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# A Descriptive Analysis of State Credentials for Mental Health Counselors

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## BACKGROUND

Over 144,000 Mental Health Counselors (MHCs) are active across the United States[1], and an estimated 19% growth is expected in the field over the next 10 years.[2] Demand for professional counseling services is growing, as approximately 18% of all adults in the United States were reported as having some form of mental illness in 2015[3], and mental health care costs amounted to $201 billion in 2013[4] - more than heart conditions or trauma.

The scope of practice (SOP) for MHCs varies across the country, although all states grant the authority to perform core mental health services.[5] State legislatures are influenced by political considerations that cause deviations from national standards. While the education and training are routinely uniform, thanks to accrediting organizations like the Council for Accreditation of Counseling & Related Educational Programs (CACREP), nuances in wording can impact the practice authority. Mental health service delivery is a key component of the SOP, but states also authorize addiction services, highlighting the versatility of MHCs. According to CACREP, an acceptable counseling curriculum for entry-level MHCs includes "theories and etiology of addiction and addictive behaviors."[6] Other counseling specialties include school, rehabilitation, and marriage and family,[6] but these are frequently credentialed separately from the MHC.[5]

The purpose of this pilot study is to conduct a comprehensive analysis of state SOPs for MHCs with focus on the various state credentials for MHCs, and explore how licensing policies affect the current MHC workforce and their delivery of behavioral health care.

## METHODS

In 2016, the Behavioral Health Workforce Research Center (BHWRC) collected online licensing and SOP statutes and administrative rules for 10 behavioral health professionals, including MHCs, across all 50 states and the District of Columbia.[5] In 2017, additional data were collected to include all potential MHC titles mentioned in the licensing laws/rules, instead of just one independent practice license. The new information was coded and

### CONCLUSIONS AND POLICY IMPLICATIONS

Key findings of this study show the professional counselor workforce could benefit from such policies as:

- Increasing funding to state colleges for graduate counseling programs, thus reducing the burden of student loans, and increasing the number of students who study counseling.
- Funding public education initiatives for patients to better understand the behavioral health workforce, so they can choose the professional that meets their specific needs and budget.
- Building scope of practice laws from the accredited education that LPCs receive, and precisely wording the laws to explicitly include all core mental health services.

In summary, the lack of uniformity in MHC credentials across the states, both in title and function, disservices the profession as a whole. National standardization could help this provider type to meet the growing behavioral health needs of this country.

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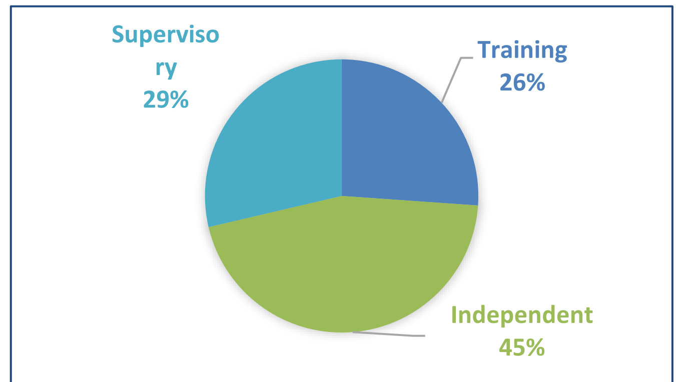
[1] Substance Abuse and Mental Health Services Administration. (2013). Behavioral Health, United States, 2012. HHS Publication No. (SMA) 13-4797. Rockville, MD: Substance Abuse and Mental Health Services Administration.
[2] Mental Health Counselors and Marriage and Family Therapists. U.S. Bureau of Labor Statistics. https://www.bls.gov/ooh/community-and-social-service/mental-health-counselors-and-marriage-and-family-therapists.htm. Updated December 17, 2015. Accessed June 2016.
[3] Any Mental Illness (AMI) Among U.S. Adults. National Institute of Mental Health. https://www.nimh.nih.gov/health/statistics/prevalence/any-mental-illness-ami-among-us-adults.shtml. Updated 2015. Accessed June 2016.
[4] Roehrig C. Mental Disorders Top The List Of The Most Costly Conditions In The United States: $201 Billion. *Health Affairs*. May 2016;35(6),1-6.
[5] Page C, Beck AJ, Buche J, Singer PM, Vazquez C, and Perron B. National Assessment of Scopes of Practice for the Behavioral Health Workforce. *Behavioral Health Workforce Research Center*. April 2017.
[6] 2015 CACREP Standards. The Council for Accreditation of Counseling & Related Educational Programs. http://www.cacrep.org/for-programs/2016-cacrep-standards/. Accessed June 2016.

analyzed with descriptive statistics. In order to add real-world context to these existing policies, qualitative data were collected through one focus group and five key informant interviews with MHCs. The interviews were conducted by phone and organized by the National Board for Certified Counselors (NBCC). The interviews were recorded, uploaded to NVivo, and coded with text analysis algorithms to identify trends.

## KEY FINDINGS

The first study component yielded 147 total credentials for MHCs across the country. The credentials MHCs could receive in a state fell into three distinct tiers: training (n=41; 26%), independent practice (n=71; 45%), and supervisory (n=45; 29%) (Figure 1).

**Figure 1.** MHC Credential Types (n=147)




*Training Credentials*

Training credentials are temporary and allow applicants to earn the necessary postgraduate experience for full licensure. MHCs with this license can have the same scope of practice as MHCs with an independent practice license, but MHCs with a training credential must practice under supervision. Most frequently, states referred to their training credentials as “temporary” licenses, “provisional” licenses, or “associate” licenses (n=28). With the exception of associate licenses, training credentials typically cannot be renewed. States also offer training credentials in the form of student, intern, or trainee registration with the state licensing board, allowing them to practice and earn supervised, postgraduate education without a state-issued practice license (n=13). The remaining ten states do not offer a training license, and instead transition graduates directly from their education program to a full license (Table 1).

Qualitative data confirmed that the current training requirements in their home states were adequate for preparing graduates to practice independently. However, the interviewees remarked that many students do not enter counseling because of the high burden of student loan debt, the length of time they must spend training with reduced income, and the relatively low starting income. These financial burdens could turn students away from the profession, lowering the supply of future MHCs, and thus hampering the behavioral health workforce. Increasing funding to state universities for counseling programs could help reduce the cost of training for students, thus encouraging them to enter the workforce.

*Independent Practice Licenses*

Independent practice licenses are provided after an applicant has graduated from an approved program, passed the National Counselor Examination or the National Clinical Mental Health Counseling Examination hosted by the NBCC, and earned the requisite postgraduate experience. Independent practice licenses must be renewed regularly. The independent MHCs’ scope of practice varies slightly by state, but all MHCs are authorized to assess patients, develop a treatment plan, engage in psychotherapy and counseling with a patient, engage in crisis management, and refer the patient to other specialists. MHCs tend to work in clinical settings with their patients, using the Diagnostic and Statistical Manual of Mental Disorders and other diagnostic materials to appraise patients and deliver behavioral heath care. Some states restrict MHCs to only diagnosing mental health disorders (as opposed to more physical ailments,) but nearly every state allows MHCs to render diagnosis.

Every state has some form of independent practice license, and it usually takes the form of a “licensed professional counselor” or “licensed mental health counselor” title (n=42) (Table 1). Some states also offer a clinical independent practice license (n=11). All MHCs perform clinical functions when working with patients, but in these states, “clinical” designations are distinguished from independent practice and grant additional practice authority. In states with clinical licenses, typically more training and education are required than to qualify solely as an

independent practice counselor. Clinical counselors usually must take the National Clinical Mental Health Counseling Examination hosted by the NBCC, in addition to the National Counselor Examination.

Table 1. MHC Credentials by Authorization Method (n=51 states and D.C.)

| Credential Type | Licensed | Registered | Certified | Other | N/A |
|---|---|---|---|---|---|
| Training | 28 | 13 | 0 | 10 | 0 |
| Independent Practice | 51 | 0 | 0 | 11* | 0 |
| Supervisory | 10 | 3 | 3 | 29 | 6 |

*Eleven states have a licensed clinical credential and a licensed non-clinical credential.

Qualitative data indicated that MHCs often suffer from lack of professional visibility. Patients seeking behavioral health care are likely to seek out a psychiatrist or psychologist because they are more familiar with those titles than "licensed professional counselor". Other BHPs have more history and name recognition, making them more widely understood by the public. This allows these providers access to more federal and state programs. An educational campaign to teach patients about the varying professions of the behavioral health workforce could encourage patients to choose a provider that best suits their individual needs and budget, possibly leading to better care outcomes and savings.

*Supervisory Credentials*

The final tier is the supervisory credential. These credentials are given to licensed independent counselors with years of experience in their role, and sometimes specialized training (n=30), to authorize the supervision of MHC in training. Most states offer a non-licensed credential to supervisors (n=35), often in the form of state licensing board approval (n=19). Only ten states had a licensed supervisory credential. States without a supervisory credential did not state in their rules what experience or education a provider must have to be a qualified supervisor, suggesting independent practice MHCs could immediately serve as supervisors (n=6) (Table 1). To maintain the credential, supervisors are typically required to partake in continuing education for supervision.

One component of supervision is competence, which is an important legal concept for MHCs, but it is either absent or nebulously defined by many state laws. Competencies allow an MHC to specialize their practice. With enough experience and education, a MHC could focus on working with children, people with substance use disorder, or other special populations. CACREP has accreditation specialties in addiction, clinical rehabilitation, school, and marriage, couple and family counseling.  According to the qualitative data, MCCs can also acquire competency through supervision, certification, or continuing education. LPCs can only gain competencies through supervision if their supervisor has already acquired that specific competency. For example, becoming competent in child counseling can only occur under the tutelage of a different LPC specialized in child counseling.

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