THE ASSISTANT SECRETARY OF DEFENSE

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WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

AUG 2 8 2006

The Honorable John W. Warner
Chairman, Committee on Armed Services
United States Senate
Washington, DC 20510-6050

Dear Mr. Chairman:

I am forwarding the enclosed report as requested by House Conference Report 109-360, which accompanied H.R. 1815, National Defense Authorization Act for Fiscal Year 2006. The report requested the Secretary of Defense to report on actions taken to improve the efficiency and effectiveness of procedures to facilitate physician referral and supervision of licensed mental health counselors (LMHCs).

The enclosed report incorporates information gleaned from each of the Services as well as the TRICARE Regional Offices regarding practices related to LMHCs. In addition, a review of accrediting agencies, Masters in Counseling program requirements, state law and regulations, and a demonstration project previously reported to Congress were used in preparing this report.

In summary, this report states that efforts are being undertaken at the service delivery level to facilitate access to LMHCs and that referral to LMHCs has been strengthened through the use of primary care physicians as the referral source. To ensure that the quality of care provided to our beneficiaries is not compromised by differences in scope of training and experience from other currently authorized mental health providers, LMHCs receive reimbursement for services provided under TRICARE as long as such services are supervised by a physician. Further exploration of issues such as supervision, referral, provider credentialing, and scope of practice may help us develop options for LMHC utilization that would preserve quality of care, safeguard the health and wellbeing of Service members, and maximize access to mental health care for all beneficiaries.

Thank you for your continued support of the Military Health System.

Sincerely,

William Winkenwerder, Jr., MD

cc:
Senator Carl Levin

Aspects of the Use of Licensed Professional Counselors in the Military Health System

Report to Congress

June 2006

I. Report Name

Aspects of the Use of Licensed Professional Counselors in the Military Health System.

II. Purpose

To respond to Congressional interest and inquiries regarding the use of Licensed Professional Counselors (LPCs) in the Military Health System (MHS) and specifically to Conference Report 109-360 that accompanied H.R. 1815.

III. Background

Licensed Professional Counselors (also practicing under the titles of Licensed Mental Health Counselor, Licensed Professional Clinical Counselor, Licensed Mental Health Professional, and others) are trained health care providers practicing in a wide variety of settings and specialty areas. The title "Licensed Professional Counselor" is the one most commonly used by the States in their licensing statutes. The practice of counseling is generally defined as the application of human development, psychological, or mental health principles through cognitive, affective, behavioral or systemic intervention strategies that address wellness, personal growth, or career development, as well as pathology. Practice settings and concentration areas include: addictions and dependency; aging and gerontology; career development; childhood and adolescence; clinical mental health; corrections and offenders; couples and family; counselor education and supervision; depression; grief; chronically or terminally ill; disaster counseling; eating disorders; mental health and agency counseling; rehabilitation; school; sexual abuse recovery; and sports counseling.

TRICARE recognized LPCs as health care providers as early as 1988, requiring their practice to be under the supervision of a physician in serving TRICARE beneficiaries.

10 U.S.C § 1079 (a) (8) states in pertinent part that, "Services of pastoral counselors, family and child counselors (other than certified marriage and family therapists) may not be provided unless the patient has been referred to the counselor by a medical doctor for treatment of a specific problem with the results of that treatment to be communicated back to the medical doctor who made the referral."

Demonstration Project for Expanded Access to Mental Health Counselors: The National Defense Authorization Act for FY 2001 (P.L. 106-398, Section 731) directed the Department to conduct a demonstration project under which licensed and certified professional mental health counselors who met eligibility requirements for participation as providers under TRICARE could provide services to covered beneficiaries without referral by physicians (as is now required) or adherence to physician supervision requirements. The evaluation of the demonstration compared the treatment outcomes of TRICARE beneficiaries treated by psychologists, social workers, marriage and family therapists, and primary care physicians with those of licensed professional counselors. Additionally, the evaluation provided comparisons of reimbursement and administrative costs, as well as level of access to mental health services under TRICARE.

The RAND report that published the results of the Demonstration Project in 2005 cited the following:

1. "The impact on beneficiaries, providers, and the TRICARE program from expanding access to LPCs for providers and beneficiaries was minimal."
2. "... our results revealed a significant decrease in the likelihood of beneficiaries seeing a psychiatrist and a decrease in the likelihood of their receiving a psychotropic drug in the demonstration areas."

3. "... merely lifting administrative requirements for the provision of mental health care, by itself, is unlikely to result in expanded access and utilization, especially when beneficiaries already have access to other types of mental health providers who do not have the same administrative requirements as the LPCs but can provide many similar services."

After looking carefully at the results of this demonstration and RAND report, the Department concluded that the findings did not provide compelling evidence to change its current policy for referral from a physician for each new clinical case and ongoing physician supervision of mental health counselor services.

In 2005, Conference Report 109-360, accompanying H.R. 1815, required the Secretary of Defense to submit a report to Congress on certain aspects of the use of LPCs in the MHS including the following:

1. Actions taken to improve the efficiency and effectiveness of procedures to facilitate referral and supervision of licensed mental health counselors;
2. A description of "best practices" employed throughout the MHS to ensure access to services provided by mental health counselors under the TRICARE program; and
3. A review of the quality of care provided by licensed mental health counselors in the MHS.

IV. Aspects of LPC Education, Training and Licensure

1. Graduate Education and State Licensure

   The majority of LPCs are Master's-level trained practitioners who complete 48 semester credit hours or more of instruction and a variable number of hours in a practicum or internship. There is no widely accepted training standard for LPCs. State licensing requirements permit a range of experiences for licensees (See Table A). The single most common training standard is that offered by the

Council for the Accreditation of Counseling and Related Programs (CACREP). CACREP, an affiliate of the American Counseling Association, is recognized for its high standards for curriculum, clinical instruction and program outcomes. However, the core CACREP accreditation standard is relevant to all settings and concentration areas in which LPCs practice. With this in mind, it is important to note that the great majority of the States do not require that a LPC graduate from a mental health specialty counseling program in order to be licensed to assess and treat persons with mental disorders. Therefore, a majority of LPCs have a minimal exposure to classroom study of mental disorders and perhaps little to no direct clinical experience with individuals with serious mental illness by the time they have earned their degree.

TABLE A: Training Standards Identified by States for Licensure of LPCs

Training Standard	Required Educational Credits for Masters Degree	Required Clinical Practicum +/- Internship	# States Using Standard*
Council for the Accreditation of Counseling and Related Education Programs (CACREP)	-48 semester hrs -60 semester hours for mental health counseling specialty	-700 hours for standard counseling degree (no req'd experience in mental health setting) -1000 hours for mental health counseling specialty (incl 360 direct service hours) in a mental health setting	17
Commission on Rehabilitation Education (CORE)	Masters in Rehabilitation Counseling	700 hours (incl 280 direct service hours to individuals with disabilities).	2
Regional or Other State Accreditation	Program dependent. Generally 48 to 60 semester hours	Program dependent. No specified standard for practicum/internship length unless specified by State.	10
i) Masters in Counseling **ii) Graduate degree in allied mental health or related field** **iii) Graduate degree including advanced counseling**	-Program dependent. 42-60 semester hours of graduate work +/- specific counseling course work. -Some States permit Master's in a "related" field with board determining if program is equivalent to counseling. Only specialty mental health counseling programs require specific skill in the diagnosis and treatment of persons with mental disorders.	Program dependent. Generally internship of not fewer than 600 hours. Programs tend to gear requirements to ensure that graduates qualify to sit for credentialing exams.	18

*Indicates the number of states using the indicated standard as their least rigorously defined requirement. Several states permit more than one education/training standard for licensure.

2. Supervised Training and State Licensure

The supervised training required by States is highly variable (Table B). The range of requirements is between one and four thousand hours of supervised clinical experience and zero to 200 hours of face-to-face clinical supervision.

Many States depend on individual training programs to determine the depth and breadth of education and training in the profession. In addition, many States fail to define the length and type of post-graduate clinical experience necessary to ensure competence for practice in specific treatment settings. Currently LPCs may qualify for licensure on the basis of post-graduate clinical experience in career counseling and then practice independently in a completely different treatment setting. The Department is concerned that the education and training LPCs receive in preparation for career counseling may not adequately prepare them for practice in a community mental health clinic where they will see individuals with diagnosable mental disorders.

TABLE B: Summary of State Post-Graduate Clinical Experience and Supervision Licensure Requirements

Supervised Clinical Experience[a]			Face-to-Face Supervision[b]		
Hours	States	% of US Population[c] Represented	Hours	States	% of US Population[c] Represented
<2000	11: SC, TN, WI, AZ (if CACREP grad), ID, IA, NM, NC, MT, LA, TX	21.51	None Required	29: TN, UT, WV, SC, RI, OH, PA, OK, OR, NY, NM, MS, NJ, MI, MN, MT, AZ, AR, CO, CT, DC, GA, IL, KS, MA, ME, AL, DE, MD	52.31
2000-2999	8: RI, WA, GA, ME, MD, OH, OR, SD	13.22	1-100	14: FL, IN, KY, LA, NH, NC, ND, VT, VA, WA, WY, AK, IA, HI	21.1
3000-3499	20: WY, AL, AK, CT, IL, NY, ND, IN, KY, MA, AZ (if NOT CACREP grad), MI, MS, MO, NE, NH, OK, VT, DE, HI)	30.17	101-199	SD	0.27
3500-3999	2: DC, PA	4.56	1 hour per	4: NE, WI, ID, MO, TX	12.83

			week		
>4000	3: KS, UT, VA	4.27			
3 yrs. Post-masters supervised exp.	1: AR	0.95			
2 yrs. Post-masters supervised exp.	4: CO, FL, WV, NJ	9.86			
Submit supervision plan to board	1: MN	1.75			
No State Licensure Offered	2: CA, NV	12.75	No State Licensure Offered	2: CA, NV	12.75

[a]Generally indicates clinical activities overseen by an approved supervisor while in the practice of professional counseling. Some States require the supervisor be on-site. Some States require all hours to be direct client contact hours, others permit a portion of the required hours to be in related activities such as preparing case notes, case consultation, etc. When a distinction is made, only direct client hours are counted for the purposes of this table.

[b]Generally refers to supervision that is live, interactive and visual. Most States permit up to one-half of these hours in group rather than individual supervision. Audio or video supervision with no interaction with the supervisor would not qualify for face-to-face supervision.

[c]Based on 2000 US Census

V. Issues of Access to and Quality of Care of LPCs in the MHS

1. Referral and Supervision Issues

Communication with administrators in the MHS has revealed methods undertaken to improve the availability and efficiency of physician referral and supervision to LPCs. For instance, in areas where there may be a shortage of psychiatrists, ValueOptions (the behavioral health managed care contractor in the TRICARE South region) has worked with other provider types such as pediatricians or primary care physicians to provide the referral and oversight. ValueOptions has also worked very closely with a number of Military Treatment Facilities (MTFs) to identify MTF physicians willing to provide referral and oversight.

Health care administrators have further commented on the difficulty in ensuring relevant physician supervision, particularly when the LPC and physician are not practicing in the same location.

2. Access to LPCs' Practice

Access to LPCs within MTFs has been facilitated in some instances through credentials review and privileging. Navy Fleet and Family Support Programs (FFSP) have identified States in which LPCs are explicitly authorized to independently diagnose, initiate, alter and terminate a regimen of clinical care. LPCs from those States can be granted a waiver of referral/supervision requirements on a case-by-case basis after review to determine if the practitioner's education, training and experience meet Navy [SECNAVINST 1754.7A] standards. In those instances where those standards are met, access to LPCs is unrestricted.

3. Quality of Care and LPCs

Quality of Care for mental health practitioners in the MHS is determined largely by the credentialing process and application for TRICARE provider status. This ensures a baseline level of education, training and experience, but does not measure "in-practice" quality of care. Adverse events and complaints against practitioners are also tracked as a measure of quality of care. However, data does not exist that would permit any conclusions regarding adverse events and patient complaints filed against LPCs.

When using the strict criteria established above to privilege LPC providers, Navy FFSPs have not noted any consistent differences in the quality of care provided by LPCs when compared to other Master's-level practitioners. Similarly, no qualitative differences in care are noted by health care administrators operating in the TRICARE managed care system.

VI. Issues Related to Practice Authority for LPCs in the MHS

1. Provider Shifting:

It is critically important that combat veterans seeking care for war-related mental health disorders (e.g., posttraumatic stress disorder, major depression, generalized anxiety disorder, pain disorder, adjustment disorder) receive medically appropriate, high quality behavioral health services. The assessment for the need to institute

pharmacologic treatment for the range of illnesses present in warfighters is considered a critical component of high quality care. The RAND finding that providing non-referral, non-supervised access to LPCs resulted in "... a significant decrease in the likelihood of beneficiaries seeing a psychiatrist and a decrease in the likelihood of their receiving a psychotropic drug ..." strongly suggests that if the conditions of the demonstration were adopted, service members may receive a level of care insufficient to the seriousness of their mental health problem.

2. *Lack of uniformity in LPCs pre-practice training, education and experience standards:*

The Department assures that TRICARE beneficiaries receive quality healthcare through rigorous requirements for academic and professional credentials, relevant experience, licensure, and periodic recertification of authorized providers. The generally recognized standard for the education and training of providers who evaluate and treat the mentally ill includes psychopathology, family systems, pharmacology, differential diagnosis, normal development and the special needs of populations. Well-established, nationally recognized accreditation bodies assure that all TRICARE-certified psychiatrists, psychologists, social workers, clinical nurse specialists, and marriage and family counselors meet this standard. On the other hand, there is no well-established, nationally recognized accreditation body for LPCs. States have a wide range of standards, licensure and certification requirements for LPCs. While CACREP accredits mental health counselor training programs that are in compliance with the nationally recognized standards, there are only 17 States that explicitly require graduation from a CACREP-accredited school to qualify for state licensure. The absence of a national homogeneous standard curriculum to guide the training of LPCs fails to meet beneficiaries' expectations for the national, uniform quality of care that is the Department's mandate. This mandate recognizes standards for health care systems such as those created by the Joint Commission on Accreditation of Healthcare Organizations.

3. *Ability to safeguard the safety and well-being of service members with serious health diagnoses*

   Though the scope of LPCs clinical practice overlaps with other Master's level counselors (e.g., Licensed Clinical Social Workers), theoretical orientations and treatment emphasis have considerable variation. Further removed from the "medical model," such counselors may be less timely in recognizing symptoms of major psychiatric disorders (e.g., major depression, posttraumatic stress disorder, generalized anxiety disorder). In a bio-psycho-social continuum of assessment, this licensure is less likely to be familiar with bio-medical and bio-psychiatric aspects. This could result in a delay in a timely biomedical assessment, differential diagnosis, and biomedical treatment for these conditions.

VII. Conclusions

1. Efforts are being undertaken to a limited degree at the service delivery level to facilitate access to LPCs. These efforts are particularly important in those areas with a low concentration of mental health providers.
2. Physician oversight of LPC clinical work appears difficult to ensure to any great degree. Health care administrators admit that supervision occurs predominantly on paper.
3. Referral to LPCs has been strengthened through the use of primary care physicians as the referral source.
4. There remains significant variability among the states in training programs and requirements for licensure as a mental health counselor. As shown in Table A, some counselors attend training programs accredited by the CACREP, a nationally recognized accrediting agency, while many do not. In most states a qualifying education requires only minimal coursework in diagnosis and treatment of mental disorders and no specific clinical experience with individuals with mental disorders. In some states licensure as a professional counselor can be obtained with a Masters-

level postgraduate degree in fields only "related" to counseling. While there is evidence that the extent of training variability has decreased over time, it remains a reality that professional counselors licensed to practice have an unevenness of exposure to classroom education and supervised clinical experiences in the assessment and treatment of persons with mental disorders.

5. The Department is committed to providing the highest quality clinical care possible to all DoD beneficiaries. Currently, LPCs receive reimbursement for services provided under TRICARE as long as such services are supervised by a physician. The purpose of this supervision is to ensure that the quality of care provided to our beneficiaries is not compromised by differences in scope of training and experience from other currently authorized groups of providers.
6. Given the practical obstacles to physician supervision of LPCs and the perceived impediment to accessing services caused by the physician referral requirement, it would be prudent to explore issues of supervision, referral, provider credentialing, and scope of practice to develop options that would preserve quality of care, safeguard the health and well-being of Service members and maximize access to mental health care for all beneficiaries. An examination of these issues would certainly support other activities having the goal of improving mental health care to veterans, active duty service members and their families, including the recent creation of the DoD Task Force on Mental Health.