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# Examining State Licensing Requirements for Select Master's-Level Behavioral Health Providers for Children

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## Abstract

**Objective:** The authors characterized licensing requirements for select children's behavioral health care providers.

**Methods:** Statutes and regulations as of October 2021 related to the licensing of Licensed Clinical Social Workers, Licensed Professional Counselors, and Licensed Marriage and Family Therapists were reviewed for all 50 U.S. states and the District of Columbia.

**Results:** All jurisdictions had laws regarding post-graduate training and license portability. No jurisdiction included language about specialized post-graduate training related to serving children and families or cultural competence. Other policies related to the structure, composition, and authority of licensing boards varied across states and licensure types.

**Conclusions:** States could consider statutes and regulations to address barriers to licensure, expand the workforce, and ensure children have access to quality and culturally responsive care.

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Mental, emotional, and behavioral disorders among children and adolescents are a public health issue in the United States because of their prevalence, impact, and social and economic costs (1). Despite growing need, many families are unable to access quality and timely care (2). Policies and practices related to obtaining clinical licensure could influence the supply of behavioral health care providers (3).

While licensing is intended to protect public health by maintaining necessary standards of care, restricting entry into occupations may limit practitioner supply (4). Securing supervised post-graduate clinical experience required for licensing can be challenging and costly for new providers (5,6). License portability can also differ across states, which may create challenges for providers moving across state lines and may put a particular strain on military families seeking care, practitioners within these families, and others who relocate frequently (7).

This review characterized regulatory structures governing licensing requirements for master's-level Licensed Clinical Social Workers (LCSWs), Licensed Professional Counselors (LPCs), and Licensed Marriage and Family Therapists (LMFTs), which are among the largest occupational groups of behavioral health providers for children and adolescents (8). Policies specific to school counselors, who do not provide long-term treatment and often refer students to LCSWs, LPCs, and LMFTs, were excluded (9).

## Methods

Utilizing public health law research methods, we searched the Westlaw legal database and state government websites for statutes and regulations ("laws") related to licensing for LCSWs, LPCs, and LMFTs as of October 1, 2021 for the 50 U.S. states plus D.C. for three domains: post-graduate training requirements; licensing board structure, composition, and the scope of board authority; and license portability.

Keyword searches were supplemented by reviewing the table of contents of each relevant section of state law. For licensing boards and supervised post-graduate experience, laws were accessed through state licensing board websites. Following data collection, a second reviewer independently reviewed a sample of the laws as a validation check to verify accuracy.

Discrepancies were minor and inconsistencies were resolved by consensus. This work involved abstraction of published information, and thus was exempt from Institutional Board Review.

## Results

All states plus D.C. required post-graduate supervised professional experience to obtain licensure. However, variability was observed in the amount of required experience and in the metrics that states used to set minimum requirements. In addition, requirements sometimes differed within the same state across the three provider types.

Most states required a minimum number of total hours of clinical and non-clinical supervised post-graduate professional experience to obtain licensure, with many states also specifying a minimum number of direct client contact and supervision hours within that total. Among the 46 jurisdictions that required a minimum number of total supervised hours for LCSWs, that number ranged from 3,000 hours in 30 jurisdictions to 4,000 hours in eight states. Five states used requirements other than minimum number of total hours: four required that prospective LCSWs complete a specified amount of direct client hours within a minimum number of years or months but did not require supervisees to account for additional non-clinical supervised hours; one required that supervisees seeking LCSW licensure complete two years of supervised experience, without specifying a minimum amount of direct client or non-clinical hours.

Forty-four jurisdictions mandated a minimum number of total hours for LPCs, ranging from 1,500 in one state to 4,000 in four states. Six states set a direct client hour requirement that prospective LPCs must complete within a minimum number of years or months and did not require a specified number of additional non-clinical supervised hours. One state required supervisees seeking LPC licensure to complete 2,000 direct client contact hours within a maximum of four years preceding their application.

For LMFTs, only 33 jurisdictions specified minimum requirements in terms of total number of supervised hours, ranging from 1,500 hours in two states to 4,000 hours in three states. Twelve states set a direct client hours requirement to be completed within a minimum number of years or months but did not require additional non-clinical supervised hours. Four states required prospective LMFTs to complete a certain number of direct client hours but did not specify a minimum timeline for accrual of hours. Two states required prospective LMFTs to complete a minimum number of years or months of supervised experience but did not specify a minimum amount of direct client or non-clinical hours. No states required specialized post-graduate, pre-licensure cultural competency training or training to serve children and youth.

Forty-nine jurisdictions used licensing boards to regulate and manage LCSW, LPC, and LMFT licensure. Two states did not have licensing boards for these professions, but regulated licensure through state agencies. The majority of LCSW boards (k=34) were independent (primarily composed of members from that profession), while the majority of LPC and LMFT boards (k=37 and 35, respectively) were composite (regulating several professions and drawing members from across those professions). Often, jurisdictions regulated both LPCs and LMFTs under a single composite board.

Nearly all jurisdictions required members of the public to be included on licensing boards with some exceptions and additional provisions. All jurisdictions except one required the inclusion of public members on LPC and LMFT boards, and all except three required public members on LCSW boards. Four states specifically required that boards reflect the racial and ethnic diversity of the state. Two states required that a certain number of board appointees be members of a specific community of color or another underrepresented group, whereas one explicitly prohibited the consideration of “race, color, disability, sex, religion,

age, or national origin of the appointee." One state required racial and ethnic diversity as well as political diversity among members of its LCSW board.

LCSW and LPC licensing board members are appointed by the governor in 40 states, and LMFT board members are appointed by the governor in 39 states. In D.C., the mayor appoints board members across all three licensure types. Board members are appointed by another official (e.g., director of a state agency) in six states, and by a combination of the governor and another official in three states (LMFTs) and two states (LCSWs and LPCs).

All jurisdictions articulated a licensure process for providers with an existing LCSW, LPC, or LMFT license in another jurisdiction wishing to move or practice across jurisdictional lines. Approaches to license portability and the language states use to describe them varied across states and provider types. In some cases, states used the terms 'reciprocity' and 'endorsement' interchangeably. In other states, 'reciprocity' specifically referred to a pathway to licensure established vis-à-vis formal agreements between states (which allow practitioners to be licensed based on their existing license in a partnering state) and/or used 'endorsement' to refer to being able to apply for a license based on training obtained in a different state (which can involve having to meet additional requirements). States also varied in how they determine whether a practitioner qualifies for licensure by reciprocity or endorsement and what those application processes entail. Overall, most states permitted licensure by reciprocity or endorsement on a case-by-case basis, when applicants have an existing license in good standing in another jurisdiction whose education, experience, and other licensing requirements are substantially equivalent to or greater than their own. Other states required applicants to have a minimum amount of experience as an independently licensed provider (between one and five years, depending on the state) to qualify for licensure by reciprocity or endorsement.

Although not systematically extracted from all jurisdictions, we observed that some states offered multiple pathways to licensure by reciprocity or endorsement, including a simplified application process for candidates with a certain amount of previous experience and a more involved process for those with less experience.

## Discussion

This review identified similarities and differences in licensing policies for LCSWs, LPCs, and LMFTs. All 51 jurisdictions had statutory and/or regulatory language regarding post-graduate training and portability mechanisms to allow previously licensed providers to obtain licensure in their jurisdiction. We identified no jurisdiction that required specialized post-graduate training to serve children or related to cultural competence. Policies varied across states and across licensure types in terms of how minimum standards for post-graduate training are defined, how much post-graduate training is required, whether licensing boards must include a member of the public or represent a diversity of racial and ethnic backgrounds, and processes and requirements for license portability.

Jurisdictions considering changes to support trainees in obtaining clinical supervision can find potential options from a variety of sources. Based on results of a mandatory licensing

renewal survey in New Mexico in 2015, Altschul et al. recommended that provider agencies offer supervisors incentives and supports for providing clinical supervision to trainees, and jurisdictions permit the fulfillment of clinical supervision hours from an array of qualified, interdisciplinary behavioral health professionals (5). Healthcare Management Associates and the National Council for Mental Wellbeing have recommended leveraging state funds to provide reimbursement for the cost of supervision for providers seeking licensure to practice independently (10). University partnerships that match recent graduates with qualified supervisors, such as the University of Pittsburgh's LCSW Training Institute & Supervision Matching Program may serve as approaches to increase access to supervision (11). Although some accrediting institutions require that behavioral health degree programs include coursework on child development and cultural competency (12), states did not report requirements for post-graduate, pre-licensure training to work with children or develop a culturally responsive practice– or that information was not codified in law.

Jurisdictions have options beyond licensure to strengthen the workforce. To increase recruitment and retention of behavioral health providers who can provide culturally responsive care, Oregon created a Behavioral Health Workforce Initiative in 2021 (13). The initiative provides grants to pay experienced providers to supervise recent graduates who are Black, Indigenous, People of Color, tribal members, or residents of rural areas of the state. Published resources also exist that provide guidance for competency-based clinical supervision models (14), to improve the quality of care that is provided after licensure.

States considering structural reforms to increase their supply of qualified providers for children and youth could consider enacting requirements around licensing board structure, composition, and discretionary authority. Graddy and Nichol (15) found that the addition of public members increases the emphasis of board performance in the public interest; they also suggest requiring state senate approval of gubernatorial appointments to licensing boards. The existing body of research on these topics is limited and further exploration could be valuable to better understand their impacts on the size and quality of the behavioral health workforce.

Because of challenges around re-licensure for practitioners in military families, given frequent geographic relocations, many states have implemented measures to support practice across state lines for military spouses, including expedited applications, temporary licenses, or license reciprocity (16).

States, practitioner and regulatory board associations, and other interested parties are actively partnering to simplify the licensure portability process, increase access to treatment, and balance this with vetting standards intended to mitigate the risk of harm to the public (17). One strategy includes interstate compacts, wherein practitioners can hold one multistate privilege that is valid for practice in all compact states, and benefit from streamlined licensure requirements and fewer licensure fees (6,18). Through a cooperative agreement, Department of Defense funding will allow selected professions to work with the Council of State Government's National Center for Interstate Compacts to develop model interstate occupational licensure compact legislation (17). As of the date of this writing, professional counselors and social workers are among the licensed professions

that are currently developing or implementing an interstate compact, and applications for Counseling Compact privileges to practice are expected to open as early as 2024. Another option proposed by AAMFT is the "full endorsement" portability model, which supports the licensing of an applicant as a LMFT if the applicant has a valid and unrestricted license in another state. Finally, evaluation of public health emergency policies that modified licensing requirements for telehealth across state lines in response to COVID-19 could identify potential long-term benefits and/or unintended effects of maintaining those changes.

## Limitations

These findings are subject to the limitations associated with reliance on publicly available documents related to state licensing laws. Results represent discoverable jurisdictional policies in effect at the time of the review. Language related to jurisdictional requirements that are not in statutory or regulatory text (e.g., requirements outlined in licensing boards' operating procedures) might not have been revealed through this search.

## Conclusions

We documented similarities and variability across jurisdictions and across license types with respect to polices that set requirements for supervised post-graduate degree professional experience, licensing board structure, composition, and the scope of board authority, and licensure portability of LCSWs, LPCs, and LMFTs. Future research could assess how these structures and requirements promote or restrict the supply and quality of behavioral health care for children and families. Better understanding these policy options may help jurisdictions balance protection of consumer health and safety and expanding the behavioral health workforce to meet the existing demand.

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## References

1. Bitsko RH, Claussen AH, Lichstein J, et al. : Mental Health Surveillance Among Children — United States, 2013–2019. MMWR Suppl 2022 2022;71(Suppl-2):1–42.
2. Whitney DG, Peterson MD: US National and State-Level Prevalence of Mental Health Disorders and Disparities of Mental Health Care Use in Children. JAMA Pediatr 2019;173:389–91. [PubMed: 30742204]
3. McCarty RL, Schwartz MR, Skillman SM: Washington's Behavioral Health Workforce Assessment: Input from Key Informants. Seattle, WA: University of Washington Center for Health Workforce Studies, 2016. https://familymedicine.uw.edu/chws/wp-content/uploads/sites/5/2016/11/WA-BH-Key-Informants-FR-2016-Nov.pdf

4. Occupational Licensing: A Framework for Policymakers. Washington, D.C. U.S. Department of Treasury Office of Economic Policy Council of Economic Advisers and U.S. Department of Labor, 2015. https://obamawhitehouse.archives.gov/sites/default/files/docs/licensing_report_final_nonembargo.pdf
5. Altschul DB, Bonham CA, Faulkner MJ, et al. : State Legislative Approach to Enumerating Behavioral Health Workforce Shortages: Lessons Learned in New Mexico. Am J Prev Med 2018;54:S220–S9 [PubMed: 29779546]
6. Sustaining Georgia's Child and Adolescent Behavioral Health Workforce Through Supervision. Georgia, Voices for Georgia's Children, 2021. https://georgiavoices.org/wp-content/uploads/2021/03/BHWF-Brief-FINAL.pdf
7. Military Spouse Licensure: State Best Practices and Strategies for Achieving Reciprocity. U.S. Department of Defense, November 2019. https://download.militaryonesource.mil/12038/MOS/Reports/military-spouse-licensure-report-2019.pdf
8. Occupational Outlook Handbook for Social Workers, Marriage and Family Therapists, and Substance Abuse, Behavioral Disorder, and Mental Health Counselors. Bureau of Labor Statistics, U.S. Department of Labor, 2023. https://www.bls.gov/ooh/community-and-social-service/social-workers.htm; https://www.bls.gov/ooh/community-and-social-service/marriage-and-family-therapists.htm#tab-1; and https://www.bls.gov/ooh/community-and-social-service/substance-abuse-behavioral-disorder-and-mental-health-counselors.htm#tab-1
9. The School Counselor and Student Mental Health; in ASCA Position Statement. Alexandria, VA American School Counselor Association, Adopted 2009, Revised 2015 and 2020. https://www.schoolcounselor.org/Standards-Positions/Position-Statements/ASCA-Position-Statements/The-School-Counselor-and-Student-Mental-Health#:~:text=Although%20school%20counselors%20do%20not,developmental%20needs%20of%20all%20students
10. Behavioral Health Workforce is a National Crisis: Immediate Policy Actions for States. Health Management Associates and National Council for Mental Wellbeing, 2021. https://www.healthmanagement.com/wp-content/uploads/HMA-NCMW-Issue-Brief-10-27-21.pdf
11. LCSW Supervision Matching Program. Pittsburgh, PA, University of Pittsburgh School of Social Work, 2023. https://www.socialwork.pitt.edu/researchtraining/lcsw-training-institute-supervision-matching-program
12. Accreditation Standards: Graduate & Post-Graduate Marriage and Family Therapy Training Programs. Version 12.5. Council on Accreditation for Marriage and Family Therapy Education (COAMFTE), August 2021. https://coamfte.org/documents/COAMFTE/Accreditation%20Resources/COAMFTE%20Standards%20Version%2012.5%20-%20Published%20August%202021%20-%208.26.21%20(with%20links).pdf
13. Key Behavioral Health Investments (21–23 biennium) Expected to Increase Resources and Improve Outcomes for the Population Needing Intensive Services. Oregon, Oregon Health Authority, June 2022. https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le4247.pdf
14. Falender CA, Shafranske EP: Clinical supervision: A competency-based approach (2nd ed.). Washington, D.C., American Psychological Association, 2021.
15. Graddy E, Nichol MB: Structural Reforms and Licensing Board Performance. Am Polit Q1990;18:376–400.
16. License Recognition. Washington, D.C., Veterans' Employment and Training Service, U.S. Department of Labor. https://www.dol.gov/agencies/vets/veterans/military-spouses/license-recognition
17. Department of Defense Interstate Compact Support. National Center for Interstate Compacts, The Council of State Governments. https://compacts.csg.org/our-work/ics/
18. Meyers L: Interstate compact plan provides hope for licensure portability. Alexandria, VA, Counseling Today, American Counseling Association, April 2020. https://ct.counseling.org/2020/04/interstate-compact-plan-provides-hope-for-licensure-portability/

## Highlights

- All 50 U.S. states and the District of Columbia had laws in 2021 regarding post-graduate supervised experience and portability to allow LCSWs, LPCs, and LMFTs to obtain licensure in their jurisdiction.
- Policies varied across jurisdictions and licensure types in terms of definitions and minimums for post-graduate training, the composition of licensing boards, and processes and requirements for license portability.
- No jurisdictions required specialized training to serve children and families or related to cultural competence.
- Policy options could help jurisdictions balance protection of consumer health and expanding the behavioral health workforce to meet demand.