Addressing Children's Behavioral Health Workforce Shortages Through State Licensure Systems

A Resource for State Legislators, Licensing Board Members, and Changemakers Working with Children and Families

ChangeLab Solutions

Contents

Overview

In light of a deepening behavioral health crisis among children, ChangeLab Solutions (ChangeLab) examined all fifty states and the District of Columbia's **licensure statutes and regulations for three types of behavioral health providers (licensed social workers, licensed professional counselors, and licensed marriage and family therapists)** who commonly provide treatment for children and youth outside school-based settings.

Through this examination, ChangeLab identified three promising areas where improvements to state licensure systems could help to address behavioral health workforce shortages affecting children: **postgraduate training requirements, license portability processes,** and **licensing board structure, composition, and scope of authority**.

This resource provides a brief introduction to each area, highlighting existing challenges and potential policy levers to support state legislators, state licensing board members, and changemakers working with children and families in **considering licensure policy approaches to addressing children's behavioral health workforce shortages**.

A Complex and Multifaceted Issue

While the focus of this resource is on state licensure systems, it is important to note that the barriers contributing to behavioral health workforce shortages are complex and multifaceted and require a broad range of complementary solutions to address.[1] Other promising approaches that federal and state policymakers across the country are exploring include **integrating behavioral health** into family care and larger health care and social systems, **increasing Medicaid reimbursement rates** and expanding coverage to more provider types, implementing student loan repayment programs, and addressing unique barriers to entry for groups such as **military spouses and veterans** and **immigrant workers**. To learn more about some of these approaches, see the **HHS Roadmap for Behavioral Health Integration**, Kaiser Family Foundation's **A Look at Strategies to Address Behavioral Health Workforce Shortages: Findings from a Survey of State Medicaid Programs**, and the National Conference of State Legislatures' **State Strategies to Recruit and Retain the Behavioral Health Workforce**.

Background

Workforce shortages are contributing to a deepening behavioral health crisis among children

All children deserve the opportunity to grow up healthy and to have the support and resources necessary to navigate challenges at school, at home, and in their communities. However, as young people across the nation are experiencing a deepening behavioral health crisis[2] (characterized by rising rates of depression, anxiety, and deaths by suicide[3,4,5]), many families are unable to access the quality and culturally responsive behavioral health care they need in a timely way.[6] Black, Indigenous, and People of Color (BIPOC) children face higher rates of behavioral health challenges and steeper barriers to care than their white counterparts that were exacerbated by the disproportionate health and economic impacts of the COVID-19 pandemic.[7,8,9] Among other factors, a shortage of behavioral health providers contributes to many families' persistent inability to connect with care.[10]

Young people across the nation are experiencing a deepening behavioral health crisis (characterized by rising rates of depression, anxiety, and deaths by suicide).

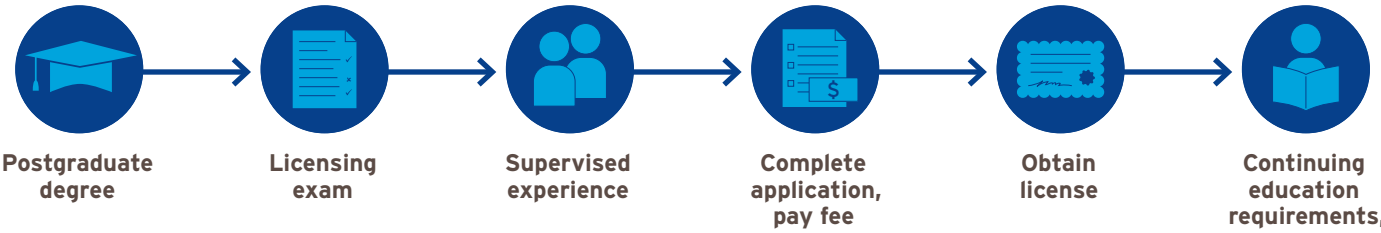
Licensed clinical social workers (LCSWs), licensed professional counselors (LPCs), and licensed marriage and family therapists (LMFTs) are among the largest occupational groups of behavioral health providers[11,12] and play a critical role in delivering therapeutic services for common behavioral health concerns for children and youth. Given that these occupations are master's-level professions that do not require a doctoral or medical degree,[13] LCSWs, LPCs, and LMFTs have the potential to augment the child- and family-serving behavioral health provider workforce. School counselors also play a critical role in providing behavioral health services, but they do not provide long-term behavioral health treatments and often refer students to LCSWs, LPCs, and LMFTs for such care; thus, they are beyond the scope of this report.[14] Policy and practice changes to address workforce shortages among these provider types could help ensure that all communities have a sufficient supply of behavioral health providers to support children's long-term behavioral health needs.

State licensure systems play a significant role in shaping the behavioral health workforce for children

LCSWs, LPCs, and LMFTs, like other types of licensed behavioral health providers, must follow state licensing laws that control the right to practice and define the scope of practice for each profession. State licenses to practice independently require, at a minimum, obtaining a postgraduate degree, passing a licensing examination, and completing postgraduate supervised experience. Specific requirements for each license can vary from state to state, and recent graduates may have little support as they navigate a complex patchwork of licensing rules.[15]

Although licensure plays an important role in protecting patients and ensuring that providers have adequate training,[16] requirements that are confusing to navigate or unduly burdensome to complete could deter qualified providers from entering the workforce and exacerbate workforce shortages.[17] Additionally, patchwork requirements can create significant barriers for already licensed practitioners seeking to apply their qualifications toward licensure in other states.[18,19] These barriers are particularly detrimental to providers in military families and in rural communities and geographic areas close to state lines.[20,21]

Licensure Process



Note: This visual illustrates the licensure process at a high level; every state differs in its process and requirements.

Methodology

To identify policy options to address children's behavioral health workforce shortages, ChangeLab Solutions conducted a comprehensive review of the licensing landscape for LCSWs, LPCs, and LMFTs across all states and the District of Columbia as of October 2021 and conducted a series of interviews with key experts. Through these methods, we identified three promising areas where improvements to state licensure systems could help to address behavioral health workforce shortages affecting children: **postgraduate training requirements, license portability processes,** and **licensing board structure**.

Postgraduate Training Requirements

As part of licensure requirements in every state, LCSWs, LPCs, and LMFTs must complete a minimum amount of postgraduate supervised experience to become licensed to practice independently. Supervised experience, sometimes also referred to as *clinical supervision*, occurs once a new provider has completed a postgraduate degree and begun work in the field. Supervised experience provides oversight by clinical supervisors, who monitor their supervisees' work, review individual cases, assist with the development of treatment plans, and support ongoing professional development.[22] This experience can be a valuable part of training for new behavioral health providers,[23] yet many recent graduates face barriers to securing and completing supervision requirements.[24,25] These barriers can limit entry into the field and therefore exacerbate workforce shortages, which ultimately reduce children's access to needed behavioral health care.

Many recent graduates face barriers to securing and completing supervision requirements.

Requirements differ across states and can be difficult to fulfill

- **Clinical supervision hours requirements vary widely by state and provider type.** Recent graduates navigate a complex patchwork of clinical supervision requirements, generally ranging from 1,000 to 3,000 clinical supervision hours. (See the **Appendix** for more detail on postgraduate training requirements by state.) States also have differing rules regarding the extent to which supervision can be provided to a group or must be provided individually and whether telesupervision is allowed.
- **Finding a supervisor can be challenging.** Experienced clinicians who are qualified to provide supervision may be unable to take on supervisees because they often have full patient caseloads, cannot be reimbursed for time spent providing supervision, and may be unwilling to assume the professional liability or organizational costs associated with the supervision of a clinician in training.[26,27]
- **Supervision can be costly.** Some recent graduates are required to pay to obtain supervision (with some LMFTs, for example, paying approximately $50 to $100 per hour).[28] These costs may be prohibitive given typical annual salaries in the field[29] and supervisees' regular expenses, including student loan debt.[i]

i The Bureau of Labor Statistics reports that, in 2022, **marriage and family therapists had a median salary of $56,570** per year and **social workers had a median salary of $55,350** per year. (Data were not available for LPCs.) Supervisees just entering the field may earn salaries that are lower than the median.

What can be done?

To help address workforce shortages, states can consider helping recent graduates meet their postgraduate supervised experience requirements in these ways:

- Supporting telesupervision as an approach to expand access to supervisors who can provide in-depth training and support. For example, Colorado's policy permits 100% of **LCSW**, **LPC**, and **LMFT** supervision hours to be obtained via telesupervision.
- Expanding the options for providing supervision — for example, by allowing a range of licensed and experienced behavioral health providers rather than only those with the same license type to serve as a supervisor for recent graduates, as is permitted in some states (such as Georgia).[ii]
- Allowing group supervision or increasing the number of supervisees permitted per group, or both. For example, California's 2021 legislation expands the allowable supervisor-to-supervisee ratio from 1:3 up to 1:6.
- **Leveraging state funds** to reimburse trainees' out-of-pocket expenses to pay for supervision and pay supervisors for their time, incentivize employers to provide in-house supervision, and provide training and support for supervisors
- Helping recent graduates find a supervisor — for example, developing **university partnerships** and graduate program–provider agency pipeline programs to match recent graduates with supervisors

ii Georgia's requirements differ across the three license types, but all candidates are permitted to obtain at least some portion of their required supervised postgraduate training hours under the supervision of a range of qualified providers, including LCSWs, LPCs, LMFTs, psychologists, or psychiatrists. For more information on supervision requirements in Georgia, see: **https://rules.sos.ga.gov/GAC/135-5-.04**; **https://rules.sos.ga.gov/GAC/135-5-.02**; **https://rules.sos.ga.gov/GAC/135-5-.06**.

License Portability Processes

A license issued by one state does not authorize the licensee to practice in any other state. Accordingly, a provider who is licensed in one state and seeks to practice in another state must first become separately licensed in the new state.

License portability refers to the ease with which a provider who holds a professional license in one state may obtain a license to practice in another state. License portability barriers are a key area for policy change because they can exacerbate behavioral health workforce shortages, be particularly burdensome for military spouses, and impede continuity of care in our increasingly mobile society.[30,31] Relatedly, addressing license portability issues may also help to facilitate telehealth services and improve access in rural communities and geographic areas close to state lines.[32]

License portability barriers are a key area for policy change because they can exacerbate behavioral health workforce shortages.

License portability requirements vary greatly

In most states, behavioral health licensure candidates who are already licensed in another state may bypass some requirements in the traditional licensing process if certain conditions are satisfied. For example, streamlined licensure pathways may be available if a candidate can show that the requirements for their out-of-state license (or, alternatively, the candidate's individual credentials) are "substantially equivalent" to the requirements of the state they are applying to be licensed in.

The process of proving substantial equivalence varies from state to state and can pose barriers such as requirements relating to providing documentation or completing additional examinations (or both), course work, or supervision hours. Some behavioral health licensing boards have sought to mitigate barriers associated with substantial equivalence standards through mechanisms such as a **reciprocity agreement** (also known as a *reciprocal licensing agreement*), which recognizes the substantial equivalence of the party states' respective licensure standards.[iii]

Growing interest in behavioral health provider mobility has sparked a push for the development of interstate compacts to facilitate practice across state lines. An **interstate compact** is a legally binding contract that creates a formal relationship between member states through joint enactment of model legislation authorizing the compact in each state. In the professional licensure context, compacts can facilitate interstate practice by, for example, establishing uniform licensure standards and providing for multistate privileges that enable providers to practice in all other member states without having to complete separate licensure processes in each state.[33]

iii In contrast to legislatively enacted interstate compacts (discussed below), reciprocal licensing agreements do not require any legislation and may instead be adopted, modified, and terminated at the discretion of state licensing boards.

What can be done?

State policymakers and licensing boards can make license portability easier for behavioral health providers in these ways:

- Ensuring that licensure processes and requirements for all candidates, including providers moving from other states, are clearly identified and easily accessible online — for example, the Ohio Counselor, Social Worker, and Marriage and Family Therapist Board's **web page** with instructions for out-of-state applicants
- Maintaining up-to-date lists of out-of-state licenses that have already been deemed to satisfy substantial equivalence requirements — for example, the Minnesota Board of Behavioral Health and Therapy's **list** of out-of-state licenses approved for LPC or LPCC reciprocity licensure
- Entering into reciprocity agreements that recognize the substantial equivalence of the party states' licensure standards — for example, the **Reciprocity Agreement Between Tennessee and Kentucky**
- Establishing probationary licenses that authorize providers whose out-of-state licenses are deemed not substantially equivalent to practice while working toward fulfillment of additional requirements for full licensure — for example, Washington's **probationary license program** (for out-of-state social workers, mental health counselors, and marriage and family therapists)
- Shifting to portability models that allow recognition of valid out-of-state licenses without a showing of substantial equivalence — for example, the **MFT License Portability Model**
- Joining interstate compacts — for example, the **Counseling Compact**

Licensing Board Structure, Composition, and Scope of Authority

Occupational and professional licensing, including for behavioral health providers, is primarily regulated at the state level. State laws define the scope of practice for each profession and reserve the right to practice for providers who have obtained the appropriate license.

Each state and the District of Columbia delegate some degree of responsibility over licensing of behavioral health professions to designated state entities — typically licensing boards. Licensing board functions can include determining requirements for licensure and setting professional standards, screening licensure applicants and issuing licenses, and investigating complaints and disciplining licensed professionals who violate applicable rules or standards. Licensing boards' activities are generally funded, at least in part, from fees paid by candidates applying for licensure.

Given their central role in regulating licensed professions and shaping the workforce, the structure and function of licensing boards are other areas that policymakers can consider for addressing behavioral health workforce shortages affecting children and families.

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The structure of a licensing board may influence its effectiveness

States have taken differing approaches to behavioral health licensing boards across a variety of different characteristics:

- **Oversight of a single profession versus multiple professions.** Some behavioral health licensing boards are single-profession, or independent, boards dedicated to regulating a particular type of licensed professional (e.g., LMFT). Others are composite boards that are responsible for overseeing multiple licensed behavioral health professions (e.g., LPCs and LMFTs). Some advocates suggest that benefits of single-profession boards include greater subject-matter expertise and representation by members of the regulated profession,[34] whereas consolidation of separate licensing agencies into one entity is viewed as a cost-saving measure that can help take advantage of economies of scale and improve coordination.[35] Some jurisdictions have also explored in-between options such as retaining independent boards while consolidating some common functions, such as administrative and enforcement functions, under a central umbrella entity.[36]
- **Authority relative to a centralized body.** Behavioral health licensing boards can operate under varying degrees of autonomy or oversight in relation to a central government agency bearing responsibility for regulating behavioral

health professions. For example, some licensing boards may be fully autonomous while others may serve only in an advisory capacity, with final decision-making authority resting with the central agency.[37] Some states have also enacted policy to promote oversight of board decision making, including, for example, sunrise and sunset legislation that creates formal processes by which the executive branch or legislative branch, or both have an opportunity to review and evaluate occupational licensing rules and regulations.[38]

- **Board composition.** Behavioral health licensing boards vary in their composition and the balance of representation across their members. Nearly all states require some combination of licensed practitioners from the regulated profession(s) and public members, who are seen as playing an important role in representing the public interest[39] and improving board accountability and credibility.[40] Some states have also adopted racial, ethnic, cultural, or political diversity requirements to ensure that board composition reflects overall demographics in the state, while others have expressly prohibited such requirements. This is an evolving area of law, and policymakers considering legal reform on board diversity should consult an attorney licensed in their jurisdiction.

What can be done?

To help address workforce shortages, state policymakers can assess the behavioral health licensing board structures in their state and identify potential reforms to promote more equity and effective licensing board operations in these ways:

- ✔ Evaluating current board structures to determine the extent to which licensing boards for various professions should operate independently or be consolidated and improving cross-board communication, collaboration, and coordination. An example of a middle option between fully independent and consolidated boards is the Texas Sunset Advisory Commission's 2017 **report** recommending the creation of an umbrella Texas Behavioral Health Executive Council.
- ✔ Evaluating whether the degree of decision-making authority allotted to one's state's licensing boards is appropriate by understanding the degree of autonomy that licensing boards currently have and understanding the benefits and challenges of various models between licensing boards and a centralized agency. The Council on Licensure, Enforcement and Regulation's **report** on US state regulatory structures provides information about the benefits and challenges of various models.
- ✔ Evaluating whether licensing boards adequately represent the perspectives and experiences of the public, including communities most in need of behavioral health care services, through board appointments and relationships with community-based organizations. The Citizen Advocacy Center's **toolkit** on this topic offers considerations related to improving public representation on licensing boards.
- ✔ Instituting other oversight or shared decision-making mechanisms (e.g., **sunrise and sunset processes**) to ensure fair decision making, reduce bias and unnecessary barriers, and avoiding actual or perceived violations of antitrust laws. To learn more about potential reforms, see the National Conference of State Legislatures' 2020 **report** on lessons learned from the Occupational Licensing Learning Consortium.

Conclusion

In summary, there is considerable variation in the legal landscape governing states' licensing and practice requirements for LCSWs, LPCs, and LMFTs, which may have implications on the availability, accessibility, and quality of mental health care for children. The following policy levers may serve as important starting points for states committed to strengthening and building the children's behavioral health workforce:

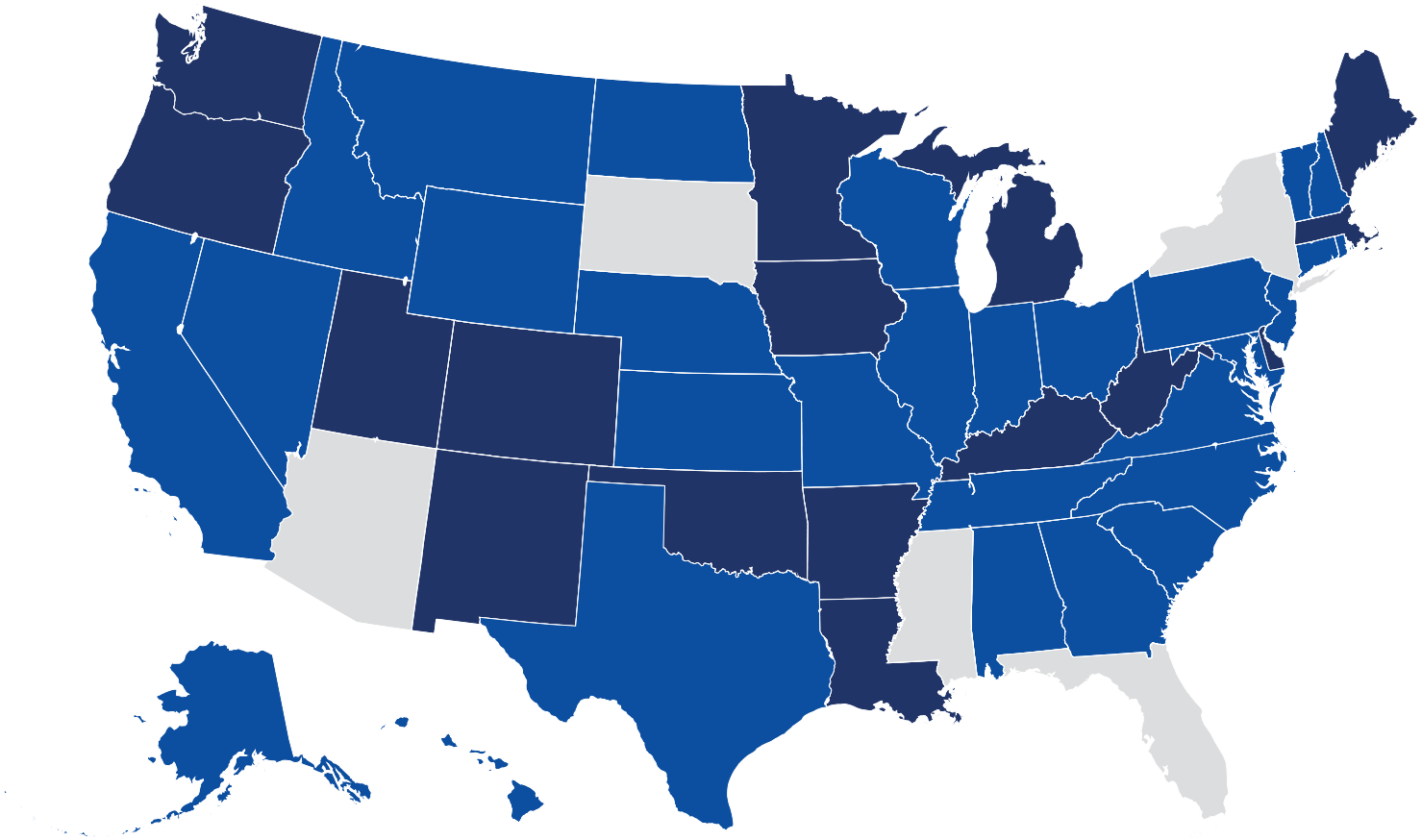
- **License portability processes** or state-determined processes by which a provider who holds a license in one state can practice in another state (often called *reciprocity*) or can obtain a license to practice in another state (also called *endorsement*);
- State-defined characteristics of **licensing boards** such as which professions are regulated by a particular licensing board, the types of individuals who must be represented on the licensing board, and which authority appoints licensing board members; and
- **Postgraduate training requirements**, which are established by state licensing boards to ensure a qualified behavioral health workforce, including supervised clinical experience or specialized training after graduation before an individual can provide services independently.

To learn more about additional policy levers that may expand the behavioral health workforce, see the following companion materials:

- **Policy graphic**: Expanding the Behavioral Health Workforce: Policy Levers to Expand the Behavioral Health Workforce & Provider Participation Rates in Medicaid & the Children's Health Insurance Program (CHIP)
- **White paper**: Addressing Children's Behavioral Health Workforce Shortages Through Medicaid and the Children's Health Insurance Program: A Resource for State Legislators and Changemakers Working with Children and Families

Appendix: Postgraduate Training Requirements by State

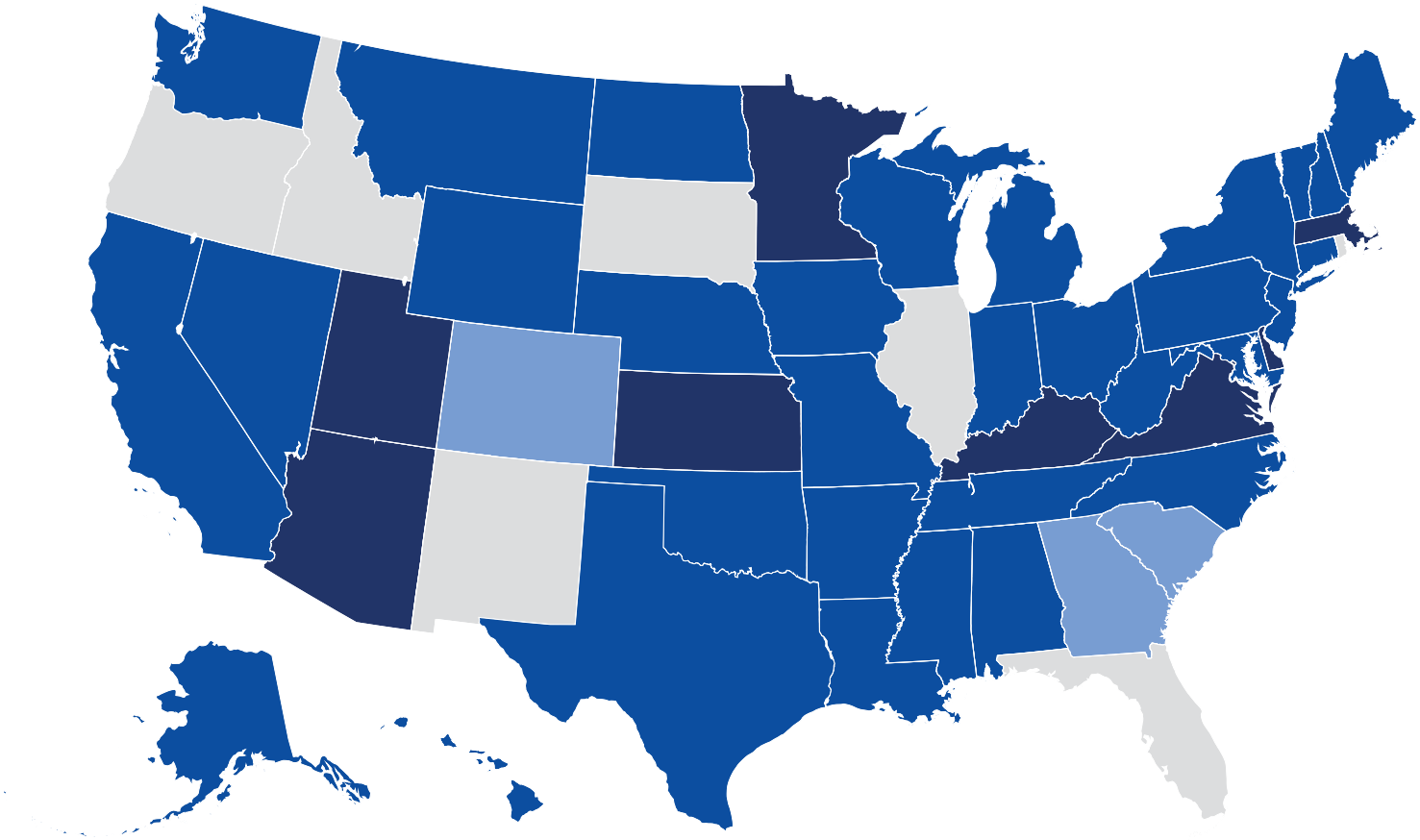
FIGURE 1: Minimum Hours of Supervised Postgraduate Professional Experience, by State, for Licensed Clinical Social Workers



- Above the US median (3,200–4,000 hours)
- US median (3,000 hours)
- State requirements defined differently than minimum number of supervised hours

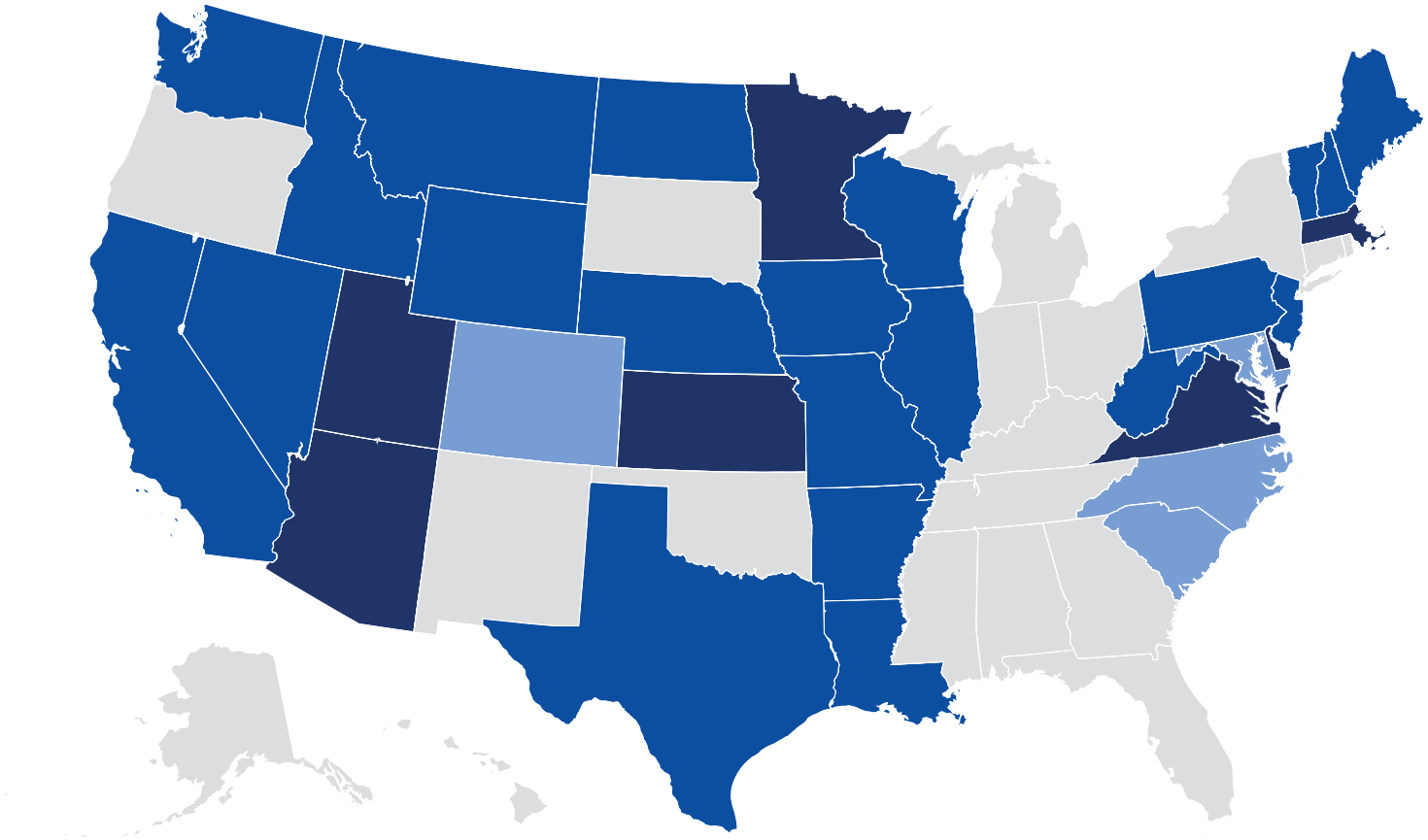
No states were below the US median.

FIGURE 2: Minimum Hours of Supervised Postgraduate Professional Experience, by State, for Licensed Professional Counselors



- Above the US median (3,200–4,000 hours)
- US median (3,000 hours)
- Below the US median (1,500–2,400 hours)
- State requirements defined differently than minimum number of supervised hours

FIGURE 3: Minimum Hours of Supervised Postgraduate Professional Experience, by State, for Licensed Marriage and Family Therapists



- Above the US median (3,200–4,000 hours)
- US median (3,000 hours)
- Below the US median (1,500–2,400 hours)
- State requirements defined differently than minimum number of supervised hours

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