most commonly authorized for psychiatrists (47 states), followed by psychologists (45 states), and then APRNs (40 states). Paraprofessionals never had explicit authorization to engage in diagnosis.
- Some states explicitly deny authority to diagnose patients for some licensed behavioral health professionals: APRNs in Colorado; addiction counselors in Tennessee and Utah; MFTs in Indiana; and mental health counselors in Indiana, Kansas, Maine, and Texas.

Figure 1. Availability of Behavioral Health Scopes of Practice by Profession



Notes: Analysis includes the District of Columbia
APRNs, Advanced Practice Registered Nurses (psychiatric nurses)
MFTs, Marriage and Family Therapists

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