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Note

Breaking Barriers: Cross-State Licensing Reform for Licensed Professional Counselors

Madeleine Rossi*

The United States is facing a mental health crisis, in part driven by a lack of mental health counselors to meet increasing demand for services.1 Simultaneously, the country is experiencing an increase in the use of telehealth services that was accelerated by the onset and aftermath of the COVID-19 pandemic.2 Telemental health services, such as providing traditional talk therapy via an online videochat service, have the potential to increase access to mental healthcare across the nation. However, it can be extremely difficult for licensed counselors to provide these services across state lines. In most cases, to legally provide care, mental health counselors must hold licenses in both their home state and their client’s state of residence.3 Amidst a complex regulatory landscape, applying for multiple licenses is often a confusing and time-consuming endeavor.4 As such, state-by-state licensing requirements create unnecessary barriers to mental healthcare access by

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geographically limiting the range of practice for counselors. In an age where technical literacy and telehealth usage are increasing, licensing barriers unnecessarily restrict mental health counselors from expanding their teletherapy services. Some states have attempted to combat this issue by creating temporary statutory exemptions or pathways to reciprocal licensure. Additionally, an interstate compact for Licensed Professional Counselors, titled the Counseling Compact, will start taking applications from eligible counselors in 2024.5

These tactics, however, have and will continue to fall short of a workable solution. This Note first examines the history of occupational licensing for counselors, the current state of the regulatory landscape, and why it should be reformed. Next, it analyzes why current approaches to reform have been insufficient. It concludes by finding that states are unlikely to adequately address the issue on their own, leaving ample room for the federal government to step in. It proposes some ways that the federal government can address licensure portability, both by issuing guidance and by creating more federal pathways to multi-state licensure. Lastly, this Note addresses the potential disciplinary concerns associated with implementing cross-state licensing.

I. BACKGROUND

State-by-state counseling licensure has inadvertently created a huge burden on mental health counselors. To understand why this burden exists, it is first important to understand the history behind professional regulation in the United States. Part I explains how we got here, where we are now, and why there is room for change.

A. HISTORY OF COUNSELOR LICENSING

Occupational licensing has its roots in the regulation of medicine. The first licensing statutes were passed in the late 1860s when there was relatively open entry to the medical field.6 At the time, there were still no formal training requirements for

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physicians. Additionally, medical schools were numerous, primarily privately owned, and granted entry to nearly any applicant willing to pay tuition. The ease of entry into medicine created a surplus of physicians with differing curricular standards and diverging views on what constituted appropriate medical care. Because of this, states began to enact laws that gave them regulatory power over the profession. Wisconsin, South Carolina, and the Dakota Territory were the first to require either a Medical College Diploma or a Medical Society Certification to practice medicine. The main goals of these new laws were to protect the general public from incompetent doctors as well as standardize and improve the curriculum at medical schools.

The first iterations of these regulatory statutes were relatively lax, requiring only that a person had a diploma from a medical college, regardless of the curriculum, rigor, or credibility of the institution. Because nearly anyone could acquire a diploma, states revised the statutes in order to establish licensing boards as early as the 1870s. These boards were intended to evaluate medical colleges and determine their quality. No longer could any medical diploma grant entry into the field; the board first had to determine the adequacy of each school’s curriculum. In 1889, shortly after this development of licensing boards, a lawsuit challenging the validity of the West Virginia licensing statute made its way to the Supreme Court of the United States. The West Virginia statute was fairly representative of others at the time. It required that any medical practitioner petition the State Board of Health in order to obtain a certificate to practice medicine.

7. Id. at 174.
9. Id. at 75.
10. Baker, supra note 6, at 175.
11. Id. at 174.
12. Id. at 173.
13. Id. at 178.
14. Id. at 178.
15. Id. at 178.
16. Id. at 181.
this case, Frank Dent, had learned the practice of medicine through an apprenticeship with his father and received a diploma from the American Eclectic Medical College in Cincinnati.\textsuperscript{20} The State Board of Health determined that the institution was fraudulent and refused to issue a certificate to practice.\textsuperscript{21} Dent argued that the state did not have the right to interfere in the practice of a lawful profession, and therefore, that the regulation was unconstitutional.\textsuperscript{22} The Supreme Court disagreed, and held that "no one has a right to practice medicine without having the necessary qualifications of learning and skill."\textsuperscript{23} The case definitively established the right of the states to regulate professions through licensing.

The Supreme Court later expanded states’ ability to regulate licensed professions in \textit{Hawker v. New York}. The New York legislature had passed laws restricting the ability of convicted felons to practice medicine, regardless of whether they had met all other requirements.\textsuperscript{24} Dr. Hawker, a convicted felon, argued that the law should not apply to physicians who had been licensed prior to its enactment.\textsuperscript{25} In addressing the issue, the majority opinion reiterated the states’ interest in protecting their citizens from harm, and held that states may pass new regulations for the practice of medicine that would apply to those already in the field.\textsuperscript{26} They further expounded on the power of legislatures to enact licensure laws, including those that require a showing of "good character."\textsuperscript{27}

In subsequent decades, many additional professions became subject to licensing requirements and state board regulation. For example, the first nursing license was established in North Carolina in 1903 and Wyoming became the first state to require licenses for engineers in 1907.\textsuperscript{28} Whether a given profession is

\begin{footnotesize}
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\item State ex rel. Swearingen v. Bond, 122 S.E. 539, 541 (W. Va. 1924).
\item See \textit{Dent}, 129 U.S. at 114.
\item \textit{Id}. at 121.
\item \textit{Id}. at 123.
\item \textit{Hawker v. New York}, 170 U.S. 189, 190 (1898). It is interesting to note that Dr. Hawker was convicted for performing an abortion on a patient, which was a felony punishable by ten years of incarceration. \textit{Id}. This case questioned if he could retain his license post-conviction. \textit{Id}.
\item \textit{Id}. at 191.
\item \textit{Id}. at 197–98.
\item \textit{Id}. at 195.
\item Phoebe Pollitt & Wendy Miller, \textit{North Carolina, Pioneer in American Nursing}, 110 AM. J. NURSING 70, 70 (2010); \textit{Wyoming Paths to Professional}
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licensed or not will vary from state to state, but today about 21% of working Americans hold a professional license. The licensing of mental health counselors has a newer history. While the profession has been formally recognized for over a century, it was not until the late twentieth century that states began to impose licensing restrictions.

The counseling profession did not develop formal roots in the United States until the early 1900s. The first institution providing counseling services began in Boston in 1909, but the term “counseling” would not appear in print for another two decades. Over the first half of the twentieth century, different counseling specialties continued to spring up to address the needs of diverse clients. At the time, these counseling services were not necessarily focused on mental healthcare or therapy. For example, career development counselors appeared in schools and were soon mandated through the Smith-Hughes Act of 1917. As early as 1918, with the passage of the Soldiers Rehabilitation Act, Congress recognized the role of counseling in the health of disabled veterans. These rehabilitation counselors assisted with mental, physical, and emotional guidance to reintegrate disabled veterans into civilian employment. By 1929, New York City had the first marriage and family counseling center in the country, opened by married physicians Abraham and Hannah Stone.

Just like the earlier days of medicine, the emerging field of counseling had little supervision and was not regulated by any

31. Id. at 4.
32. Id. at 3.
33. Id. at 4.
34. Career development counselors assisted students with navigating entry into the working world. Id. at 4.
36. Leahy et al., supra note 30, at 4.
37. Id. at 4.
central body. The first licensing requirements did not appear until the 1970s. In 1974, the American Personnel and Guidance Association, now the American Counselor Association, released a statement titled “Counselor Licensure: Position Statement.” The Association called for the establishment of licensing requirements for professional counselors at the state level. The desire for regulatory standards was partly in response to external pressure coming from the regulation of psychologists. Counselors in a number of states had been threatened by state psychology boards and told to discontinue their practices or risk legal action for practicing psychology without a valid license. Broad statutory definitions of psychology tended to include at least some of the services commonly provided by counselors. Additionally, while states had previously allowed any person holding a doctoral degree to sit for the psychology licensing exam, in the 1970s, there was an increasing push to require that the doctoral degree be specifically in psychology. The simultaneous tightening of psychologist licensing requirements and broad definition of the practice of psychology threatened to box many existing counselors out of their professions. States began to take notice of this conflict, and just one year after the Association released their statement, Virginia passed the country’s first professional counseling licensing statute.

The Virginia legislation created a new board with an overarching responsibility to regulate the behavioral sciences professions. Sub-boards would supervise counselors, psychologists, and social workers. Other states quickly followed suit, and by the end of 1994, forty-one states, the District of Columbia, Guam, and Puerto Rico had all passed

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38. *Id.* at 3.
40. *Id.*
42. *Id.* at 604.
43. *Id.* at 605–06.
44. *Id.* at 604–05.
45. *Id.* at 605.
46. Leahy et al., *supra* note 30, at 7.
47. Cottingham, *supra* note 41, at 606.
licensing statutes.\textsuperscript{48} Today, mental health counselors in all fifty states and the five main U.S. territories, are regulated by licensing laws.\textsuperscript{49}

**B. MENTAL HEALTH COUNSELOR LICENSING TODAY**

Every state and territory in the nation regulates mental health professionals.\textsuperscript{50} Most commonly the license for a general practitioner is called a Licensed Professional Counselor (LPC). While the title will vary by state, this Note uses the term LPC to refer to all generally practicing mental health counselors.\textsuperscript{51} Some states have a two-tiered system where an LPC can work towards a higher credential, commonly titled a Licensed Professional Clinical Counselor (LPCC). Because this two-tiered system does not exist in every state, when a two-tiered system exists, this Note focuses on the lower of the two tiers. In addition to generally practicing mental health counselors, all states regulate specialized counselors. Each state has some form of license to regulate Marriage and Family Therapists (MFT),\textsuperscript{52} and states commonly regulate Drug and Alcohol Counselors (LADC).\textsuperscript{53} While MFTs and LADCs undoubtedly play a significant role in mental healthcare, this Note focuses on the regulation of LPCs.

While there are similarities across states, requirements to attain an LPC license vary widely.\textsuperscript{54} For example, while all states require either a master’s or doctoral degree, Utah requires sixty semester hours, while Minnesota requires forty-eight

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\textsuperscript{48} Leahy et al., supra note 30, at 7. \\
\textsuperscript{49} See Licensure Requirements, AM. COUNSELING ASS’N, https://www.counseling.org/knowledge-center/licensure-requirements (last visited Apr. 20, 2024) (including the District of Columbia, Puerto Rico, Guam, the Northern Mariana Islands, and the U.S. Virgin Islands). \\
\textsuperscript{50} Id. \\
\textsuperscript{51} Id. Other titles include but are not limited to: Licensed Mental Health Counselor (LMHC), Licensed Clinic Professional Counselor (LCPC), Licensed Professional Clinical Counselor of Mental Health (LPCC), Licensed Clinical Mental Health Counselor (LCMHC), and Licensed Mental Health Practitioner (LMHP). \\
\textsuperscript{52} AMFTRB Is . . . , AM. ASS’N FOR MARRIAGE & FAM. THERAPY, https://amftrb.org (last visited Dec. 1, 2023). \\
\textsuperscript{53} See, e.g., Licensed Alcohol and Drug Counselor (LADC), MINN. ELICENSING, https://mn.gov/elicense/a-z?id=108323136#list/appId/filterType/filterValue/page1/sort/order (last visited Apr. 20, 2024). \\
\textsuperscript{54} See Bradley, supra note 39, at 185.
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semester hours. Additionally, states will vary in the type of coursework required for the degree. Minnesota has ten required subject areas, while Idaho has eight. Although all eight of Idaho’s mandated subjects are reflected in Minnesota’s statute, the remaining two Minnesota subject areas are not required for LPCs in Idaho. Another major component of licensure is post-graduation supervised practice hours. All states require this, but the amount can vary from 1000 to 3000 hours. In addition to educational and experiential requirements, all states will require applicants to pass an exam before they can qualify for a license. Once these steps are complete, a prospective counselor must apply to their state board and pay the associated fees. There is typically a fee to apply and a fee for the license itself. If qualified, after a short waiting period, they will be officially licensed in that state. In a state like Minnesota, which requires 2000 post-graduate supervision hours, the entire process would take about three years. This does not take into account the time

55. UTAH CODE ANN. § 58-60-405 (LexisNexis 2023); MINN. STAT. § 148B.53 (2023).
56. IDAHO ADMIN. CODE r. 24.15.01.150 (2023); MINN. STAT. § 148B.53 (2023).
58. During post-graduation supervision, a trainee will meet with a board approved LPC for training and to discuss ongoing cases and treatment strategies. In Minnesota, two hours of direct supervision are required for each 40 hours of work. Often, the LPC in training will need to pay for the approved LPC’s supervision time. LPC Supervised Professional Practice, MINN. BD. BEHAV. HEALTH & THERAPY, https://mn.gov/boards/behavioral-health/applicants/supervised-professional-practice/lpc-supervised-professional-practice.jsp (last visited Apr. 20, 2024); MINN. STAT. § 148B.5301 Subd. 2(c) (2023); Tamara Suttle, Clinical Supervision and ‘Money Gouging’, TAMARA SUTTLE, https://tamarasuttle.com/clinical-supervision-and-money-gouging (last visited Apr. 20, 2024).
it would take to obtain a bachelor’s degree prior to applying for a master’s program.61

Regulation of the mental health profession serves an undeniably important public purpose. For example, the Minnesota Board of Behavioral Health and Therapy’s mission includes “protect[ing] the public” and “ensur[ing] a standard of competent and ethical practice.”62 State licensing boards also provide an important avenue for clients to lodge potential complaints.63 While most LPCs are trustworthy professionals who care for and respect their clients, there is always the potential for abuse in power-imbalanced relationships.64 A person seeking mental healthcare is often putting themself in a vulnerable position.65 Without proper oversight, this type of relationship is ripe for abuse by bad actors.66 State regulatory boards have an important role to play in ensuring that receiving therapy from an LPC will help rather than hurt the client. Verifying that a counselor has met the requirements for licensure is a large part of ensuring safety for clients, but state boards are also responsible for maintaining a complaint process, establishing disciplinary procedures, and determining appropriate disciplinary action.67 Typical disciplinary action includes license suspension, civil fines, or additional education

61. 2000 hours of practice is about fifty forty-hour work weeks. A master’s degree to complete the required forty-eight semester hours could be completed within two years while taking twelve credits a semester. In Minnesota, an LPCC requires 4000 hours of work, which would impose an additional year of supervised practice. MINN. STAT. § 148B.5301 (2023).
62. Licensed Professional Counselor (LPC), Licensing Contact, MINN. ELICENSING, https://mn.gov/elicense/a-z/?id=1083-231433#/list/appId//filterType//filterValue//page/1/sort//order (last visited Apr. 20, 2024).
66. Id.
67. Complaints and Discipline, supra note 63.
requirements. In extreme cases, an LPC’s license may be revoked.

Because of the structure of the state-by-state licensing scheme, counselors must be licensed by the board in each state in which they would like to practice. This means holding a license not only in their home state, but in each state where a client resides. If a client is temporarily living elsewhere, for example, a student who is away at school, their counselor must determine whether they can continue care based on both the student’s state of residence as well as the counselor’s state of residence. If a client is permanently moving out of state, that often means the end of the counselor-client relationship.

Today, 90% of Americans own a smartphone, which typically have the capability to connect remotely to virtual videochat sessions. Whether a client has permanently moved residences, or is temporarily out of state, most Americans should have the ability to attend a virtual therapy session with relative ease. However, licensing requirements can get in the way. In situations like this, statutory exceptions do provide one avenue for counselors to continue providing care. For example, in Minnesota, an LPC from another state can practice for up to thirty days in any calendar year as long as they are licensed and in good standing in their state of residence, provide proof of their good standing to the Minnesota Board, and are granted permission. Exceptions like this one can alleviate licensing concerns on a temporary basis. They also typically do not require an LPC to pay any monetary fees to the Board. However, most

68. See, e.g., Disciplinary/Corrective Actions, MINN. BD. OF BEHAV. HEALTH & THERAPY, https://mn.gov/boards/marriage-and-family/consumer-info/discipline (last visited Apr. 20, 2024) (providing a list of disciplinary decisions made by the Minnesota Board of Behavioral Health and Therapy).

69. Id.

70. College students are just one demographic with rising mental health needs. In the 2020-2021 school year, studies found that nearly two-thirds of college students “met the criteria for at least one mental health problem.” Zara Abrams, Student Mental Health is in Crisis. Campuses Are Rethinking Their Approach, 53 AM. PSYCH. ASSN. 60, 60 (2022).


73. MINN. STAT. § 148B.592 Subd. 5 (2023).
statutory exceptions are not automatic and still require an LPC to notify and receive permission from a state’s regulatory authority. They are also time limited and not a permanent solution.

Some states have also written reciprocity into their statutes. Reciprocity generally requires that an LPC has received their license from a state with “substantially similar” requirements to the one where they are seeking additional licensure. A person applying for reciprocity is applying for a full license under the new state, not just a temporary waiver or exception. As a result, they will need to apply to the relevant board, pay associated fees, and pay for the license itself. Some states may have additional elements or require an applicant to complete requirements that may not have been imposed by their home state. Once an LPC applies for a reciprocal license, the wait time can vary, but will commonly be over a month.

Another way that LPCs can practice in a state other than their own is if they work through certain federally funded programs. The federal government has the power to create certain conditions and requirements for federally funded programs, and the Constitution allows federal laws to preempt state laws that interfere with interstate commerce. In 2018, Congress passed the VA MISSION Act, which required the states to give automatic reciprocity to healthcare providers working within the Veteran Affairs System (VA). Automatic reciprocity allows a healthcare provider who is licensed and in good standing in their home state to treat any patient regardless of that patient’s location. They do not need to notify the state board where their patient is located or pay any fees. Similar reciprocity is required for clinicians within the federally funded Tri-Care system. Tri-Care is the comprehensive healthcare

74. See, e.g., MINN. STAT. § 148B.56 (2023).
75. For example, the Arkansas board requires all applicants to pass an oral interview in addition to the standard written exam. ARK. BD. EXAM’RS COUNSELING & MARRIAGE & FAM. THERAPY RULES § 3.2 (b) (2021).
78. Ateev Mehrotra et al., Telemedicine and Medical Licensure — Potential Paths for Reform, 384 NEW ENG. J. MED. 687, 688 (2021).
79. Id.
program for service members and their families.\textsuperscript{80} However, these federal opportunities are only available to a limited number of LPCs. For example, the VA did not start hiring counselors as part of its mental health program until 2010, and as of 2022 still only employed fewer than 500 LPCs and MFTs.\textsuperscript{81}

\textbf{C. The Need for Reform}

Throughout the United States, there are wide disparities in the availability of healthcare, particularly in access to mental healthcare.\textsuperscript{82} Rural counties are highly likely to be mental healthcare deserts, with 75\% of rural counties having either “no mental health providers or fewer than 50 per 100,000” residents.\textsuperscript{83} When a person puts off receiving care, they are more likely to require higher intensity, inpatient psychiatric care later on.\textsuperscript{84} Not only does this create a significant and negative strain on the patient, but it ultimately strains the entire healthcare system.

In addition to the lack of access to mental healthcare, the need for access has increased.\textsuperscript{85} In particular, the COVID-19 pandemic put both mental and physical stress on American people. Reported rates of anxiety and depression, drug overdose, alcohol-related deaths, and suicides all increased from 2019 to 2021.\textsuperscript{86} In the 18–24 age group, reports of anxiety or depression in 2023 were as high as 50\%.\textsuperscript{87} Additionally, while many surveys do not include youth under the age of eighteen, there has been

\begin{itemize}
\item \textsuperscript{80} TRICARE 101, TRICARE, https://www.tricare.mil/Plans/New (last visited Apr. 20, 2024).
\item \textsuperscript{81} U.S. GOVT ACCOUNTABILITY OFF., GAO-22-104696, VETERANS HEALTH CARE: EFFORTS TO HIRE LICENSED PROFESSIONAL MENTAL HEALTH COUNSELORS AND MARRIAGE AND FAMILY THERAPISTS (2022).
\item \textsuperscript{82} Kelly Livingston & Maggie Green, America’s Mental Health Care Deserts: Where is it Hard to Access Care?, ABC NEWS (May 18, 2022, 1:52 PM), https://abcnews.go.com/Health/americas-mental-health-care-deserts-hard-access-care/story?id=84301748.
\item \textsuperscript{83} Id.
\item \textsuperscript{84} Id.
\item \textsuperscript{87} Id.
\end{itemize}
an increased national concern around youth mental health. The U.S. Surgeon General, Dr. Vivek H. Murthy, indicated that both the pandemic and the widespread use of social media have contributed greatly to declining mental health among American youth. While the federal COVID-19 public health emergency officially ended in May 2023, the pandemic's social impacts will linger. During quarantine and social distancing measures, many children were denied important opportunities for social and academic development. In addition, it is unlikely that there will be any reduction in social media usage among that group, with more than half of U.S. teens (age thirteen to seventeen) reporting that “it would be hard to give up.” More than ever, Americans should be adding visits with mental healthcare providers into their health routine when needed.

However, even if a person lives in an area with sufficient mental healthcare providers, they may not be able to find a counselor who specializes in their needs. For example, the US Department of Health and Human Services found that youth with specific needs or vulnerabilities, such as youth with disabilities, racial and ethnic minorities, and LGBTQ+ youth have been most heavily affected psychologically by the COVID-19 pandemic. Due to their identity within a certain group, clients may want to work with a counselor who either identifies with that group or specializes in their treatment. Clients may

89. Id. at 3–4.
94. Id. at 11.
also seek out counselors with specific language skills other than English. Furthermore, once a client has found a counselor that they like, it can be disruptive to a client’s care if either they or their counselor relocate geographically. Even when a counselor does pursue licensure in a client’s new home state, the client may need to wait weeks or months for the license to become active. In a survey by Alma, an online therapy platform, nearly 70% of surveyed counselors reported that they had experienced losing a client due to that client’s relocation. Those same counselors overwhelmingly (89%) stated that they would support a system where their license was valid nationwide.

II. ANALYSIS

States have begun to take notice of the strain that the rigid licensing scheme has taken on LPCs. While some reforms have been made, they have and will continue to be inadequate. Part II explores the current approaches and why they are falling short. It then looks at opportunities for the federal government to work on licensure portability. Finally, it addresses concerns over cross-state licensing disciplinary actions.

A. CURRENT APPROACHES TO REFORM ARE INADEQUATE

Reciprocal licenses are currently the best option for LPCs who would like to either expand their practice to a new state or are considering a permanent change in residence. This process will look different depending on the state where the LPC’s original license is from and the new state that they are attempting to enter into. Some counselors may find it to be fairly straightforward, while others may spend months or years navigating the process. One survey found that 25% of counselors waited four to six months, and 11% waited seven to twelve months for reciprocal licensure. One counselor applying for reciprocity in Arizona detailed her experience online, eventually qualifying for the license after a total of seventeen months. The process can take time as well as cost a significant amount of

95. Burky, supra note 71.
96. Id.
98. Wilson, supra note 4.
money. At a bare minimum, a counselor pursuing a new license will need to pay the application and license fee for that state. They may also be required to take additional classes, sit for state-specific exams, or obtain additional hours of supervised practice. In extreme cases, an LPC may be forced out of the profession entirely or required to start their schooling over.\textsuperscript{99} The American Counseling Association has identified the portability of counselor licensure as “problematic” and a “crisis.”\textsuperscript{100} They describe receiving calls from counselors around the United States who feel trapped in their state of license.\textsuperscript{101}

Leniency and stringency vary by state and may fluctuate due to the current demand for LPCs. For example, during the COVID-19 pandemic, many states relaxed licensing and reciprocity requirements for a variety of healthcare professions. In Minnesota, Governor Walz recognized the increased need for mental healthcare and issued an executive order that gave near-automatic reciprocity to licensed counselors in other states.\textsuperscript{102} These counselors could provide telehealth services to Minnesota residents without the waiting period required for obtaining a reciprocal license, and were not restricted to a limited number of visits.\textsuperscript{103} Counselors needed only to register their interest with the Behavioral Health and Therapy Board and receive confirmation that their registration was received.\textsuperscript{104} Once these steps were complete, they could begin providing services. These special exemptions from state requirements ended about a year after they began when hospitalizations from COVID-19 decreased and pandemic-related measures were scaled back.\textsuperscript{105} While the existing thirty days of temporary practice exception could potentially ease the transition, the end of pandemic

\textsuperscript{99} The American Counseling Association publishes the experiences of professional counselors and has described a “licensure portability crisis.” See Anna Elliott et al., Interstate Licensure Portability: Logistics and Barriers for Professional Counselors, 9 PRO. COUNS. 252, 252 (2019).

\textsuperscript{100} The ACA Licensure Portability Model FAQs, AM. COUNS. ASS’N, https://www.counseling.org/docs/default-source/licensure/portability-faq.pdf (last visited Jan. 20, 2024).

\textsuperscript{101} Id.; Elliott et al., supra note 99, at 254.


\textsuperscript{103} Id.

\textsuperscript{104} Id.

measures abruptly halted many counselors’ ability to provide services to clients across state lines. The privilege of cross-state practice disappeared as quickly as it had been granted.

While individual states have the power to ease reciprocity requirements, as seen during the pandemic, they are unlikely to do so on their own. There is a longstanding history of states handling licensing requirements and regulations independently of one another. Occupational licensing schemes have developed independently of each other, in each state and territory, over the last one hundred and thirty years. Historically, licensure has been a means of professionalizing certain occupations, and local counselors may have a great desire to maintain control over their profession’s image and exclusivity through their state board. Additionally, there have been concerns that state boards are more “focused on protecting their members from competition rather than serving the public’s interest.” 106 The North Carolina State Board of Dental Examiners was successfully sued by the Federal Trade Commission (FTC) in 2014 for excluding certain non-dentist professionals from offering teeth-whitening services. 107 The FTC argued that the board’s actions were anticompetitive and contrary to the public interest. 108 For similar reasons, some boards have been challenged for their reluctance to allow virtual services. 109 In addition to the control asserted over the profession, boards collect revenue in the form of application, renewal, educational, and testing fees. They may be reluctant to allow nonresident counselors to bypass these fees. Despite these challenges, some attempts at licensure reform have been made in the past few decades.

One way that states are transforming the occupational licensing landscape is through interstate compacts. These compacts are agreements among participating states and territories that attempt to remove barriers for licensed professionals to practice outside of their state of residence. The currently operating compacts include, but are not limited to, the Interstate Medical Licensure Compact (IMLC) and the Nurse

106. Mehrotra, supra note 78, at 688.
107. Id.
108. Id.
109. Id.
Licensure Compact (NLC). The counseling profession is next in the long line of licensed professions to gain a compact. The Counseling Compact plans to become operational in mid-2024. However, it is unlikely to have a significant effect in meeting mental healthcare demands around the country.

Each compact operates in a distinct way, with varying benefits for member states and different degrees of usage among the affected professionals. For example, the IMLC is merely a centralized hub where physicians can apply for licensure in other states. The physician must still pay and satisfy the individual requirements of each participating state’s medical board where they would like to practice but can now do so through one centralized location. Once approved in the desired state, the physician becomes fully licensed in that jurisdiction. In contrast, the NLC operates as a multistate nursing license. Once a nurse applies and receives a compact license, they may practice in any member state as long as they are licensed and in good standing in their home state. The construction of the NLC is much more flexible and removes far more barriers than the construction of the IMLC. As a result, the two compacts have seen widely disparate usage. In 2020, nearly a quarter of all nurses held a multi-state license through the compact. In contrast, only approximately 10,000 physicians had applied for any license through the IMLC by August 2020. That represents about 1% of the active physicians in the United States.

111. Id.
113. Id.
114. Id.
115. Id.
States in that year.\textsuperscript{118} Although some of these physicians may have applied for multiple states, they are unlikely to have applied to all thirty-nine of the participating jurisdictions. In contrast, nurses with multi-state licenses through the compact automatically have the ability to practice in all forty-one NLC jurisdictions.\textsuperscript{119} The age of the compact is not contributing to this disparity, as both the NLC and IMLC in their current forms were established in 2015.\textsuperscript{120}

The Counseling Compact will operate more similarly to the IMLC than the NLC. Counselors will need to apply for a “compact privilege to practice” through each state in which they wish to provide services.\textsuperscript{121} It is unclear whether fees will be associated with each application to a new state through the compact.\textsuperscript{122} Because counselors will be applying to each new state individually, they may also be required to sit for additional examinations before being granted a “privilege to practice.”\textsuperscript{123} While the compact will certainly assist and streamline the application process by creating a centralized location for applications, it does not significantly reduce the piecemeal approach of applying for multiple licenses state-by-state.

Another barrier is that interstate compacts require voluntary participation from states and territories. At first glance, the Counseling Compact has made great strides in expanding its membership. Currently, the total number of member states had increased to thirty-four.\textsuperscript{124} However, there is

\textsuperscript{118} There were approximately 1,018,776 licensed physicians in the United States in 2020. Aaron Young et al., \textit{FSMB Census of Licensed Physicians in the United States}, 2020, 107 J. MED. REGUL. 57, 57 (2021). The 10,000 physicians who had applied for licenses through the IMLC by August 2020 represent .98% of that total. \textit{Id}.

\textsuperscript{119} \textit{NURSE LICENSURE COMPACT, supra} note 114.

\textsuperscript{120} While an original version of the NLC was originally adopted in 2022, the compact began to stall and ultimately ceased. In 2015, new legislation was introduced and ultimately adopted to reflect the current version of the NLC. Sandra Evans, \textit{The Nurse Licensure Compact: A Historical Perspective}, 6 J. NURSING REGUL. 11, 14 (2015); Ian Marquand, \textit{The IMLCC: The First Year}, 3 INTERSTATE MED. LICENSURE COMPACT 1, 1 (2022).

\textsuperscript{121} FAQ for Counselors, COUNSELING COMPACT, https://counselingcompact.org/faq (last visited Jan. 25, 2024).

\textsuperscript{122} States will have the ability to set fees and costs associated with applying for a privilege to practice. This information will not be available until the compact is fully operational. \textit{Id}.

\textsuperscript{123} \textit{Id}.

\textsuperscript{124} Map, COUNSELING COMPACT, https://counselingcompact.org/map/ (last visited Jan. 25, 2024).
one notable state absent from membership. California has introduced, but not enacted, any legislation regarding the Counseling Compact, and has also not joined the IMLC.125 Legislation to join the NLC was introduced in February 2024.126 Based on their lack of participation, it is unlikely that California will quickly join the Counseling Compact. Unfortunately, California is the resident state of nearly half of the nation’s LPCs.127 Because the Counseling Compact is designed to benefit counselors whose home state is a compact member, all California-based counselors will be excluded from the compact.128 One final downside to the Counseling Compact is that it is only available for LPCs. Although this Note does not focus on other counselor license types, it is important to mention that specialized Marriage and Family Therapists, as well as Licensed Drug and Alcohol Counselors, will not be eligible to participate in the compact.

B. THE PATH FORWARD

The Counseling Compact is a good first step towards licensure reform and is an indication of the desire for greater flexibility and licensure portability. Counselors around the country should have the option to expand their licensing in order to meet the growing demand for services. In theory, an interstate compact should increase counselors’ ability to do so by issuing licenses to states where an LPC could engage with clients through telehealth. However, as it is currently structured, the Counseling Compact is unlikely to address this issue meaningfully. It is likely to see low utilization, similar to the IMLC, and will only be available to about half of all LPCs. Although an interstate compact modeled after the NLC could significantly open up multi-state licensing, changing a compact’s

125. Id. (showing legislation in California was filed, but not enacted); Participating States, INTERSTATE MED. LICENSURE COMPACT, https://www.imlcc.org/participating-states (last visited Apr. 20, 2024).
128. Counselors who hold a license in a state that is part of the compact, but is not their home state, are not eligible to apply for privileges to practice. FAQ for Counselors, supra note 121.
structure is difficult once adopted. Compacts require legislation that states agree to verbatim. They cannot be unilaterally amended, and all participating states must agree to any changes. Because of the difficulty in amending the existing Counseling Compact, as well as states’ general unwillingness to cede control over licensing requirements, there is room for the federal government to step into this gap. First, the federal government should pressure states to work together in an effort to increase licensure portability. Second, the federal government should explore ways to create more federal pathways to multi-state licensure in addition to the current reciprocity offered through the VA and Tri-Care systems.

1. Federal Guidance to the States

The federal government has indicated an interest in addressing the mental health challenges faced by Americans today. Additionally, in 2018, the FTC released a policy paper detailing options to increase portability for occupational licenses. The FTC and the Surgeon General are well positioned to offer joint guidance to the states that focuses specifically on the need for LPC (and other licensed mental health professions) licensure portability. In the Surgeon General’s advisory report on protecting youth mental health, they identified expanding the use of telehealth and the mental health workforce as two ways that state governments could combat the mental health crisis. Their guidance does not include reference to the current barriers that counselors have faced when attempting to expand their practices across state lines through virtual counseling. Combined guidance from the FTC and Surgeon General could highlight the intersectionality and urgency of this issue.

In issuing any such guidance, the federal government should put an emphasis on solutions that will have the broadest reaching effects. For example, the FTC has identified “Harmonization of Licensure Requirements” as one way to both

130. Id.
131. Id.
133. FTC Policy Paper, supra note 129.
increase confidence in licensed practitioners and to make it easier for them to either expand their practice across state lines, or transfer their license in the event of a change of residence.\footnote{135 FTC Policy Paper, supra note 129, at 20–21.} In issuing such harmonization guidance, the FTC and Surgeon General should focus on reducing the barriers to entry in states that have the most restrictive qualification requirements rather than increasing requirements in less restrictive states. The FTC should conduct research into which qualifications are necessary for a counselor to have adequate training. In doing so, they may find that some states would need to increase their required practice hours or add certain educational focus areas. However, by focusing on reducing barriers, this guidance could ensure that the majority of currently licensed LPCs would benefit from harmonization rather than impose additional requirements on current practitioners. This requires analyzing the current standards in three main areas: Education Requirements (including semester hours and specific coursework), Experiential Requirements, and Exam Requirements. Releasing one standard for states to model their statutes after could reduce the burden associated with overhauling existing regulatory schemes.

In addition to harmonizing licensure requirements, federal guidance could encourage reciprocity based solely on an LPC’s good standing in their home state. This would function in much the same way that many emergency orders were structured during the pandemic. An LPC licensed and in good standing in their home state would be able to practice, without applying for a formal license, in any other jurisdiction as long as they notified the board. This type of reciprocity eliminates both the fees and waiting period associated with current reciprocal licenses.

One way that the federal government can influence states to align themselves with federal guidance would be through funding incentives. The federal government allocates grants to the states for a variety of purposes, but the vast majority of those funds are dedicated to healthcare.\footnote{136 What Types of Federal Grants Are Made to State and Local Governments and How Do They Work?, TAX POLICY CTR. (last updated Jan. 2024), https://www.taxpolicycenter.org/briefing-book/what-types-federal-grants-are-made-state-and-local-governments-and-how-do-they-work.} Grants are sometimes awarded according to specific criteria or to incentivize policy
change. Funding incentives which use a carrot approach, meaning that they give the state funds to implement a desired policy, have been shown to increase the rate at which the policies are adopted. Because the federal government already funds healthcare initiatives so heavily, there are ample opportunities to use existing grants as incentives. For example, the government currently administers the Community Mental Health Services Block Grant program to help states and territories provide community health services. Grants such as this one could be tiered, with higher funding amounts going to states that had either decreased reciprocity barriers for LPCs or had aligned themselves with a national licensing standard. There are numerous other grant, incentive, and aid opportunities that could be used to encourage state compliance with a national standard for LPC licensure.

C. FEDERAL PATHWAYS TO MULTI-STATE LICENSURE

The federal government also has an opportunity to expand cross-state licensure through the doctrine of federal preemption. The Constitution allows Congress to regulate interstate commerce and to preempt state laws that may interfere with those goals. As previously described, the VA MISSION Act expanded cross-state licensure to many medical professions, working within the VA systems, including mental health counselors. In 2013, a bill proposed in the House titled the “TELE-MED Act of 2013” proposed a similar scheme for Medicare providers. Although ultimately not enacted into law, the bill would have permitted practitioners to provide telemedical services to Medicare beneficiaries anywhere in the United States, provided that they were licensed and in good

138. Id. at 718.
139. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT (2023).
140. For example, another federal block grant focused on mental health is the Substance Use Prevention, Treatment, and Recovery Services Block Grant. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., SUBSTANCE USE PREVENTION, TREATMENT, AND RECOVERY SERVICES BLOCK GRANT (2023).
141. Legal Info. Inst., supra note 77.
142. Mehrotra et al., supra note 78, at 688.
standing in their home state. Medicare did not cover mental healthcare services at the time; in January 2024, Medicare began covering services provided by licensed LPCs and MFTs. Allowing LPCs working with Medicare patients to have automatic reciprocity would greatly expand telehealth access to Americans sixty-five and older, a population that is also more likely to experience mobility burdens and may benefit from telemedicine options. Future federal laws could expand this model to include other federally funded programs, such as Medicaid.

Finally, the federal government could consider a federal licensing scheme. In 2012, Senator Tom Udall began drafting legislation that would create a federal licensing scheme specifically for physicians. Although the bill was ultimately never introduced, it would have worked in tandem with state boards and specifically authorized the use of telemedicine. The tandem license would require a physician to hold one state license (in their state of residence) and one national license. As long as their state license was in good standing, they could then provide telehealth services nationally through their national license.

Although Senator Udall was focused on physicians, this kind of regulatory scheme would work extremely well for LPCs. LPCs regularly provide traditional talk-therapy services, a model that is highly adaptable to telemedicine. A national telehealth license would greatly expand LPCs’ ability to expand their practices and provide care across state lines. Because they would still be required to hold a license in their home state, the state boards would still retain control over the LPCs within their borders. One of the main concerns with allowing cross-state telehealth visits is the handling of disciplinary concerns. There

144. Id.
145. CTRS. FOR MEDICARE & MEDICARE SERVS., MEDICARE & YOUR MENTAL HEALTH BENEFITS 7 (2023).
147. Id.
could potentially be an increase in complaints against providers who are not within the state, and it may be more difficult for boards to police bad behavior. Section D addresses these concerns.

D. CROSS-STATE DISCIPLINARY CONCERNS

Licensure reform will need to contend with the issue of maintaining disciplinary control over the counseling profession. State boards play a critical role in taking disciplinary action against providers who violate their duty of care to their clients. Additionally, boards are responsible for safeguarding the residents of their state from unlicensed, incompetent, or predatory practitioners. Allowing counselors in other states to provide services across state lines would require boards to relinquish some control over these duties. However, all proposed licensure reforms still require an LPC to be licensed and in good standing in their state of residence. Regulations could require counselors to list their license type and state of resident in a manner that is easily accessible to their clients. Clients would simply make a complaint to the board in their counselor’s state of residence, rather than the board in their own. State boards would still have full control over their resident counselors, whether the complaint ultimately comes from outside the state or within.

Furthermore, states that have expanded telehealth opportunities to out-of-state practitioners have seen few complaints. For example, Florida passed legislation in 2019 that made it easier for healthcare workers to provide telemedicine services to Florida residents from other states.\textsuperscript{149} Cross-state registrations began in October 2019, and only sixteen complaints were filed against out-of-state providers between then and January 2023.\textsuperscript{150} Of the ten complaints that had concluded before January 2023, nine were found to have not committed a licensure violation.\textsuperscript{151} The one complaint where a violation was found resulted in a guidance letter, but no further disciplinary action was taken.\textsuperscript{152} Widespread usage of telehealth is still in its

\textsuperscript{150} Id. at 7.
\textsuperscript{151} Id.
\textsuperscript{152} Id.
infancy, and data on cross-state licensure disciplinary actions is sparse. However, early results from states that have embraced licensure flexibility have not yet raised any cause for concern.153

III. CONCLUSION

Mental health service providers are uniquely situated to be a priority for both the federal and state governments when reforming licensure portability. Both the states and the federal government have identified a mental health crisis in the United States. The pandemic has only increased the need for mental health access while simultaneously increasing telemedicine usage. Additionally, LPCs and the FTC have long been aware of the hard burden that state-by-state licensing has placed on licensed professionals. Practitioners in various medical professions have chronicled the strain that moving, or having a client move, has put on the continuity of care. Lastly, LPCs are ready and able to offer telehealth services.154 Most counselors offer traditional talk therapy, which can easily be administered online. Online services are not only easy to adapt to but may reduce costs for clients. A counselor who exclusively offers virtual services need not rent office space, and a client who struggles with mobility due to a disability or financial strain can attend their appointments from home. Clients who reside in rural counties, often mental health care deserts, would be able to attend sessions without excessive travel times. Virtual services are also optimal for people who work traditional hours, as they can easily take an appointment in the middle of the week without having to spend extra time traveling to and from a counselor’s office. The state-by-state licensing scheme has not yet caught up to a world where virtual services are both available and desirable. An LPC who is effective, respectful, and well-liked by their clients in Minnesota will be no less good at

153. As teletherapy usage by out-of-state providers increases states should continue to monitor complaint rates. Few complaints could indicate few violations, but it could also indicate that virtual therapy clients with out-of-state providers are less likely to report.

154. During the pandemic, many mental health professionals moved their practices online. In surveys of those practitioners, a majority responded that they would not be returning to in-person full time. The mental health field generally expects that remote therapy will become a dominant clinical practice. David Scharff, The Data Are In: Telehealth is Here to Stay, PSYCH. TODAY (Nov. 10, 2021), https://www.psychologytoday.com/us/blog/psychoanalytic-exploration/202111/the-data-are-in-telehealth-is-here-stay.
their job in Washington. The states and the federal government
have a vested interest in helping counselor licensure find its way
into the twenty-first century.