



Mental Health Workforce Reforms

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Key Points

- Eliminating unnecessary regulations surrounding APRNs, peer support specialists, and telemedicine will increase options for mental health providers and lead to job growth.
- The state should consolidate health profession licensing and regulation into a single board with advisory panels similar to TDLR that is controlled by public appointees rather than market participants.
- The state should consider a certification process rather than licensure for certain mental health professions.

Introduction

In July 2015, approximately 81 percent of Texas counties were designated full or partial mental health professional shortage areas ([Texas Counseling Association, 1](#)). Although Texas has a lower prevalence of mental illness than most states, Texas is among the states with the lowest rates of access to mental health care for people seeking care ([Mental Health America, 13](#)).

Texas has these mental health workforce challenges at least in part because of the way Texas licenses and regulates health care professions. Texas prevents qualified providers from practicing their profession to the full extent of their knowledge and training, especially Advanced Practice Nurses and nontraditional providers like peer support specialists. It limits the use of innovative technology to increase access to care in communities with a limited provider base. It allows established market participants to regulate their own profession and act as monopolies. And it gives licensing boards overly broad regulatory authority.

In the 85th Texas Legislature, most of the health professional licensing boards will be up for Sunset review including many that regulate mental health providers like the Texas Board of Examiners of Professional Counselors, the Texas State Board of Examiners of Marriage and Family Therapists, the Texas Medical Board, the Texas Nursing Board, the Texas State Board of Examiners of Psychologists, and the Texas State Board of Social Work Examiners.

This provides an excellent window of opportunity for legislators to consider how current licensing and regulation stymie workforce development when it comes to mental health.

This paper will not look at all the reforms that could maximize the use of mental health professionals regulated by each licensing board under Sunset review, but it will examine two questions: first, how do we eliminate regulations that restrict access to mental health care? And second, how do we restructure the authority and composition of our health professional licensing boards to prevent them from restricting competition in the mental health workforce?

Increasing Access to Mental Health Care

Three ways to expand access to mental health care would be to 1) allow advanced practice nurses who specialize in mental health independent practice and independent prescription in Texas, 2) expand opportunities for peer support specialists, and 3) consider joining multistate licensing compacts and repealing restrictions on telemedicine to allow more providers to serve Texans.

Scope of Practice for Nurse Practitioners and Certified Nurse Specialists

Like Texas, New Mexico has struggled with health professional shortages. In 2013, New Mexico's governor launched a campaign to actively recruit Nurse Practitioners (NP) to deal with this shortage ([Massey](#)). In New Mexico, NPs are allowed independent practice and prescriptive authority. The NP recruitment campaign highlighted that neighboring states like Texas have restrictive scope of practice laws, and therefore, NPs cannot run their own clinics or practice without physician oversight ([Martinez](#)).

Indeed, Texas has some of the most restrictive scope of practice regulations for NPs and

other Advanced Practice Registered Nurses (APRN). Texas requires NPs and most other APRNs to practice with some form of supervision, delegation, or team management by a physician (this varies based on the site and type of practice). New Mexico, along with 17 other states and Washington, D.C., allows all NPs and Certified Nurse Specialists (CNS) to evaluate patients, diagnose, initiate and manage treatments, and prescribe medications under the authority of their state boards of nursing.

State scope of practice laws extend to Advanced Practice Psychiatric Mental Health Nurses (APRN-PMH). APRN-PMHs are trained to assess, diagnose, and treat individuals with mental illness, and to work with communities, families, and more to assess mental health needs, implement a plan to address those needs, and evaluate it for effectiveness. APRN-PMHs are typically NPs or CNSs who have a master's or doctoral degree in psychiatric mental health nursing.

Looking at New Mexico as an example, it becomes clear that broader scope of practice laws for APRNs correlate with better access to mental health care. Even though New Mexico has the highest prevalence of behavioral health issues in the country according to a study by Mental Health America, it has a significantly higher rate of access to care than Texas and is among the 10 best states for mental health workforce availability ([Mental Health America, 13, 40](#)).

In Texas, physicians may delegate authority for APRNs to prescribe schedule II controlled substances in hospice and hospital settings ([Texas Nurse Practitioners](#)). This authority may be given through a Prescriptive Authority Agreement (PAA) or by protocol in facilities-based practice rather than by an onsite physician ([Texas Nurse Practitioners](#)). And physicians may supervise up to seven APRNs in certain settings ([Texas Nurse Practitioners](#)). But Texas is still falling short.

To remain competitive with other states and fill persistent gaps in mental health care delivery, Texas lawmakers should expand scope of practice laws for NPs and CNSs. Ideally, Texas law would mirror the most liberal scope of practice laws in the country, such that APRNs are allowed to practice to the extent of their education and training, including prescriptive and diagnostic authority, to operate independent on-site clinics, and hence to add to Texas' seriously limited mental health workforce capacity.

Specifically, Texas should allow NPs and CNSs with a psychiatric mental health specialty to practice independently without physician supervision. Texas should also allow NPs and CNSs with a psychiatric mental health specialty to prescribe schedule II drugs without a PAA.

Fears that APRNs provide inferior care or produce worse health outcomes are unsupported by data. A survey of 37 articles published between 1990 and 2009 on the quality, safety, and effectiveness of NPs compared to physicians found that outcomes were comparable across all categories (Stanik-Hutt, et al., 492-500). Although there is no similar study for APRN-PMHs, the results would likely be similar. Most states allow nurses to prescribe schedule II controlled substances, and many allow independent prescription of schedule II drugs.

Additionally, mental health services provided by NPs and CNSs in independent clinics are likely going to have lower per visit cost, and eliminating scope of practice restrictions could have a large effect on the cost savings that NP-operated clinics are able to achieve (Spetz, et al., 32). The expansion and modernization of scope of practice laws for NPs and CNSs in Texas would not only alleviate provider shortages, it could also create jobs that would contribute to Texas' GDP (Perryman Group).

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Texas has less overall need for mental health services than most states, but the need that exists is often not being met and typically comes with a high cost. Although Texas has been cited for spending less on mental health than most other states, the numbers that were used in those studies may have unrepresented the full extent of Texas' mental health spending. The most recent numbers from the Legislative Budget

Board show that Texas spends \$6.7 billion on mental health ([Senate Committee on Finance](#)). Expanding scope of practice for APRN-PMHs is a common-sense, proven policy reform that should be part of Texas' solution to the mental health care challenges it now faces.

Peer Support Specialists

Peer support is when people help other people with similar life experiences. In the context of this paper, peer support is when people who have experienced mental illness or a substance use disorder and have some formal training help others move toward recovery. In 1999, the Surgeon General's report noted that peer support was the fastest growing service for people in recovery and has really been transforming how mental health care is delivered ([U.S. Department of Health and Human Services, 94-102](#)).

Peer providers are not clinicians and often do not work in a clinical environment, although they may work as part of a clinical team in certain circumstances. Peers may be found in mental health clinics, substance use treatment centers, psychiatric hospitals, housing facilities, jails, primary care settings, and more. Often peer support programs have better outcomes than traditional clinical interventions, including higher rates of engagement, decreased rates of hospitalization, increased medication adherence, and higher recovery rates.

As peer support becomes a more popular behavioral health intervention, some states are looking to standardize training and use Medicaid to pay for and financially support peer providers. However, there is concern that standardization and professionalization could jeopardize the effectiveness of peer support. Some argue that standardization would expand peer roles into more areas and create greater service capacity because many states that have more informal peer support pay their peer providers less, making it a less desirable profession; cost savings from decreased utilization of services and increased quality of care would offset the investment in peer provider salaries. However that is not currently coming to bear in the market.

Initially, peer support programs were mostly paid for by state general funds or grant funding. Recently, Medicaid has been funding peer support at an increasingly higher rate because many states are choosing to use Medicaid to pay for the services rather than general funds. To bill Medicaid for peer support services, peers must be supervised by a competent mental health professional, act as part of a coordinated recovery plan,

and complete a training and certification as defined by the state. This formalization is exactly what people are concerned about.

The state should consider ways to encourage gainful employment for certified peer specialists and maximize their use in treatment-based and non-clinical settings without imposing unnecessary regulations or overly burdensome certification processes.

Telemedicine

In April 2015, the Texas Medical Board (TMB) passed telemedicine rules that made Texas the most heavily regulated state in the country for this useful technology. These restrictions are problematic because telemedicine or telehealth is generally cheaper, has shorter wait times, and can provide services to people in areas without enough providers. Fortunately, there are exceptions for behavioral health that make telemedicine or telehealth a more viable option for mental health treatment in Texas. However, some regulations should be lifted to truly maximize this useful technology.

The new rules make an exception for behavioral health services, so people with mental illness can access behavioral health telemedicine or telehealth services unless they are experiencing a behavioral health crisis (meaning they are likely to hurt themselves or others). This rule is a little odd because many people initially access mental health services through crisis or suicide hotlines, which are typically staffed by trained volunteers rather than clinicians or doctors, and physicians are already barred by the FDA from prescribing most psychiatric medications over the phone or via some other technology. Behavioral telehealth services are in high demand and are used more than any other telemedicine or telehealth services currently available in Texas.

The unnecessary restriction on accessing mental health services through telemedicine or telehealth services was again highlighted in Texas when the Texas Board of Examiners of Professional Counselors considered a similarly restrictive rule on the use of telehealth by professional counselors. The board in this situation decided against tightening regulations because no one had complained about remote counseling services.

The Legislature should lift the current regulations on telemedicine, including the restrictions on the use of telemedicine to address behavioral health emergencies. These emergency situations may actually be the time when remote, affordable care is most important.

Preventing Anticompetitive Regulation of Mental Health Professionals

In the last year, two of our health professional licensing boards have come under fire in federal lawsuits—the Texas Medical Board and the Texas State Board of Examiners of Psychologists. The Texas Medical Board has been sued under federal antitrust law for passing anticompetitive regulations that limit the use of telemedicine in Texas. All of the boards are vulnerable to similar suits because of the Supreme Court decision in *North Carolina State Board of Dental Examiners v. F.T.C.*, which held that state licensing boards comprised mainly of market participants are subject to heightened scrutiny when facing antitrust challenges. Each of these boards is comprised primarily of market participants, and regulation of a profession, even if proper, is inherently anticompetitive, making these boards vulnerable to lawsuits. Texas must look at the composition, structure, and authority of each board with this in mind and make some changes.



In *Serafine v. Branaman*, the Fifth Circuit struck down the statute enabling the Texas State Board of Examiners of Psychologists to regulate the practice of psychology as overbroad as applied, and on its face in violation of the First Amendment. The court held that the definition of the “practice of psychology” is broad enough to apply to Alcoholics Anonymous, Weight Watchers, golf coaches, yoga teachers, life coaches, various self-help groups, or even newspaper columnist advice. The court considered the statute to be ripe with opportunities for abuse.

A statute that limits the ability of individuals to give advice about mental or emotional problems based on knowledge from a graduate class could prohibit protected speech. This case suggests that the authority granted many mental health professional licensing boards may be too broad and ought to be reconsidered.

Licensing Board Restructure

The state of Texas could use the precedent set forth in *North Carolina State Board of Dental Examiners v. F.T.C.* and simply repurpose the Health Professions Council (HPC). The mission of the HPC is “to coordinate regulatory efforts among the various health care licensing boards represented on the HPC.” All health professions that are represented, as well as the Texas Board of Examiners of Professional Counselors, the Texas State Board of Examiners of Marriage and Family Therapists, and the Texas State Board of Social Work Examiners, should be consolidated into the Health Professions Council, which would then serve in a capacity similar to the Texas Department of Licensing and Regulation for health professions.

The existing licensing boards would morph into an advisory board to educate members of the HPC on how their profession ought to be regulated, so they can provide the same level of expertise that is necessary for effective regulation.

The composition of the HPC would have to change. Instead of having one member from each licensing board serving, members of the general public should be appointed by the governor. A person would be ineligible as a member if the person or the person’s spouse was regulated by the HPC; was employed by or participated in the management of a business entity or other organization regulated by or receiving funds from the HPC; owned or controlled, directly or indirectly, more than a 10 percent interest in a business entity or other organization regulated by or receiving funds from the HPC; used or received a substantial amount of tangible goods, services, or funds from the HPC, other than compensation or reimbursement authorized by law for HPC membership, attendance, or expenses; or was an employee of the HPC.

This would prevent the risk of lawsuits to the state, reduce unnecessarily anticompetitive regulations, and resolve conflicts that arise between the boards about who has the authority to regulate, which is also a problem. For example, in 2008 the orthopedists and podiatrists had a conflict over who could treat the “ankle,” which had to be resolved in court. Also in 2008, the chiropractors and doctors had a dispute over the scope of chiropractic practice. And in 2014, marriage and family therapists and doctors argued over whether therapists could diagnose “mental disease.” These are just a few examples of the issues these boards can have that could be resolved through the structure described above.

Certification of Mental Health Professionals in Lieu of Licensure

In light of the *Serafine v. Branaman* case, the state could consider certification in lieu of licensure for non-medical mental health professionals. Generally speaking, psychotherapy has been shown to improve mental health better than psychopharmacological interventions ([American Psychological Association](#)). In fact, the recovery movement has shown that non-traditional therapies, social inclusion, and very unexpected interventions may be more effective at helping people cope with or recover from their mental illness. At the very least, there is debate among professionals about what works and what does not work. We often hear mental illnesses compared to chronic physical illnesses. And to a certain extent that is a fair comparison. They are often beyond the individual’s con-

trol, treatment is effective but varies among individuals, and people can recover from both physical and mental illnesses. But for example, if you have cancer and you stand on your head every day for a month, and claim to feel better, you likely still have cancer. If you have major depression, and you stand on your head every day for a month and claim to feel better, it may work because you were suffering from a mood disorder or a behavioral disorder.

This would mean that psychologists, social workers, professional counselors, and marriage and family therapists could go through a state certification and registration process rather than a licensing process before engaging in the practice of their profession, which would open up the profession and not chill the speech of unlicensed people who might give advice about how to address emotional or behavioral problems.

Conclusion

Texas should allow APRN-PMHs to practice to the full extent of their knowledge and training, create opportunities for peer support specialists to work in a variety of settings throughout Texas, and take full advantage of the remote care options available through telemedicine.

At the same time, Texas should restructure its health professional licensing boards to ensure the most competitive health care market possible and deregulate non-medical mental health professionals. ★

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