A Descriptive Analysis of State Credentials for Mental Health Counselors/Professional Counselors

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KEY FINDINGS

Scopes of practice (SOPs) define which services a state or territory permits a mental health counselor (MHC) to perform. These essential constructs can vary by state, potentially leading to service coverage gaps on a national scale. The same statutes and administrative rules that contain SOP information also include other vital licensing information, such as educational and experience requirements.

The Behavioral Health Workforce Research Center extracted SOP information from online statutes and administrative rules for MHCs from all 50 states and Washington D.C. The purpose of the study was to: 1) summarize descriptive information about MHC licensing and regulation across the country; and 2) interview key informant MHCs to add practical context to the SOP data.

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

- Opening up licensure by endorsement and licensure by reciprocity policies across states. This would allow the MHC workforce to be more mobile, potentially alleviating unmet mental health care needs in underserved areas.
- Funding public education initiatives for patients to better understand the behavioral health workforce. This would enable patients to choose the professional that meets their specific needs and budget.
- Building scope of practice laws from the accredited education that MHCs receive, and precisely wording the laws to explicitly include all core mental health services. This could empower the MHC workforce to meet the growing behavioral healthcare needs of our country.

In summary, more uniformity in MHC credentials across the states, both in title and function, would benefit the profession and public. National standardization could help this provider type to meet the growing behavioral health needs of this country.

CONTENTS:

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.

Scopes of practice (SOPs) for MHCs vary across the country, although all states grant the authority to perform core mental health services, such as provide professional assessment/appraisal, engage in psychotherapy/counseling, and make referrals to other healthcare professionals.[5] While the education and training is 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.[6]

Mental health service delivery is a key component of the MHC SOP, but states also authorize addiction services, highlighting the versatility of MHCs. For example, the definition of "counseling," according to §34-8A-2 of the Code of Alabama, includes "individual counseling, family counseling, marital counseling, group therapy, school counseling, play therapy, rehabilitation counseling, art therapy, human growth and development counseling, couples counseling, chemical abuse or dependency counseling, career counseling, and vocational disability training."[7] According to CACREP, an acceptable counseling curriculum for entry-level MHCs includes "theories and etiology of addiction and addictive behaviors."[8] Other counseling specialties include school, rehabilitation, and marriage and family,[8] 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. Throughout the report, mental health counselor and mental health counseling will be abbreviated as MHC.

METHODS

Phase 1: Scope of Practice Statutes and Rules

In 2016, the Behavioral Health Workforce Research Center (BHWRC) collected online licensing SOP statutes and administrative rules for 10 behavioral health professionals, including MHCs, across all 50 states and the District of Columbia.[5] To keep the data collection consistent across professions,

only one credential was collected per profession, per state. For instance, even though Idaho offers both a "licensed professional counselor" credential and a "licensed professional clinical counselor" credential, only the latter was collected and coded for Idaho in 2016. In 2017, additional data were collected to include all potential MHC credentials mentioned in the licensing laws/rules, instead of just one. The new information was coded into a Microsoft Excel spreadsheet, the quantitative variables were analyzed with Stata™ descriptive statistics, and the qualitative variables were summarized.

The raw data exhibited considerable heterogeneity in the type and structure of the documents; therefore, the research team constructed a standardized coding system that was used to extract comparable data. Spreadsheets were developed to summarize information from statutes and administrative rules into three categories: Regulatory Information, Licensure and Certification Requirements, and Service Authorization. Definitions for all variables used in this study are available in Appendix 1.

Regulatory Information: These data included broad information about relevant laws and rules, such as year the statute/rule was enacted, year the statute/rule was last updated, name of body that confers the license or certification, whether that licensing body focuses on a single occupation or is part of a consolidated board, whether or not the professional title is protected by law, web address for the source of the SOP, and the exact language of the SOP.

Licensure and Certification Requirements: These variables include: the number of education hours required for initial licensure eligibility; minimum number of post-degree practice hours (i.e., hours performed under the direction of a supervisor, but the supervisor is not required to be present) required before obtaining license/certification; post-degree supervision hours required for license/certification (i.e., hours requiring direct supervision); minimum number of continuing education hours required to maintain license/certification, as well as required continuing education content; minimum amount of time in which the practice and/or supervision hours can be completed from time of application to licensure/certification, measured in months; and the number of months the license/certification is valid until renewal is required. In addition, data were collected on licensure and certification through reciprocity or endorsement. Reciprocity refers to being able to apply for a license in one state based almost solely on having a comparable, active license in another state. Endorsement refers to being able to apply for a license in one state based on having comparable experience and education from another state. Reciprocity laws tend to be a "rubber

stamp", in that an incoming professional needs to do very little, outside of paying a fee and taking a jurisprudence examination, to get a new license; they are licensed in a new state based off their being licensed in a different state. Endorsement laws, on the other hand, tend to require more examinations, practice, and verification; they are licensed in a new state based on training received in a different state (Appendix 2).

Authorized Services: These data summarized whether the following services were legally authorized by the SOP for each occupation: assessment, diagnosis, psychotherapy, crisis intervention, telehealth, whether the credentialed MHC could practice independently (without supervision,) and whether the credentialed MHC could provide professional supervision.

All document sources and coded data were saved in a database. Quantitative descriptive statistics were generated for several of the Licensure/Certification Requirement variables such as educational hours, practice hours, supervised hours, and continuing education hours. Other variables included qualitative data for which themed summaries were generated.

Phase 2: Qualitative Interviews with Key Informant MHCs

In order to add real-world context to these existing licensing policies, qualitative data were collected through one focus group and three key informant interviews with licensed MHCs. The interviews were recorded, dictated, uploaded to NVivo™, and coded with text analysis algorithms to identify trends.

All interviews were organized by the National Board for Certified Counselors (NBCC). In order to be eligible for interview, the MHCs must have been: licensed to practice independently for at least three years, meaning they had renewed their licensed at least once, and had experience supervising other MHCs, professionally. The focus group was conducted via conference call on June 13th, 2017, and the three key informant interviews were conducted via phone call on August 28th, 29th, and 31st of the same year. All interviews were recorded, with the permission of those involved, with a Sony™ ICD-PX470 digital voice recorder, and later transcribed.

The transcribed interviews were uploaded to NVivo™, and coded into five separate nodes: MHCs in the Workforce, Internship and Practicum, Scope of Practice, Reimbursement, and Continuing Education. Any recorded dialogue that related to any of these nodes were mapped to them, accordingly.

MHCs in the Workforce: This node spoke to the general experience of an MHC serving as part of the greater behavioral health workforce. Themes captured included the national shortage of licensed MHCs, competition between other behavioral health providers, issues of access for patients, and collaborative efforts made with other behavioral health professionals.

Internship and Practicum: This node spoke to the professional experience MHCs must acquire before they become licensed to practice independently. Themes captured included whether this experience was adequate to prepare MHCs, the barriers students face when learning to become an MHC, and burnout.

Scope of Practice: This node spoke to the services MHCs were legally authorized to perform in their state, the services they regularly provide, and the congruency between the two. Themes captured included the familiarity of MHCs with the exact letter of the authorization laws, how professional competencies are defined/acquired, the potential difference between "assessment" and "diagnosis," and the profession's opinions on whether their state's scope of practice laws should be stricter or more lenient.

Reimbursement: This node spoke to how MHCs are paid for the services they provide, and how these methods have changed over time. Themes captured included how diagnostic services are billed, the differences in reimbursement between MHCs and other behavioral health providers, and how certain policies improve or inhibit reimbursement for services.

Continuing Education: This node spoke to the continuing education that states mandate MHCs acquire before they can renew their license. Themes captured included the ubiquity of "ethics" as a requirement, the efficacy of continuing education course, and some of the barriers or difficulties providers face with continuing education.

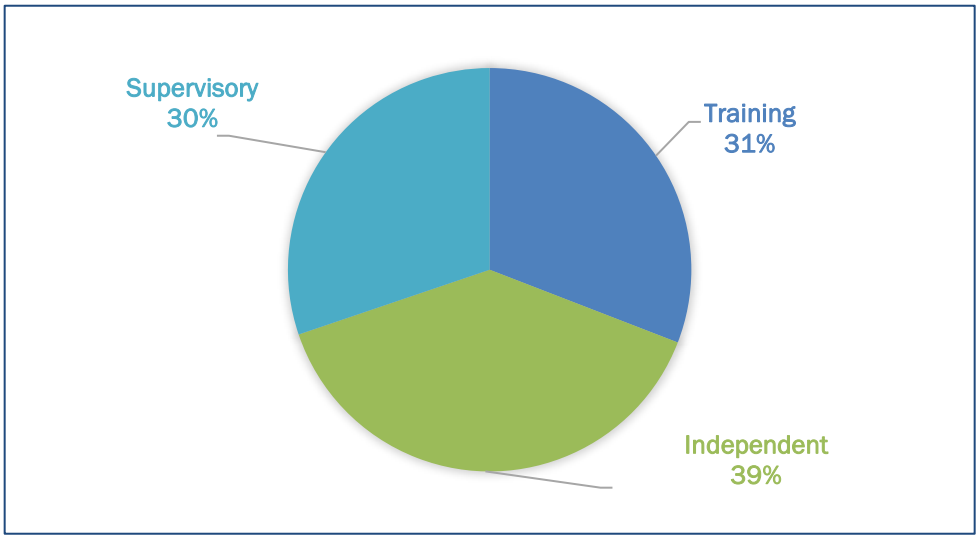
Once the interviews were coded by node into NVivo™, summaries were written as to the consensus on each point.

RESULTS

Phase 1: Scope of Practice Statutes and Rules

Phase 1 yielded 148 total credentials for MHCs across the country. The credentials MHCs could receive in a state fell into three distinct types: training (n=46; 26%), independent practice (n=58; 45%), and supervisory (n=45; 29%) (Figure 1).

Figure 1. Mental Health Counselor Credential Types (n=149)



Training credentials are typically temporary credentials that allow applicants, while under the supervision of a licensed counselor, to earn the necessary postgraduate professional experience for full licensure. These credentials are temporary in that they will expire after a set time, and if the MHC-in-training has not yet acquired the necessary experience for an independent license, then the trainee will have to re-apply for a new training credential and begin the experience-gaining process over again.

In contrast, independent practice credentials allow a professional to perform counseling services without supervision, and are permanent licenses – meaning that after the license expires, it can be renewed. There are provisions attached to renewal that vary by state, but typically, in order to renew an independent practice license, an MHC must acquire a certain amount of continuing education credits and pay a fee.

Lastly, the supervisory credential is given to licensed independent counselors with years of experience in their role, and sometimes specialized training (n=30), to authorize their supervision of MHCs in training. This credential is rarely its own license (n=10), meaning that, typically, the credential automatically renews when an MHC supervisor renews their independent practice credential – provided they've met the requisite continuing education for both.

The form that these credentials take varies by state. While the independent practice credential is always a license, it's possible that the training credential is a license, registration with the state licensing board, or a formal "carve-out" in the SOP that allows a graduate to practice, without a

credential, under certain circumstances. Similarly, a supervisory credential can be a license, registration with the state licensing board, certification, or "specialization" attached to an independent practice license (Table 1).

Table 1. States' Mental Health Counselor Credentials by Authorization Method (n=51)

Credential Type	Licensed	Registered	Certified	Other	N/A
Training	33	2	0	11	5
Independent Practice	51*	0	0	0	0
Supervisory	19	2	3	27	0

*Seven states offer two different independent practice credentials: a "professional counselor" and a "clinical professional counselor" credential.

Regarding the requirements needed for each credential, most states did not require applicants to have earned any professional experience or supervision prior to receiving their trainee credential. However, most states did require applicants to have all of their education requirement completed prior to receiving their trainee credential. State approval was usually given to education programs that followed the CACREP curriculum.

Independent practice licenses were fairly uniform with regard to education requirements, thanks to the ubiquitous acceptance of CACREP education standards for graduate programs in mental health counseling, but supervision and practice hour requirements could vary significantly from state to state. For instance, to qualify for a licensed professional counselor in South Carolina, an applicant needs to document 1500 practice hours working directly with individuals, couples, families or groups, but to be a licensed professional counselor in Virginia, an applicant needs to document 3400 practice hours with 2000 of them being in direct client contact. This highlights the important distinction between general practice hour requirements and direct client contact requirements. 'Direct client contact' means professionals must log hours of providing service to clients, which is intensive and time-consuming, while general practice hours can be spent maintaining records or performing administrative tasks. General practice hour requirements are always equal to or greater than direct client contact hour requirements. Most independent practice credentials (n=47) were valid for two years.

Of the three credential categories, supervisory credential requirements varied the most. Only 43 states reported having a type of supervisory credential, and only half of those (n=24) reported an educational requirement. Of the eight states not reporting a supervisory credential, the state SOPs revealed that mental health counselors with an independent practice credential in that state could serve as supervisors without adding another credential. Only twelve states required a specific amount of practice hours prior to being eligible to be a supervisor of mental health counselors. Instead, most (n=39) required a minimum number of months or years of licensed practice. See Table 2 for a more thorough breakdown of the licensing requirements for each credential category.

Table 2. Credential Requirements Identified in State Scopes of Practice by Credential Type (n=147)

Credential Type		Education Hours	Practice Hours	Supervision Hours	Completion Time (Months)	Continuing Education Hours	Renewal Time (Months)
Trainee	n	48	5*	5*	4*	22	38
	Mean	55.6	2600*	110*	18*	27.4	27.2
	Mode	60	3000*	100*	24*	20	24
	Range	12-60	2000-3200*	100-150*	12-24*	10-55	12-72
Independent Practice	n	52	56	52	45	57	58
	Mean	56.4	2862.1	124.3	24.9	32.8	22.1
	Mode	60	3000	100	24	40	24
	Range	42-60	1000-4000	50-400	12-48	10-55	12-36
Supervisory**	n	14, 10	6	5	38	29	30
	Mean	2.8, 28.6	1687.5	22.8	37.9	32	23.2
	Mode	3, 30	1500	25	24	40	24
	Range	1-4, 12-45	25-4000	10-36	12-60	6-55	12-60

*All of the states reporting do not have a separate trainee and independent practice credential.

** Education requirements for supervisors were reported as both contact hours and credit hours. Rather than convert, these different types of requirements were averaged separately. The first statistic is in credit hours and the second is in contact hours.

For a state-by-state breakdown of licensure requirements, see Appendix 3.

Training Credentials

Regulatory Information

A total of 46 states had language for some form of training credential in their SOP statutes and rules. The five states that did not have such language (Alaska, Connecticut, Minnesota, South Dakota, and Tennessee) seemed to transition graduates directly from their training program to an independent practice license. This happened in one of two ways: either the credential required

postgraduate experience to obtain, meaning that graduates were implicitly allowed to practice without one in order to qualify for licensure (Alaska, Connecticut, South Dakota, and Tennessee,) or they were given an independent practice credential upon graduation but had to be supervised for the first 2000 hours of their practice (Minnesota.)

As per Table 1, the majority of training credentials (n=33) are state-issued licenses. These carry such titles as "associate licensed professional counselor," "provisionally licensed professional counselor," "licensed graduate mental health counselor," or "licensed professional counselor intern." These are not full licenses, meaning trainees cannot maintain this credential for the entirety of their careers. They must either transition into an independent practice credential after earning enough post-graduate work experience, or, if they haven't earned enough experience by the time their training license expires, they must re-apply for a new training credential and begin acquiring experience all over again. Kansas is unique in that their training credential is also a full license, meaning their "licensed professional counselors" can continue renewing their credential indefinitely, so long as they're willing to continue to practice under supervision. If they want to practice independently, they need to transition to a "licensed clinical professional counselor" credential.

Thirteen states do not offer a formal credential, such as a certificate or license, for their mental health counselor trainees. Instead, these states take one of two tactics: either a graduate from a mental health counseling master's program must register with the state board prior to earning postgraduate work experience, or there are legal carve-outs that allow graduates to practice under the supervision of licensed mental health counselors for the sake of earning postgraduate work experience. The second practice is akin to the process mentioned for Alaska, Connecticut, South Dakota, and Tennessee, only the carve-out is explicit in the language of the SOP, and the SOP gives a title to these mental health counselor trainees.

Credential Requirements

Overall, there is minor variability in credentialing requirements for mental health counselor trainees across states. Variability primarily exists in the length of the credential, and the states' specific education course requirements.

Education: All states, with the exception of California, require an applicant to complete a graduate degree (master's or PhD) before being eligible for a training credential. In California, an applicant can be eligible for a "clinical counselor trainee" credential if they are actively enrolled in a qualifying

degree program and have earned at least 12 graduate semester credit hours in that program. Most states (n=34) require 60 graduate semester hours of credit in an educational program. Eleven states require 48 graduate semester hours, but many of those have statutes in place that will change the requirement to 60 in the coming years. Most states accept the National Counselor Examination, hosted by the NBCC, as proof of mastery of core material. The most popular subjects required by states included: counseling theory, counseling techniques, human growth and development, the helping relationship, multicultural counseling or diversity training, group dynamics, lifestyle and career development, appraisal, research and evaluation, professional orientation, and a practicum.

Practice, Supervision, and Continuing Education Requirements: With the exception of five states (Alaska, Connecticut, Minnesota, South Dakota, and Tennessee), no trainee credential required postgraduate practice or supervision hours to obtain. These five states' independent practice credential doubles as their training credential, which explains the experience hour requirement.

Renewal: These state-issued licenses typically last up to a maximum of 5 or 6 years. This period can look like a credential length of one year with up to six renewals (as in Washington), a credential length of two years with up to three renewals (as in Maryland), or a credential length of six years with no renewals (as in Texas). Some credentials do not have a fixed limit, such as Utah, which requires applicants to submit a proposed "supervision plan" wherein the applicant anticipates how long it will take them to earn the required professional experience. If the supervision plan is approved, the applicant has the proposed amount of time to earn the experience, though some extensions can be granted in extenuating circumstances, provided the applicant has shown a good-faith attempt to earn the appropriate amount of experience.

Authorized Services

MHCs with a trainee credential are typically allowed to perform all of the same services as their independent practice counterparts, with the exception that the trainee must be supervised while practicing. Often, an MHC with a trainee credential must also identify themselves to patients as being in training, and not being a fully-licensed MHC.

Independent Practice Credentials

Regulatory Information

All 50 states and DC offer at least one independent practice credential, and all independent practice credentials are state-issued licenses. Five states (Idaho, Maine, Minnesota, New Jersey, North Dakota) offer two independent practice licenses: a "professional counselor" license, and a "professional clinical counselor" license. Two states (Tennessee and South Dakota) also offer two independent practice licenses, but there's are called "professional counselor" licenses and "professional mental health counselor" licenses. These distinct titles are misleading; all MHCs with an independent practice credential serves in a clinical capacity providing behavioral health services, regardless of if they have the word "clinical" or "mental health" in their title. However, in these seven states that make a distinction between the two licenses, a "clinical" or "mental health" counselor typically are required to have more training/education, and are granted additional practice authority.

Licensure Requirements

Overall, there is variability in credentialing requirements for MHC independent practice credentials across states, particularly with regard to practice, supervision, and continuing education requirements.

Education: 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 (depending on the state and credential sought) hosted by the NBCC, and earned the requisite postgraduate experience and supervision hours. Typically, the education requirements are met by applicants when they hold the state's MHC training credential.

Four states (Kansas, Maine, Maryland, and North Dakota) that distinguish between "professional counselors" and "professional clinical counselors" require extra education for the latter credential, usually six graduate semester credit hours between the subjects of diagnosis, using the Diagnostic and Statistical Manual of Mental Disorders (DSM), psychopathology/abnormal psychology, and clinical counseling. This is not to suggest that states without a "clinical counselor" credential produce mental health counselors that are unfamiliar with diagnosis, the DSM, or clinical counseling; mental health counselors, regardless of having a "clinical" title, are trained to identify and diagnose behavioral and mental health disorders. One of the eight CACREP "common core areas" that "represent the foundational knowledge required of *all* entry-level counselor education graduates" is "Assessment and Testing" which includes the "use of assessments for diagnostic and intervention planning purposes" and the "use of assessment results to diagnose developmental,

behavioral, and mental disorders." Whether the state then expressly includes diagnosis in the scope of practice for their licensed mental health counselors is secondary.

Practice, Supervision, and Continuing Education Requirements: Of the 58 credentials collected in this category, 56 required a specific amount of postgraduate work experience hours (mean: 2862 hours, mode: 3000 hours) and 52 required a specific amount of postgraduate supervision hours (mean: 124 hours, mode: 100 hours.) There was wide variability between the states as to the specific hour requirements, but the comparisons were not always parallel as they sometimes compared client contact hours to supervision hours. Further, 41 states required over 3000 hours of supervised experience. Most credentials (34) were intended to be completed in no fewer than 2 years.

Renewal and Continuing Education: Independent practice licenses must be renewed regularly. All 58 credentials in this category reported the length of their license, with 12 licenses lasting one year, 43 licenses lasting two years, and 3 licenses lasting three years. 57 licenses require a specific amount of continuing education hours for renewal (mean: 33 hours, mode: 40 hours). The most common continuing education requirement was ethics, which was required for renewing 40 of the credentials.

Authorized Services

The independent practice 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 health care.

Seven states (Arkansas, California, Idaho, Iowa, Missouri, Pennsylvania, and Utah) do not mention diagnosis as part of the scope of practice for an MHC, but no state explicitly denies MHCs the authority to diagnose. Three states, (Indiana, New Jersey, and New York) do not explicitly authorize diagnosis, but do mention the use of the DSM. Also, diagnosis is reserved for only one specific tier of independent practice MHCs in Maine, North Dakota, and Ohio. In Maine and North Dakota, licensed professional counselors are not permitted to diagnose, but licensed clinical professional counselors are. Similarly, in Ohio, licensed professional counselors may only diagnose when under supervision of a behavioral health provider who is legally authorized to diagnose, but licensed professional clinical counselors are authorized to diagnose without such supervision.

Supervisory Credentials

Regulatory Information

As per Table 1, supervisory credentials took the most diverse array of forms out of all the MHC credential categories. All 50 states and DC had an MHC supervisor credential. Nineteen states had a licensed MHC supervisor credential, but only 12 of those were specifically a "supervisor" license. The remaining 7 states were independent practice licenses that authorized the holder to serve as a supervisor. These dual-purpose licenses were categorized as independent practice credentials when building Figure 1, and were not double-counted as supervisory credentials. With the exception of these 9 dual-purpose licenses, every credential included the word "supervisor" somewhere in the title, be it "board-approved supervisor," "licensed professional counselor supervisor," or "registered clinical supervisor." Alabama was the only state to have two supervisory credentials: a "supervising associate" credential, for training as a supervisor, and a "supervising counselor" certification for serving as an MHC supervisor.

The majority of MHC supervisory credentials took the form of a supplementary credentials. Instead, of a separate certificate or license to authenticate the holder's authority to serve as a supervisor, MHC will be authorized to serve as a supervisor if they hold an independent practice license and fulfill the issuing state's specific requirements. The requirements tend to be: seeking certification with the NBCC affiliate Center for Credentialing & Education (CCE), seeking continuing education into supervisory practices, and/or earning a set number of years of experience as an independent practice MHC. In some states, behavioral health providers besides MHCs, such as psychiatrists, psychologists, social workers, and marriage and family therapists, can supervise the training or practice of MHCs. For the purpose of this analysis, only credentials that MHCs qualify for were considered.

Licensure Requirements

Overall, there is little standardization around the process of credentialing MHC supervisors. While there are some national certifications that are gaining ground (the Approved Clinical Supervisor credential from the CCE and the Clinical Supervisor certification from the International Certification & Reciprocity Consortium, to name a few,) states tend to create their own standard for MHC supervisors.

Education: Of the 44 states with a specific MHC supervisory credential, only 24 required supplementary education beyond what was required to achieve the state's independent practice MHC license. Fourteen states required graduate semester credit hours in subjects such as "counselor supervision," "counselor development," and/or "counselor evaluation," for an average of 2.8 credit hours and a mode of 3 credit hours. The remaining 10 states required contact hours of training in the same subjects for an average of 28.6 contact hours and a mode of 30 contact hours.

Practice and Supervision Requirements: Twelve states, including seven of the dual-purpose independent practice licenses, detailed a specific number of practice hours required for the supervisory credential, with an average of 2328.8 hours and a mode of 3000 hours required. More, however, detail a specific number of years that an MHC must have practiced independently before being eligible to serve as a supervisor; 38 of the credentials specified a minimum amount of time of post-licensure practice as an MHC, with an average of 37.9 months of experience and a mode of 24 months of experience required. Lastly, ten states, including five of the dual-purpose independent practice licenses, detailed a specific number of supervision hours required for the supervisory credential, with an average of 71.4 hours and a mode of 100 hours required.

Continuing Education: Of the 36 supervisory credentials that require continuing education, 20 require contact hours in training to be a supervisor. The average amount of continuing education contact hours required for renewal is 31.9 hours and the mode is 40 hours.

Authorized Services

There are some limits on how many supervisees a MHC with a supervisory credential are allowed to oversee at once. At least 7 states have such restrictions spelled out in the SOP for their MHC supervisory credentials. Alabama limits their MHC supervisors to no more than 5 associates, California to no more than 3, Kentucky to no more than 12, Louisiana to no more than 10, Missouri to no more than 3, New York to no more than 5, and Pennsylvania to no more than 6.

Phase 2: Qualitative Interviews with Key Informant MHCs

The following subjects were the main topics that recurred in the Phase 2 focus group and key informant interviews.

MHCs in the Workforce

Compared to other behavioral health professionals, licensed mental health counselors are a relatively newer occupation. As such, the profession is not as well established as psychiatrists, psychologists, or social workers. These professions have a long history of being integrated into

states' public health systems, social services, and licensing boards. As one focus group participant states, "When people think of getting counseling, they think of seeing a psychiatrist or psychologist first. Maybe a social worker."

Moreover, the public doesn't understand the difference between the MHC and other behavioral health professionals. While MHCs are qualified to provide diagnosis, referral, and psychotherapy, often for cheaper than a psychiatrist or psychologist, the average citizen is more familiar with those professions and would seek them out instead. Said one key informant, "The public doesn't really know what licensed professional counselors are. They don't really know what that means and so they say, 'Well, are you a psychologist? I want a psychologist,' not really understanding that there are services that the counselors provide are just as competent as what they could get from a psychologist."

Because of the similarity in the clinical training and skills of MHCs to other behavioral health professionals, MHCs could make for invaluable additions to accountable care teams, in terms of lowering treatment costs without affecting patient outcomes. And MHCs are willing to enter into care teams, according to one informant: "I think that we're all helping professionals and we all have similar training. Some disciplines say social [workers] are more geared toward a lot of linkage, but I have worked alongside independently licensed social workers that their clinical skills are just top-notch." Another informant echoes this sentiment: "I think there should be a concerted effort on all helping professionals, regardless of their discipline, to work together for the greater good of clients. I don't think that we should give in to the ego."

Unfortunately, there's a nationwide shortage of MHCs, both in terms of the professionals as well as in the number of available training programs – especially in rural areas.

Internship and Practicum

During any CACREP accredited master's program, a training MHC will be required to take on an internship or practicum.[8] This requirement provides field experience for the student so that they can put into practice the theories they learn during their studies. The internships/practicums are typically unpaid. While it's not unusual for a college internship to be unpaid, requiring an unpaid MHC internship along with a full course-load, and a part-time/full-time job to help cover tuition and living expenses, could cause burnout or dissuade a student from pursuing the degree in the first place. One concerned interviewee said, "These students are working full time jobs elsewhere, and then doing their internship on top of that. And so they're burnt out, they're tired, they're sick, they're

vulnerable. And I don't think that's an ideal type of experience for someone to learn these really important [skills]. They're just so exhausted, but they don't have a choice… [they] have to work, they have to pay their rent, they have to pay tuition."

Students with children have a particularly hard time arranging for child care or sitter services. One interviewee said, "I still, to this day, don't know how I was able to manage a full time job, school, and an internship. So, it does create a lot of hardship, and sometimes a huge financial hardship for individuals. And if they don't have a good support system to help them through that process, I'm sure that that would compound [burnout] greatly."

One solution many MHC students have found is doing paid caseworker assignments for the organization hosting their internship. But according to one key informant, this raises a different problem: "One of the things that I've noticed is that the students who have to work try to get creative and try to find sites that will allow them to work and do their internship there… they're usually hired as case managers. So my concern as the internship instructor is – are they really getting an internship? Or are they doing case management? This is not case management that we're trying to train them to do."

On the whole, the internship/practicum experience is important for training MHCs, but it is not as significant as postgraduate experience, which is often longer, paid, and rooted in real-world clinical practice. As one key informant summarized, "The [internship] was great, and it definitely prepared me to practice. My postgraduate experience, however, was with the social services agency in employee assistance. That's where I got the remainder of my experience prior to licensure."

Scope of Practice

Practicing MHCs tend to be familiar with the spirit of their scope of practice, even if they don't know it word-for word. Those MHCs that do know the particular details of the state defined SOP tend to be instructors or supervisors. Often, MHCs are more familiar with what they are not authorized to do, rather than what they are authorized to do. Even this bothers some MHCs, as having their practice authority tied to their profession instead of their training can sometimes limit service provision. One MHC expressed his concern, saying, "I'm all for oversight to keep consumers safe, but the assumption seems to be that I'm incompetent in the Board's eyes until I prove otherwise. That's upsetting. It's one thing to say that you need training in something before you offer it to people. I understand and agree with that. It's another to say I can't perform a task, even though I've been trained in it, just because I'm an LPC."

Regarding possible changes to SOP language, MHCs tend to be conservative. While it's possible to change the language of the statute/rule to empower the profession to do more, there's a risk of not hitting the right balance. To quote one interviewee, "The SOP can't be too specific, or else it restricts LPCs from certain services. But if it's too vague, that also causes problems. For instance, if the SOP says that LPCs can diagnose, but it doesn't define diagnosis, it's possible that a different professional group might try to define what LPC diagnosis looks like. Weak SOPs also keep professionals out of advisory panels in some states, and those panels are responsible for so much professional development in a state."

Along the same lines as SOPs, competencies are often poorly defined; there are many accepted ways to acquire or document a competency, but one party's definition of competency may not be another's. Like one informant related, "I'm specialized in trauma and sexual abuse. I've written books on the topic, I teach it, I attend continuing education courses, and so on. But even with all of that experience, a lawyer could still challenge my competence by saying, 'Yes, but have you had your practice supervised by a qualifying professional?' And the answer is no, I haven't."

All MHCs tended to agree that the ultimate decision about whether an MHC is competent comes from litigation. One interviewee summarized this sentiment: "The assumption regarding competencies is that you're competent within your scope of practice until there is a suit filed against you."

Reimbursement

SOPs are the basis of reimbursement within a state. As one interviewee explained, "Reimbursement isn't great for LPCs, and that requires advocacy with private insurance payers. Scope of practice laws give LPCs a seat at the table to negotiate Medicaid reimbursement rates, so it all starts with the SOP."

In general, MHCs are paid less than psychiatrists or psychologists for the same services. The starting wages for MHCs are also low compared to the amount of student loans they take on. To quote one key informant, "Starting off, an LPC can expect to make around $30,000 a year in our state. That's not a small amount of money, but when you compare to the two and half years of student loans, it might not seem worth it."

Furthermore, some state-based policies reduce the amount of service LPCs can provide or be reimbursed for. One interviewee explained, "There are many reimbursement policies that inhibit me from offering services. One policy is that some insured people cannot see two behavioral health

practitioners within the same week, meaning if the patient is seeing me and an MFT, the two of us have to split up the weeks. Another policy is that we can see individual children in therapy, but we cannot practice family therapy with the child and his/her parents." The interviewee went on to add, "High Deductible/Low Premium plans, which are typically combined with a health savings account, also tend to reduce the amount of services people use – even if they need those services."

Continuing Education

Continuing education requirements were summarized by one interviewee in the following way: "At some point, it was decided that continuing education was an aspirational, good goal. And it is, and so the licensing boards took it upon themselves to stipulate how many hours." Refreshing MHCs' knowledge on new forms of treatment, professional developments, or ethical duties is an inherently positive idea. However, requiring MHCs to obtain a certain number of hours for renewing their license might inhibit their intrinsic motivation to pursue professional growth. They may have wanted to take more than the required number of hours, but now that they have an objective goal to meet, they will not go further than is necessary. They also might show up to seminars and courses, but not pay attention, because they're only there to fulfill the requirement. One way to improve attention and assure the courses are effective is to include post-tests to measure the attendee's mastery of the material presented.

Ethics is a ubiquitous requirement across state continuing education requirements, and it can be necessary – especially for independent practitioners, according to one key informant. "Within an agency, you have case reviews and you have supervision. There's a lot of things to keep you in line and remindful of the ethical code and ethical dilemmas that you can get into. Yet the private practitioners who are not exposed to those seem to get in trouble more so than those that are in a work group or within an agency, and I think it's essential that at least those three hours of [ethics continuing education] occur." But continuing education in ethics might not actually produce more ethical practitioners. Not only does it run into the same pitfalls as other continuing education courses in terms of attendees not being motivated to actually master the material, but learning about ethical codes does not necessarily translate into practicing ethically. Two alternatives are suggested: supervision, and developing the professional community.

By having normally independent practice MHCs submit to supervision, ethical violations can become much easier to identify and correct before causing harm to patients. But it might also be unpopular, according to one interviewee. "[Continuing education courses] might be too weak,

compared to clinical supervision. But what person with several years of experience practicing independently is going to want to submit themselves to voluntary supervision?"

Similarly, by fostering a more community-based approach among MHCs, practitioners would be more likely to keep in contact with one another and work out practice dilemmas without the need for stricter regulation. Encouraging cooperation among MHCs would build an intrinsic motivation to be self-policing, as opposed to an extrinsic requirement to correct problematic practices. One informant reflected, "What really can create a better environment for people to do quality work? We're getting there. I really do think we've come a long way. People are much more likely to confront each other and file complaints than they were, historically. I think we need to continue to reward that, that ability to say, 'You know what, I think you might be in some trouble here,' and 'what can we do as a community to support you in getting the help you need,' like maybe taking a break from the field or whatever it is."

CONCLUSIONS AND POLICY CONSIDERATIONS

This project successfully addressed its aim of cataloging SOPs for mental health counselors and identifying and comparing SOP variables, with the help of key informant interviews, so as to guide policies to improve workforce capacity. Among the key findings of this study:

- MHC credentials generally fall into three categories: training, independent practice, and supervisory. Applicants for licensure as an MHC in any state tend to follow the same path; an applicant finishes their education, applies for a training credential, earns postgraduate work experience and supervision, applies for an independent practice credential, and then decides whether they want to continue with that credential or take on extra education/practice to earn a supervisory credential.
- While education requirements are similar for MHCs across the country, due to the wide acceptance of CACREP standards, postgraduate practice hours, supervision, and continuing education hours can vary significantly across the states. Higher postgraduate requirements extend the amount of time an MHC spends in training, which typically means they are earning less income. Due to the high amount of student debt an MHC accrues during their graduate program and the comparatively low starting wage of MHCs, potential applicants can be deterred from the profession if the postgraduate experience requirement is too long.
- National reports[9] and the key informant mental health counselors interviewed in Phase 2 recognize workforce shortages in states across the country. Two policies could alleviate these

shortages: increasing the number of MHC graduate programs in underserved areas[10], and opening up state licensure by endorsement/reciprocity statutes. Increasing the number of MHC graduate programs in underserved areas could mean setting up internship or practicum opportunities in these populations, which could specialize in-training MHCs to seek out that population later in their profession, or establishing new degree programs in underserved areas to attract would-be MHCs from the underserved community. Furthermore, opening up endorsement/reciprocity statutes adds to ease of movement for licensed MHCs, meaning there would be less of a barrier for an MHC to leave a state densely populated with competing MHCs to a state where there's less competition, e.g. an underserved area.

- Unlike "counseling" and "assessment," the term "diagnosis" was not explicitly included in the SOP language in the states of Arkansas, California, Idaho, Iowa, Missouri, Pennsylvania, and Utah. Although the term 'assessment' in these states is usually interpreted to authorize the use of the DSM, the omission of 'diagnosis' could lead to restrictions on practice or reimbursement. Most states allow MHCs to diagnose based solely on the competencies they earn during their graduate training. This is likely because CACREP stipulates that any accredited program must train a student in "use of assessments for diagnostic and intervention planning purposes" as part of the 'Assessment and Testing' core area. This suggests that MHCs likely have the training to competently diagnose, but may be subject to limitations for political reasons. This could reduce the access that the public has to psychodiagnostic services, and could arbitrarily increase the amount citizens pay for the service by reducing competition. One solution would be to align state SOP language with the competencies listed by accredited education programs.
- Citizens are less likely to be aware of the mental health counseling profession than they are of psychology, psychiatry, or social work. This hurts the MHC workforce in two ways: it makes a student preparing to be a behavioral health provider less likely to choose mental health counseling as vocation, and it reduces the likelihood of clients seeking out an MHC over these other professions. MHC services are typically less expensive than clinical psychologists or psychiatrists,[11] and are effective at treating depression, anxiety, and other common behavioral health conditions.[12] As such, due to a lack of understanding about MHCs, the public is more likely to utilize behavioral health services that are more expensive but not necessarily superior. To help reduce costs of behavioral health care and improve the public's ability to make informed decisions on their care, advocates for MHCs could launch education campaigns to teach citizens about the diverse array of behavioral health professionals.

Although changes in SOP authority may strengthen overall MHC workforce capacity, several barriers exist that could prohibit such changes. First, competing behavioral health providers may resist an expansion in MHC SOP, in order to protect their field's hegemony and differentiate themselves in the service market. Second, if states expand authority for MHCs, they would need to update government programs and policies to reflect the practice authority. These changes would likely take years, delaying the impact on behavioral health services. Finally, the field needs to generate empirical literature detailing how SOP changes leads to high quality and effective care delivery.

Despite these barriers, as we continue to pursue integrated and team-based care models, ensuring that all team members are authorized to work to the full extent of their training and scope of practice in every state could address some of the access to care issues impeding the behavioral healthcare delivery system. Although this study does not clearly define all solutions for addressing SOP concerns that impact workforce capacity, the data collected provide an evidence base to support several steps state policymakers could undertake to make the MHC workforce more uniform and potentially close service gaps. Future research should compare SOP variability across states and professions and determine whether enhanced SOPs are associated with better access to care and health outcomes for those with behavioral health conditions.

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Appendix 1. Variable definitions

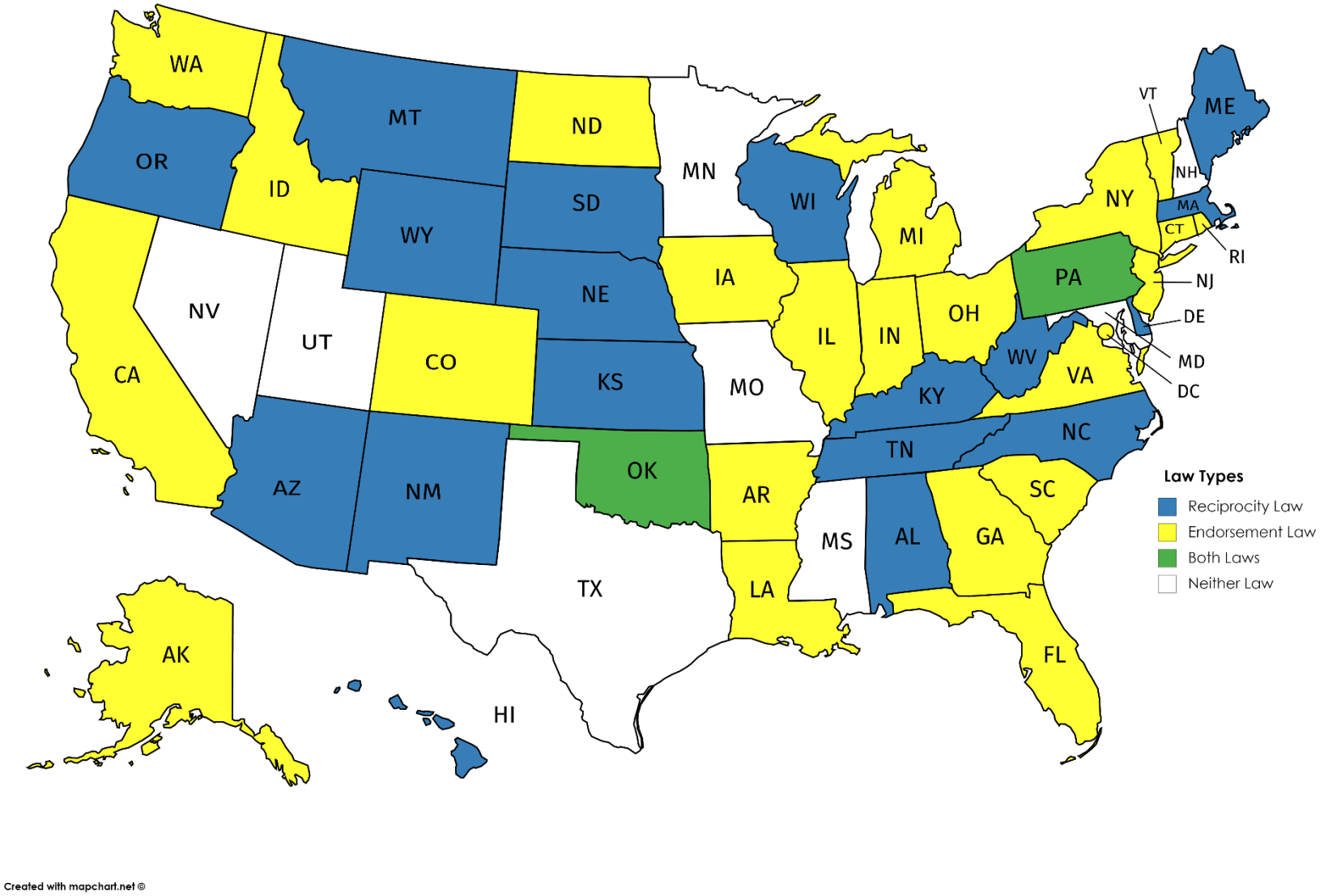
Regulatory Information Variables	
State ID	This variable helps categorize data by state. Each state is spelled out in lower case, without spaces. For instance, Washington D.C. is coded as "districtofcolumbia"
State SOP	This is a binary variable, meant to signify whether a scope of practice was found for the MHC in the specified state. Either a "Yes" or "No" is recorded. For our purposes, scope of practice had to include some specific professional responsibilities. Even if a scope of practice was not found, licensing information (such as experience or educational requirements for licensure) may still exist and have been recorded. In those instances, this variable was still coded as 'Yes'.
Year Initial	This is the year when legislation was passed in the state to allow for professional licensure. This information was difficult to ascertain, and very often the stand-in was to record the earliest date on the statute/code. Some states, instead of amending statues and codes, re-write these sections or their entire constitution every so many years.
Year Renewed	This is the most current year when the legislation for professional licensure was renewed or amended. When there was a difference between the latest renewal year of the statutes or the administrative codes, we used whichever year was more recent. This determination rarely occurred, and overall the variable was less ambiguous than the Initial Year as it required no stand-ins.
Issuer	This variable helps to determine whether licensing is done by a state board for a single profession (i.e. "Alaska state board of professional counselors"), a state board for multiple professions (i.e." Florida board of clinical social work, marriage & family therapy and mental health counseling"), or a broader regulatory body (i.e. "Connecticut department of public health"). All entries are spelled out in lower case with spaces. Whenever possible, we extracted the name for the licensing board from statutory definitions, often under the term "board."
Profession Code Definition/ Clinical Scope	These variables separate the description of the profession (definition) from the profession's scope of practice (clinical scope.) This language was usually contained under statutory definitions, but could sometimes be its own entry later in the statutes or in the administrative codes. The definition of the profession is usually broad language describing the nature of the services the professional is licensed to provide, while the clinical scope is a specific list of authorized services (like psychotherapy, diagnosis, etc.) Both variables are recorded as strings verbatim from the statutory/rule language.
Title Protect/Title Protect Desc	Title protection maintains the integrity of the profession by only allowing licensed/certified individuals to advertise themselves as a professional and/or punishing unlicensed/uncertified professionals for advertising to perform services they have not been credentialed to perform. "Title Protect" is a binary variable which is coded either as "Yes" or "No". "Title Protect Desc" is a string variable with the specific language about the title protection from the statutory/rule language.
Statute/Rule URL	These fields were meant for citing our sources for future research. The Statute URL should contain a hyperlink for the statute or state law language for the profession, and the Rule URL should contain the administrative code or rule language for the profession. Whenever possible, static links are to be provided. In the event that the link does not appear static, and is just a document upload subject to change when the document is updated, a URL is provided for the nearest static page that links to the appropriate content. In the event that statutes and rules are combined into a single document, the Statute URL variable

	will be a static URL that links to the document, and the Rule URL will be a direct link to the document.
Licensure and Certification Variables	
License Name	This variable is the full name of the license provided to the applicant, spelled out in lower case with spaces. In the event that the position is for a certified professional instead, this variable will reflect that as well ("certified professional counseling supervisor" versus "licensed professional counselor supervisor".)
Degree Type	This binary variable refers to any educational degree beyond a high school diploma. If no such degree is required, a "No" is recorded. If an associate's, bachelor's, master's, PhD, or other advanced degree is required, a "Yes" is recorded.
Education Hours/Description	The first variable is an integer meant to collect either the number of semester credit hours required in an educational program prior to licensure, or the number of training hours required before certification/licensure. Typically speaking, if the value in this variable is less than or equal to 48, then the variable is tracking semester hours of education. The second variable is a string variable meant to capture the core areas of education/training and the requisite time needed in each. In some cases, codes and statutes do not specify a minimum number of total education/training hours, but still require specified training hours in various subfields. In these instances, "edu_hours" has been left blank, even if there are minimum-standards required specified in "edu_hours_desc". This seemed more accurate than summing the number of hours in "edu_hours_desc" and using that as the "edu_hours" value. For example, a supervisory credential might require 3 hours of ethics training, 15 hours of supervised experience, and 15 hours of material explaining the supervisor/supervisee relationship – but not offer a total number of hours needed to fulfill the education requirement. Rather than marking "edu_hours" as 33, "edu_hours" was left blank, and the above values were included in "edu_hours_desc".
Exam	This is a binary variable ("Yes" or "No") that reflected whether or not an examination was required prior to licensure.
Exam Type	An addendum to the prior variable, this variable held the name of the examination required for licensure. The information was saved as a string in lower case with spaces.
Practice Hours / Number	The first variable is a binary variable referring to whether practice hours were required for licensure ("Yes") or not ("No.") The second variable is an integer variable referring to the post-degree practice hours required prior to obtaining a license. These practice hours are typically supervised. Occasionally, states will require a residency or other post-graduate training that extends for a certain period of time (like 4-years of post-licensure experience for MHCs seeking to become supervisor) but no explicit minimum-hour requirement. In these instances, the "prac_hours" variable was coded "No" and the corresponding "prac_hours_num" is blank. However, in this case, "prac_hours_desig" was coded "Yes" and the time-component was added to the field "prac_hours_desc". This process fits the actual scope of practice documents better than the alternative of assuming 2000 hours for a year's worth of experience.
Practice Hours Designation / Description	The first variable is a binary variable referring to whether the practice hours required in the previous variables had to be performed in a certain way ("Yes") or not ("No"). Possibilities include some practice needing to be performed in a community service capacity, or to certain populations. The second variable is a

	string variable that listed the specific designations as to how the practice hours were to be performed.
Supervision Hours / Number:	The first variable was a binary variable referring to whether supervised work experience was required for licensure ("Yes") or not ("No.") The second variable was an integer variable referring to the post-degree supervised practice hours required prior to obtaining a license.
Supervision Hours Designation / Description	The first variable is a binary variable referring to whether the practice hours required in the previous variables had to be performed in a certain way ("Yes") or not ("No"). Possibilities include some practice needing to be performed in a community service capacity, or in specific practice domains. The second variable is a string variable that listed the specific designations as to how the practice hours were to be performed.
Completion Time	This is an integer variable meant to capture the minimum time required of practicing post-degree, in months, prior to licensure. Any time a state reported a minimum completion time in years, the value was converted into months. Often states only had a maximum time that professionals seeking licensure could not surpass if their education, practice, and supervision hours were to count for degree. In those cases, a time was not recorded. In the case of supervisory credentials, some states differentiated post-licensure experience from total practice experience. For example, a person with four years of experience in counseling could become a supervisor, so long as at least two of those years were post-licensure. When the state differentiated, the post-licensure requirement was recorded as the completion time, rather than the entire time. This was to reduce the risk of double-counting, as it was assumed only an independent practice MHC could become a supervisor, and the pre-licensure experience was already recorded under the independent practice credential requirements.
Background Check	This is a binary variable that addresses whether a background check was explicitly required ("Yes") or not ("No"). "Background check" could mean a criminal background check and/or requiring references from professionals.
Reciprocity A and B	Reciprocity A is a binary variable meant to capture whether or not a pathway for licensure by reciprocity was spelled out in the scope of practice ("Yes") or not ("No"). Often, the word "reciprocity" was not used in the SOP, so contextually similar mechanisms by which a person with a license from another state is allowed to obtain a license based on the merits of their professional credentials, with minimal to no other requirements, were also accepted. Reciprocity B is a string variable that captures the full language of how licensure by reciprocity functions in the state. There are often provisions in statute language for licensure by reciprocity. Almost invariably, the statute reads, "the board may confer a license of reciprocity on a professional licensed in another state, without examination, provided the requirements of that state have met the minimum standards of the requirements in this state." However, the word "may" is not contractually obligating; licensing boards can choose to ignore this path to licensure at their discretion. Unless protocol for reciprocity is also spelled out in administrative codes and assured for out-of-state professionals, Reciprocity A was coded as "NA".
Endorsement A and B	Endorsement A is a binary variable meant to capture whether or not a pathway for licensure by endorsement was detailed in the scope of practice ("Yes") or not ("No"). Often, the word "endorsement" was not used in the SOP, so contextually similar mechanisms by which a person with substantial experience, but no previous license, is allowed to obtain a license based on the merits of their

	professional experience, with minimal to no other requirements, were considered. Endorsement B is a string variable that captures the full language of how licensure by endorsement functions in the state. Similar to the algorithm for Reciprocity, if a pathway for licensure by endorsement is not in both the state's statutes and administrative codes, then Endorsement A was coded as "NA".
Renewal	This is an integer variable meant to capture how long a license is valid, in months, before it must be renewed. If the scope of practice language determined this time in years, the time was converted to months before being put into the grid.
Continuing Education/Hours	The first variable is binary and meant to capture whether continuing education is a requirement for license renewal ("Yes") or not ("No"). If it was not specifically mentioned, it was coded as "NA". The second variable is an integer variable meant to capture the number of continuing education hours required for renewal.
Continuing Education Designation/Description	The first variable is binary and meant to capture whether the required continuing education hours have specific conditions that must be for license renewal ("Yes") or not ("No"). If it was not specifically mentioned, "NA" was recorded. The second variable is a string variable meant to capture the specific areas required to be covered in continuing education, as well as the specific hours for each of those areas.
Authorized Services Variables: All service variables were binary variables recorded as either "Yes" or "No." If the service was not explicitly mentioned in the SOP, "NA" was recorded to signify the term was missing.	
Assessment and Diagnosis	We defined "assessment" to mean having the knowledge and skills to generally identify symptoms and suggest a treatment. "Diagnosis," on the other hand, was more explicitly clinical and meant being able to use established diagnostic criterion to properly identify a disorder. To explain the difference, imagine someone falling and then going to an emergency room. The nurse on staff could "assess" the patient, recognize they've been injured, and properly splint the affected area. A trauma physician on staff could later "diagnose" the exact nature of the injury and suggest a more targeted treatment. For our purposes, if an SOP allowed a practitioner to diagnose, we assumed the practitioner was also allowed to assess, since diagnosis is applying specialized criteria on top of an assessment. We did not assume the reverse. Furthermore, if the SOP mentioned the MHC was allowed to use certain diagnostic tests or materials, like the DSM, then we recorded the Diagnosis field as 'Yes'.
Psychotherapy	Psychotherapy, when used in the context of professional counseling, is a specific sub-practice of counseling. Often this word does not appear explicitly in the scopes of practice. Instead, we considered words such as "therapy," "counseling," or other phrases denoting a variation of therapeutic talk-therapy to be considered as "psychotherapy."
Crisis Intervention	Crisis intervention is a specialized sub-practice that addresses severe psychological distress, such as a patient with suicidal impulses, or destructive behavior, such as a patient with a drug addiction.
Telehealth	Any provisions for providing care at a distance (via telephone, videoconference, email correspondence, etc.) were considered as allowing "telehealth" even if the term was not used explicitly. Occasionally, telehealth had its own statute or administrative code which was applied retroactively to certain licensed healthcare providers.

Appendix 2. State scopes of practice authorizing credential reciprocity and/or endorsement



Appendix 3. Training credential requirements by state

State	Training Credential Requirements						
	Credential Title	Education Hours	Practice Hours	Supervision Hours	Minimum Completion Time (Months)	Cont. Ed. Hours	Length of Credential (Months)
Alabama	Associate Licensed Counselor	48	NA	NA	NA	10	12
Alaska	Licensed Professional Counselor*	60	3000	100	24	40	24
Arizona	Licensed Associate Counselor	60	NA	NA	NA	NA	24
Arkansas	Licensed Associate Counselor	60	NA	NA	NA	24	24
California	Clinical Counselor Trainee	12	NA	NA	NA	NA	NA
Colorado	Provisionally Licensed Professional Counselor	60	NA	NA	NA	NA	NA
Connecticut	Licensed Professional Counselor*	60	3000	100	12	15	12
Delaware	Licensed Associate Counselor of Mental Health	60	NA	NA	NA	NA	24
D.C.	Graduate or Student of Professional Counseling	60	NA	NA	NA	NA	NA
Florida	Registered Mental Health Counselor Intern	60	NA	NA	NA	NA	NA
Georgia	Licensed Associate Professional Counselor	NA	NA	NA	NA	NA	48
Hawaii	Student Mental Health Counselor	48	NA	NA	NA	NA	NA
Idaho	Registered Counseling Intern	60	NA	NA	NA	NA	NA
Illinois	Licensed Professional Counselor	48	NA	NA	NA	30	24
Indiana	Licensed Mental Health Counselor Associate	60	NA	NA	NA	20	12
Iowa	Temporarily Licensed Mental Health Counselor	60	NA	NA	NA	NA	NA
Kansas	Licensed Professional Counselor	45	NA	NA	NA	30	24
Kentucky	Licensed Professional Counselor Associate	60	NA	NA	NA	10	12
Louisiana	Provisionally Licensed Professional Counselor	60	NA	NA	NA	20	24
Maine	Provisionally Licensed Professional Counselor	48	NA	NA	NA	55	24
Maryland	Licensed Graduate Professional	60	NA	NA	NA	40	24

State	Training Credential Requirements						
	Credential Title	Education Hours	Practice Hours	Supervision Hours	Minimum Completion Time (Months)	Cont. Ed. Hours	Length of Credential (Months)
	Counselor						
Massachusetts	Mental Health Counselor Intern	60	NA	NA	NA	NA	NA
Michigan	Limited Licensed Professional Counselor	48	NA	NA	NA	NA	NA
Minnesota	Licensed Professional Counselor*	48	2000	100	12	20	12
Mississippi	Counselor Applicant	60	NA	NA	NA	NA	NA
Missouri	Provisionally Licensed Professional Counselor	48	NA	NA	NA	NA	24
Montana	Professional Counselor Licensure Candidate	60	NA	NA	NA	20	12
Nebraska	Provisional Mental Health Practice Licensee	NA	NA	NA	NA	NA	60
Nevada	Licensed Clinical Professional Counselor Intern	48	NA	NA	NA	20	12
New Hampshire	Candidate for Mental Health Counselor	60	NA	NA	NA	NA	NA
New Jersey	Licensed Associate Counselor	60	NA	NA	NA	40	24
New Mexico	Licensed Mental Health Counselor	48	NA	NA	NA	40	24
New York	Mental Health Counselor – Limited Permit	60	NA	NA	NA	NA	24
North Carolina	Licensed Professional Counselor Associate	60	NA	NA	NA	40	24
North Dakota	Licensed Associate Professional Counselor	60	NA	NA	NA	NA	24
Ohio	Licensed Professional Counselor	60	NA	NA	NA	30	24
Oklahoma	Licensed Professional Counselor Candidate	60	NA	NA	NA	20	12
Oregon	Registered Intern	60	NA	NA	NA	NA	60
Pennsylvania	Professional Counselor Supervisee	60	NA	NA	NA	NA	72
Rhode Island	Clinical Mental Health Counselor Candidate	60	NA	NA	NA	NA	NA
South Carolina	Licensed Professional Counselor Intern	48	NA	NA	NA	NA	24
South Dakota	Licensed Professional Counselor*	48	2000	100	NA	40	24
Tennessee	Licensed Professional Counselor*	60	3000	150	24	20	24

State	Training Credential Requirements						
	Credential Title	Education Hours	Practice Hours	Supervision Hours	Minimum Completion Time (Months)	Cont. Ed. Hours	Length of Credential (Months)
Texas	Temporary Licensed Professional Counselor Intern	60	NA	NA	NA	NA	60
Utah	Licensed Associate Clinical Mental Health Counselor	60	NA	NA	NA	NA	36
Vermont	Registered Non-Licensed Non-Certified Psychotherapist	60	NA	NA	NA	NA	24
Virginia	Licensed Professional Counselor Resident	60	NA	NA	NA	NA	NA
Washington	Licensed Associate Counselor	NA	NA	NA	NA	18	12
West Virginia	Provisionally Licensed Professional Counselor	60	NA	NA	NA	NA	36
Wisconsin	Licensed Training Professional Counselor	42	NA	NA	NA	NA	48
Wyoming	Provisional Professional Counselor	60	NA	NA	NA	NA	24
Total n	NA	48	5	5	4	22	38
Mean	NA	55.6	2600	110	18	27.4	27.2
Mode	NA	60	3000	100	24	20	24

* There is no training credential in this state. The entry included here is for the independent practice credential, as this would be the "entry" credential for that state

State	Independent Practice Credential Requirements						
	Credential Title	Education Hours	Practice Hours	Supervision Hours	Minimum Completion Time (Months)	Cont. Ed. Hours	Length of Credential (Months)

State	Independent Practice Credential Requirements						
	Credential Title	Education Hours	Practice Hours	Supervision Hours	Minimum Completion Time (Months)	Cont. Ed. Hours	Length of Credential (Months)
Alabama	Licensed Professional Counselor	48	3000	200	24	40	24
Alaska	Licensed Professional Counselor	60	3000	100	24	40	24
Arizona	Licensed Professional Counselor	60	3200	100	24	30	24
Arkansas	Licensed Professional Counselor	60	3000	175	36	24	24
California	Licensed Professional Clinical Counselor	60	3000	150	NA	36	24
Colorado	Licensed Professional Counselor	60	2000	100	24	40	24
Connecticut	Licensed Professional Counselor	60	3000	100	12	15	12
Delaware	Licensed Professional Counselor of Mental Health	60	3200	100	24	40	24
D.C.	Licensed Professional Counselor	60	3500	200	24	40	24
Florida	Licensed Mental Health Counselor	60	NA	NA	24	30	24
Georgia	Licensed Professional Counselor	NA	2400	120	48	35	24
Hawaii	Licensed Mental Health Counselor	48	3000	100	24	45	36
Idaho	Licensed Professional Counselor	60	1000	50	24	20	12
	Licensed Professional Clinical Counselor	NA	2000	66	24	20	12
Illinois	Licensed Clinical Professional Counselor	48	3320	NA	24	30	24
Indiana	Licensed Mental Health Counselor	60	3000	100	21	20	12
Iowa	Licensed Mental Health Counselor	60	3000	200	24	40	24
Kansas	Licensed Clinical Professional Counselor	6	4000	267	24	30	24
Kentucky	Licensed Professional Clinical Counselor	60	4000	100	NA	10	12
Louisiana	Licensed Professional Counselor	60	3000	100	24	40	24
Maine	Licensed Professional Counselor	48	2000	67	24	55	24
	Licensed Clinical Professional Counselor	6	3000	100	24	55	24
Maryland	Licensed Clinical Professional Counselor	6	2000	100	36	40	24
Massachusetts	Licensed Mental Health Counselor	60	3360	130	24	30	24
Michigan	Licensed Professional Counselor	48	3000	100	24	NA	36

State	Independent Practice Credential Requirements						
	Credential Title	Education Hours	Practice Hours	Supervision Hours	Minimum Completion Time (Months)	Cont. Ed. Hours	Length of Credential (Months)
Minnesota	Licensed Professional Counselor	48	2000	100	12	20	12
	Licensed Clinical Professional Counselor	48	4000	200	12	20	12
Mississippi	Licensed Professional Counselor	60	3500	100	24	24	24
Missouri	Licensed Professional Counselor	48	3000	100	24	40	24
Montana	Licensed Clinical Professional Counselor	60	1500	75	NA	20	12
Nebraska	Licensed Professional Counselor	NA	3000	NA	NA	32	24
Nevada	Licensed Clinical Professional Counselor	48	3000	200	24	20	12
New Hampshire	Licensed Mental Health Counselor	60	3000	100	24	40	24
New Jersey	Licensed Professional Counselor	60	3000	NA	NA	40	24
	Licensed Clinical Mental Health Counselor	NA	3000	100	NA	NA	NA
New Mexico	Licensed Clinical Mental Health Counselor	48	3000	100	24	40	24
New York	Licensed Mental Health Counselor	60	3000	100	NA	36	36
North Carolina	Licensed Professional Counselor	60	3000	100	NA	40	24
North Dakota	Licensed Professional Counselor	60	NA	100	24	30	24
	Licensed Professional Clinical Counselor	NA	3000	100	24	30	24
Ohio	Licensed Professional Clinical Counselor	60	3000	NA	24	30	24
Oklahoma	Licensed Professional Counselor	60	3000	112	36	20	12
Oregon	Licensed Professional Counselor	60	2400	400	36	40	24
Pennsylvania	Licensed Professional Counselor	60	3000	75	24	30	24
Rhode Island	Licensed Clinical Mental Health Counselor	60	2000	100	24	40	24
South Carolina	Licensed Professional Counselor	48	1500	150	24	40	24
South Dakota	Licensed Professional Counselor	48	2000	100	NA	40	24
	Licensed Professional Counselor – Mental Health	60	2000	100	NA	40	24
Tennessee	Licensed Professional Counselor	60	3000	150	24	20	24

State	Independent Practice Credential Requirements						
	Credential Title	Education Hours	Practice Hours	Supervision Hours	Minimum Completion Time (Months)	Cont. Ed. Hours	Length of Credential (Months)
	Licensed Professional Counselor – Mental Health Services Provider	60	3000	150	24	20	24
Texas	Licensed Professional Counselor	60	3000	75	18	24	24
Utah	Licensed Clinical Mental Health Counselor	60	4000	100	24	40	24
Vermont	Licensed Clinical Mental Health Counselor	60	3000	100	24	40	24
Virginia	Licensed Professional Counselor	60	3400	200	NA	20	12
Washington	Licensed Mental Health Counselor	NA	3000	100	36	36	24
West Virginia	Licensed Professional Counselor	60	3000	150	NA	40	12
Wisconsin	Licensed Professional Counselor	42	3000	NA	24	30	24
Wyoming	Licensed Professional Counselor	60	3000	100	NA	45	24
Total n	NA	52	56	52	45	57	58
Mean	NA	53.8	2862.1	124.3	24.9	32.8	22.1
Mode	NA	60	3000	100	24	40	24

* There is no training credential in this state. The entry included here is for the independent practice credential, as this would be the "entry" credential for that state

State	Supervisory Credential Requirements						
	Credential Title	Education Hours	Practice Hours	Supervision Hours	Minimum Completion Time (Months)	Cont. Ed. Hours	Length of Credential (Months)
Alabama	Supervising Associate	NA	NA	NA	24	40	24
	Certified Supervising Counselor	NA	NA	NA	60	40	24
Alaska	Certified Counselor Supervisor	NA	NA	NA	60	40	24
Arizona	Registered Clinical Supervisor	12*	NA	NA	NA	30	24
Arkansas	Licensed Professional Counselor w/ Supervision Specialization	3	NA	18	36	24	24
California	Clinical Supervisor	NA	NA	NA	24	6	24
Colorado	Licensed Professional Counselor**	NA	NA	NA	NA	NA	NA
Connecticut	Licensed Professional Counselor**	NA	NA	NA	NA	NA	NA
Delaware	Board-Approved Supervisor	NA	NA	NA	24	40	24
D.C.	Licensed Professional Counselor**	NA	NA	NA	NA	NA	NA
Florida	Licensed Mental Health Counselor**	NA	NA	NA	NA	NA	NA
Georgia	Supervisor	NA	NA	NA	36	35	24
Hawaii	Licensed Mental Health Counselor**	NA	NA	NA	NA	NA	NA
Idaho	Licensed Professional Counselor Supervisor	15*	1500	NA	24	20	12
Illinois	Licensed Clinical Professional Counselor**	NA	NA	NA	NA	NA	NA
Indiana	Licensed Mental Health Counselor**	NA	NA	NA	NA	NA	NA
Iowa	Supervisor	NA	NA	NA	36	40	24
Kansas	Board-Approved Clinical Supervisor	1	NA	NA	NA	30	24
Kentucky	Licensed Professional Clinical Counselor Supervisor	3	NA	NA	24	10	12
Louisiana	Licensed Professional Counselor Supervisor	3	NA	25	24	20	24
Maine	Clinical Supervisor	NA	NA	NA	60	55	24
Maryland	Registered Clinical Professional Counselor Supervisor	3	NA	NA	24	40	24
Massachusetts	Licensed Mental Health Counselor Supervisor	NA	NA	NA	36	30	24
Michigan	Counseling Supervisor	2	NA	NA	36	NA	NA
Minnesota	Board-Approved Supervisor	45*	NA	NA	48	20	12
Mississippi	Licensed Professional Counselor-	3	NA	NA	24	24	24

State	Supervisory Credential Requirements						
	Credential Title	Education Hours	Practice Hours	Supervision Hours	Minimum Completion Time (Months)	Cont. Ed. Hours	Length of Credential (Months)
	Supervisor						
Missouri	Registered Supervisor for a Counseling-in-Training	NA	NA	NA	24	NA	24
Montana	Board Approved Supervisor	1	NA	NA	36	NA	NA
Nebraska	Qualified Supervisor	NA	NA	NA	NA	NA	NA
Nevada	Approved Supervisor	NA	NA	NA	36	NA	NA
New Hampshire	Mental Health Counselor Supervisor	NA	NA	NA	NA	NA	NA
New Jersey	Supervisor	NA	3000	NA	NA	NA	NA
New Mexico	Supervisor	NA	NA	NA	36	40	24
New York	Board-Approved Supervisor	NA	NA	NA	NA	NA	NA
North Carolina	Licensed Professional Counselor Supervisor	3	NA	NA	60	40	24
North Dakota	Certified Professional Counselor Supervisor	30*	NA	NA	60	30	60
Ohio	Licensed Professional Clinical Counselor – Supervisor Designation	24*	1500	10	12	30	24
Oklahoma	Supervisor	45*	NA	NA	24	20	12
Oregon	Registered Approved Supervisor	30*	100	12	36	40	24
Pennsylvania	Supervisor	NA	NA	NA	60	NA	NA
Rhode Island	Approved Supervisor for Clinical Mental Health Candidate	3	NA	NA	60	NA	NA
South Carolina	Licensed Professional Counselor Supervisor	3	NA	NA	36	40	24
South Dakota	Approved Clinical Supervisor	4	NA	NA	24	40	24
Tennessee	Board-Approved Supervisor	3	NA	NA	60	20	24
Texas	Approved Licensed Professional Counselor Supervisor	40*	NA	NA	60	24	24
Utah	Licensed Clinical Mental Health Counselor Training Supervisor	NA	4000	NA	24	NA	NA
Vermont	Clinical Supervisor	NA	NA	NA	36	NA	NA
Virginia	Resident Supervisor	3	NA	NA	NA	20	12
Washington	Approved Counselor Supervisor	15*	25	NA	24	NA	NA
West Virginia	Supervisor	30*	NA	NA	24	40	12

State	Supervisory Credential Requirements						
	Credential Title	Education Hours	Practice Hours	Supervision Hours	Minimum Completion Time (Months)	Cont. Ed. Hours	Length of Credential (Months)
Wisconsin	Supervisor	NA	NA	NA	60	NA	NA
Wyoming	Licensed Designated Qualified Clinical Supervisor	NA	NA	NA	24	NA	NA
Total n	NA	10*, 14	6	5	38	29	30
Mean	NA	28.6*, 2.7	1687.5	22.8	37.9	32	23.2
Mode	NA	30*, 3	1500	25	24	40	24

* This education requirement is in contact hours, as opposed to graduate semester credit hours.
** This is an independent practice license that doubles as the supervisory credential. Because there is no extra requirements to supervise with this credential, the requirements in this table are marked as 'NA' to prevent double-counting.