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A Crazy System: Mental Health Care Delivery in America

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A CRAZY SYSTEM: MENTAL HEALTH CARE DELIVERY IN AMERICA

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INTRODUCTION

The recent attention to catastrophic health care, mandatory health insurance and the "health insurance gap" have focused on the problems of providing adequately for the physical health needs of Americans.[1] Lost in the debate, as it has so often been, is the problem of providing for mental health services.[2] The failure to consider mental health services' needs is expensive in terms of human and social problems that unnecessarily go unresolved.[3] It also may be expensive in terms of physical health care costs; there is increasing evidence that mental health and physical health care are closely related and the failure to provide for mental health services may drive up the costs of physical health care.[4]

This Article reviews the need (met and unmet) for mental health services, the value of providing for better mental health services, mechanisms for delivering and paying for mental health services, government-sponsored mental health programs, licensing of mental health professionals and other legal limitations on those who can provide certain mental health services, and the prospects for future mental health services.

The thesis of the Article is that there has been, and is, a large unmet need for mental health services in America, and that the mental health care delivery system has been so poorly put together that it is incapable of meeting a major portion of the need for services. Indeed, the term "system" is unwarranted if it implies the existence of a single, organized or integrated mechanism of providing mental health care services. In fact, the "system" is fragmented, inconsistent from part-to-part, and full of holes, so that a con-

1. *E.g.*, Higgins & Meyers, *The Economic Transformation of American Health Insurance: Implications for the Hospital Industry*, 11 HEALTH CARE MGMT. REV. 21 (1986); Robinson & Luft, *Competition and the Cost of Hospital Care, 1972-1982*, 257 J.A.M.A. 3241 (1987); Zook, Moore & Zeckhauser, *"Catastrophic" Health Insurance—A Misguided Prescription?*, 62 PUB. INTEREST 66 (1981).

2. The provision of mental health services since World War II has improved, but services are still not available to many, including those who need them most. *See infra* notes 50-99 and accompanying text.

3. If mental health care can reduce mental illness, then the failure to provide mental health services will increase the level of mental illness in society. This untreated illness can reasonably be expected to increase such antisocial activity as child abuse, criminal conduct, absenteeism, underemployment and unemployment, family abandonment, and drug and alcohol abuse.

4. *See infra* notes 42-49 and accompanying text.

siderable portion of those needing mental health services do not receive them.

Contributing to the failure of the system have been years of neglect and a series of private and governmental mistakes. In reality, mental health care delivery is a product of political, social, and economic forces that too often have not taken adequate account of the needs of those the system should be serving. Federal government policies have changed with administrations and, therefore, have been shifting and inconsistent. Insurance reimbursement schemes have often been antagonistic to mental health care and have traditionally limited reimbursement to services provided by (or under the direction of) physicians, in part reflecting a strong medical bias on the part of the major health insurance providers and in part reflecting the difficulty of determining what mental health care is legitimate. The professions have not established the scientific bases for the success or failure of various types of mental health treatments and have too often been engaged in turf-protecting wars. In addition, the licensing system is inadequate to assure reasonably competent and honest practice.

The prospects for providing better mental health care in the future will be bright only if there are changes in the attitudes of those who provide reimbursement for health services (the government, employers, and private insurers), and if mental health professionals more carefully define essential and effective mental health services. Those who directly pay for services must be convinced that mental health services are a means of reducing total health care costs. Certain forms of psychotherapy must be recognized as mechanisms for dealing with serious emotional problems rather than a form of personal development or "growth" therapy. The forms of therapy that are effective must be identified. Licensing procedures must be improved to help ensure that only reasonably competent practitioners are licensed. The mental health professions must be able to establish "standard" practices that are based on effective therapy.

The mental health care delivery system is the means by which society determines what services will be available, their quality, who will receive them, their cost, and their financing. Mental health care delivery is rarely like a free, competitive market economy. A number of factors interfere with the operation of pure competition. For example, there is no free access to mental health markets (*e.g.*, licensing is required), patients do not have complete knowledge of the various services available and their efficacy, and insurance and other third-party payers warp normal costing and demand principles. Even with the increased emphasis on promoting some competi-

tion-like aspects of health care, which started in the early 1980s, the system is far from a freely competitive market.

THE DEMAND FOR MENTAL HEALTH SERVICES

The Incidence of Mental Illness

At least 15 percent to 20 percent of the population is currently in need of mental health services, and a third of us will experience a significant mental disorder at some point. The President's Commission on Mental Health reported that at any given time, about 15 percent of the population of the United States is in need of some form of mental health services.[5] More recently, a study of mental conditions in the country has revealed that over a six-month period, 17 percent to 23 percent of the population may suffer a psychiatric or emotional condition (based broadly on DSM-III categories).[6] Furthermore, about one-third of the population (ranging from 29 percent to 38 percent) has experienced a psychiatric or emotional condition during their lifetimes (again, based broadly on DSM-III categories in three metropolitan areas).[7] These studies suggest a huge need for mental health services, much of which goes unmet.[8]

General health care service costs have increased significantly. Health care costs now exceed 11 percent of the gross national product, and they continue to grow.[9] By the mid-1980s, American corporations paid more in health insurance premiums than they paid to shareholders in dividends,[10] and

5. PRESIDENT'S COMMISSION ON MENTAL HEALTH, *Report of the President's Commission on Mental Health* (1980).

6. Myers, Weissman, Tischler, Holzer, Leaf, Orvaschel, Anthony, Boyd, Burke, Kramer & Stoltzman, *Six-Month Prevalence of Psychiatric Disorders in Three Communities*, 41 ARCHIVES GEN. PSYCHIATRY 959, 966 (1984) (the study was a careful review of conditions in three metropolitan areas).

7. Robins, Helzer, Weissman, Orvaschel, Gruenberg, Burke & Regier, *Lifetime Prevalence of Specific Psychiatric Disorders in Three Sites*, 41 ARCHIVES GEN. PSYCHIATRY 949, 952 (1984). The two articles cited in notes 6 and 7 are part of an excellent and very large study of the prevalence of psychiatric conditions, based on National Institute of Mental Health (NIMH) epidemiological catchment area programs. Several articles in 41 ARCHIVES OF GEN. PSYCHIATRY No. 10 describe the study. *See* EPIDEMIOLOGIC FIELD METHODS IN PSYCHIATRY: THE NIMH EPIDEMIOLOGIC CATCHMENT AREA PROGRAM (W. W. Eaton & L. Kessler eds. 1985).

8. *See supra* notes 6 & 7. *See generally* Knesper, Belcher & Cross, *Variations in the Intensity of Psychiatric Treatment Across Markets for Mental Health Services in the United States*, 22 HEALTH SERVICES RESEARCH 797 (1988).

9. Flinn, McMahon & Collins, *Health Maintenance Organizations and Their Implications for Psychiatry*, 38 HOSP. & COMMUNITY PSYCHIATRY 255 (1987).

10. Califano, *A Corporate Rx for America: Managing Runaway Health Care Costs*, 2 ISSUES IN SCI. & TECH. 81 (1987). *See* Tsai, Bernacki & Reedy, *Mental Health Care Utilization and Costs in a Corporate Setting*, 29 J. OCCUPATIONAL MED. 812 (1987).

more than 10 percent of the federal government's budget went for two major health care programs, Medicare and Medicaid.[11]

The Nature of Mental Health Services

The level and nature of mental health services has changed dramatically since World War II. While there has been a significant increase in the number of mental health care episodes, there also has been a substantial decrease in the percentage of mental health care episodes that involve mental hospital admission.[12] These changes are demonstrated by the fact that in 1955, there were 1.7 million such episodes in the United States, with more than 75 percent of these services being provided in inpatient facilities. By 1977, there were nearly 7 million patient care episodes of which only 27 percent were in psychiatric inpatient services.[13] Even controlling for population growth, the number of patient care episodes per 100,000 population tripled during the period. These data do not include mental health care provided by partial care facilities such as halfway houses, private office practice, and general hospital medical services, and, therefore, considerably understate the true rate of mental health care episodes. It appears that between 8 and 10 million people utilized mental health services in 1975, but it is estimated that the unmet need for additional services included 11 to 16 million people.[14]

The number of mental health care episodes in *state* mental hospitals decreased from 850,000 to 576,000 annually during this period.[15] This decline reflected the discovery of psychotropic drugs, restrictive involuntary civil commitment statutes, improved psychological rehabilitation techniques, increased use of community mental health services, and financial incentives to transfer long-term mental patients to nursing homes.[16] [17] It also reflects the fact that hospitalization for mental conditions has shifted from mental hospitals to general hospitals. In 1965 there were 180,000 general hospital psychiatric inpatient episodes, while in 1979 there were approximately 1.2 million

11. Short & Goldfarb, *Redistribution of Revenues Under a Prototypical Prospective Payment System: Characteristics of Winners and Losers*, 6 J. POL'Y ANALYSIS & MGMT. 385 (1987).

12. A "mental health care episode" is an admission to an inpatient facility or presence on the role of an outpatient facility.

13. M. WITKIN, TRENDS IN PATIENT CARE EPISODES IN MENTAL HEALTH FACILITIES 1955-77 (National Institute of Mental Health Statistical Note 154, 1980).

14. Kiesler, *National Health Insurance Testimony to the House of Representatives*, in PSYCHOLOGY AND NATIONAL HEALTH INSURANCE: A SOURCEBOOK (C. Kiesler, N. Cummings & G. VandenBos eds. 1980).

15. M. WITKIN, *supra* note 13.

16. Okin, *State Hospitals in the 1980s*, 33 HOSP. & COMMUNITY PSYCHIATRY 717 (1982).

17. Kiesler, *Mental Hospitals and Alternative Care*, 37 AM. PSYCHOLOGIST 349 (1982).

general hospital psychiatric admissions. Thus, the total number of mental health related hospital episodes may have increased even though the number of patients in mental hospitals has decreased. By one estimate, mental illness still is responsible for nearly one quarter of the total hospital inpatient days.[18]

Between 1957 and 1976, there was a substantial increase in the number and percentage of the population using professional mental health services; it increased from 14 percent to 26 percent.[19] Of course, the increase in the demand for mental health services was reflected in the number of mental health professionals, which increased more than fivefold between 1947 and 1977.[20] During this thirty-year period, the number of psychologists and psychiatrists increased tenfold.[21] The costs of providing these mental health services also grew to $20 billion by 1980.[22] Ironically, the most seriously disturbed were not receiving adequate service,[23] and the real costs of mental illness were estimated to be $73 billion, even excluding drug and alcohol problems.[24]

Nearly 70 percent of the money spent on mental health care is for hospitalization. While 70 percent of mental health care costs are for inpatient care, over 70 percent of the mental health care services are for outpatient treatment.[25] The federal government currently pays about 40 percent of health care expenditures, the largest component of which is hospital reimbursement.[26] Thus, the relatively high cost of inpatient care means that there is a significant incentive to use outpatient mental health services as a means of reducing total health care costs.

The level of underutilization of mental health services, or the size of the unmet demand for those services, is most notable.[27] It is apparent from the

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18. C. KIESLER & A. SIBULKIN, MENTAL HOSPITALIZATION: MYTHS AND FACTS ABOUT A NATIONAL CRISIS (1987).

19. Kulka, Veroff & Douvan, *Social Class and the Use of Professional Help for Personal Problems*, 1957 and 1976, 20 J. HEALTH & SOC. BEHAV. 2 (1979).

20. The increase was from 23,000 in 1947 to 121,000 in 1977. D. MECHANIC, MENTAL HEALTH AND SOCIAL POLICY (2d ed. 1980).

21. Cummings & Duhl, *The New Delivery System*, in THE FUTURE OF MENTAL HEALTH SERVICES: COPING WITH CRISIS 85 (L. Cummings & N. Cummings eds. 1987).

22. Mechanic, *Correcting Misconceptions in Mental Health Policy: Strategies for Improved Care of the Seriously Mentally Ill*, 65 MILBANK Q. 203 (1987).

23. *Id*; *see generally* F. CHU & S. TROTTER, THE MADNESS ESTABLISHMENT (1974).

24. H. HARWOOD, D. NAPOLITANO & P. KRISTIANSEN, ECONOMIC COSTS AND SOCIETY OF ALCOHOL AND DRUG ABUSE AND MENTAL ILLNESS (1983).

25. Kiesler, *Public and Professional Myths About Mental Hospitalization*, 37 AM. PSYCHOLOGIST 1323 (1982).

26. DeLeon & VandenBos, *Psychotherapy Reimbursement in Federal Programs: Political Factors*, in PSYCHOTHERAPY: PRACTICE, RESEARCH, POLICY (G. VandenBos ed. 1980).

27. Goldman, Gattozzi & Taube, *Defining and Counting the Chronically Mentally Ill*, 32

data reported above that only a relatively small proportion of the group needing treatment in one year will actually receive mental health care.[28]

THE BENEFITS OF MENTAL HEALTH CARE

Efficacy of Therapy

Early studies of the efficacy of psychotherapy suggested that therapy was of little value.[29] Later studies with improved research methodology utilizing meta-analysis have demonstrated a general efficacy of psychotherapy. Smith, Glass and Miller reviewed 475 studies involving controlled evaluations of psychotherapy by considering "effect sizes" of psychotherapy.[30] They found that on average, a person after psychotherapy was better off than 80 percent of those who did not receive psychotherapy, while 9 percent of those who received psychotherapy were worse off than those who did not receive it. Their study was evaluated and amplified by Landman and Dawes, who came to similar conclusions.[31] The Office of Technology Assessment, a scientific study arm of Congress, reviewed the literature on psychotherapy outcomes. It also concluded that psychotherapy in general is effective.[32] Shapiro and Shapiro, using refined meta-analysis techniques devised by Smith, Glass and Miller, concluded that in general there is moderate positive effect found for psychotherapy.[33]

While evidence exists for the positive effects of psychotherapy generally, the more difficult question is what forms of therapy are most effective. One

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HOSP. & COMMUNITY PSYCHIATRY 21 (1981); *Test Effective Treatment of the Chronically Mentally Ill: What Is Necessary?*, 37 J. SOC. ISSUES 71 (1981). *See* Leaf, *Factors Affecting the Utilization of Specialty and General Mental Health Services*, 26 MED. CARE 9 (1988).

28. *See supra* notes 5 - 7 & 19 - 24.

29. Eysenck, *The Effects of Psychotherapy: An Evaluation*, 16 J. COUNSELING PSYCHOLOGY 319 (1952). *See* H. Eysenck, The Effects of Psychotherapy (1966); May, *For Better or For Worse? Psychotherapy and Variance Change: A Critical Review of the Literature*, 152 J. NERVOUS & MENTAL DISEASE 184 (1971).

30. M. SMITH, G. GLASS & T. MILLER, THE BENEFITS OF PSYCHOTHERAPY (1980). Effect size is the mean difference between treated and control groups, divided by the standard deviation of the control group. Effect size is thus a standardized mean difference that can be used to compare several different rating systems, instruments and therapies. It is therefore useful in reviewing a large number of studies of the consequences of therapy.

31. Landman & Dawes, *Psychotherapy Outcomes: Smith and Glass' Conclusions Stand Up Under Scrutiny*, 37 AM. PSYCHOLOGIST 504 (1982). *See also* Howard, Kopta, Krause & Orlinsky, *The Dose Effect Relationship in Psychotherapy*, 41 AM. PSYCHOLOGIST 159 (1986) (50 percent of the patients of psychotherapy were improved measurably by the eighth session, 75 percent by the 26th session; there was not much of an increase beyond that).

32. OFFICE OF TECHNOLOGY ASSESSMENT, THE EFFICACY AND COST-EFFECTIVENESS OF PSYCHOTHERAPY (1980).

33. Shapiro & Shapiro, *Meta-Analysis of Psychotherapy Outcome Studies: A Replication and Refinement*, 92 PSYCHOLOGICAL BULL. 581 (1982).

author counted 160 "brand names" of psychotherapy[34] and, as the Office of Technology Assessment noted, it is critical to know which types of psychotherapy in each setting are best for a patient. However, existing data do not, in most cases, answer these questions.[35] Although Shapiro and Shapiro found a modest superiority of cognitive and behavioral methods of psychotherapy and modest inferiority of psychodynamic and humanistic therapies,[36] these findings have been criticized.[37] While there has been some suggestion that for even severely disturbed patients intensive outpatient care is more effective than intensive inpatient care,[38] it is generally concluded that "the present evidence does not permit the identification of any procedures or techniques that are clearly ineffective or unsafe or that any are clearly more effective than others."[39]

In addition to the issue of the efficacy of various kinds of therapy, the question of comparative cost-effectiveness arises.[40] That is, determining how effective various therapies are per dollar cost of providing them. Several studies indicate that for most patients, mental hospitalization is less cost-effective than outpatient therapy.[41] The difficulty in establishing clear differences in the effects of different kinds of therapy makes it impossible to do a detailed cost-effectiveness analysis. The absence of these kinds of data is probably a major factor in the reluctance of government and private insurers to expand mental health care coverage. Because the most effective therapy may depend on the mental condition, age and status, feelings about therapy, and so on, a complicated series of studies will be necessary to determine which therapies are effective in what circumstances.

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34. Parloff, *Psychotherapy Research Evidence and Reimbursement Decisions: Bambi Meets Godzilla*, 139 AM. J. PSYCHIATRY 718 (1982).

35. OFFICE OF TECHNOLOGY ASSESSMENT, *supra* note 32; Banta & Saxe, *Reimbursement for Psychotherapy*, 38 AM. PSYCHOLOGIST 919 (1983).

36. M. SMITH, G. GLASS & T. MILLER, *supra* note 30, at 18.

37. McGuire & Frisman, *Reimbursement Policy and Cost-Effective Mental Health Care*, 38 AM. PSYCHOLOGIST 935 (1983).

38. Binner, Halpin & Potter, *Patients, Programs and Results in a Comprehensive Mental Health Center*, 41 J. CONSULTING & CLINICAL PSYCHOLOGY 148 (1973); Cassell, Smith, Gruenberg, Boan & Thomas, *Comparing Costs of Hospital and Community Care*, 23 HOSP. & COMMUNITY PSYCHIATRY 197 (1972).

39. Parloff, *supra* note 34.

40. *See* T. MCGUIRE, FINANCING PSYCHOTHERAPY: COSTS, EFFECTS AND PUBLIC POLICY (1981).

41. Kiesler, *Mental Hospitals and Alternative Care*, 37 AM. PSYCHOLOGIST 349 (1982) (reviewing 10 studies where patients were assigned either to inpatient or to outpatient care; the outpatient care was consistently more positive than inpatient care). *See also supra* note 38.

Mental Health Coverage and Health Care Savings

An important question in assessing the cost effectiveness of mental health care is the effect that the mental health care coverage has on total health care cost. Reductions are likely in total costs if patients can be diverted from expensive hospitalization to less expensive outpatient care. One study found that the cost of *comprehensive* mental health care benefits was less expensive than *selected* mental health benefits.[42] One reason for this may be that comprehensive coverage encourages outpatient care, while selected coverage encourages inpatient care. It is also possible that comprehensive services encourage early (and less expensive) treatment.

Providing mental health services may lower total health care spending by reducing the use of physical health care services. There is considerable evidence that emotional factors may cause or aggravate physical disorders. From 6 percent to 86 percent of patients in general medical settings have been found to have psychological disorders.[43] Perhaps half of the patients with psychological disorders are seen by nonpsychiatric physicians.[44] For patients with health problems, providing mental health services can significantly reduce total medical services costs.[45]

One problem with providing mental health services as part of general health insurance has been that the use of these mental health services often increases significantly. For example, when Chrysler increased employee mental health coverage, the use of these services increased more than 600

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42. Cohen & Hunter, *Mental Health Insurance: A Comparison of a Fee-for-Service Indemnity Plan and a Comprehensive Mental Health Center*, 42 AM. J. ORTHOPSYCHIATRY 146 (1972). Selective mental health benefits cost $13.80 per member, comprehensive benefits cost $3.88. If outpatient service results in even a minor reduction in inpatient services, the cost savings can be quite substantial. Therefore, even though increased mental health services were provided under the comprehensive plan, the total cost was lower because of the reduction in inpatient services. For a review of studies regarding psychotherapy and medical care utilization, see Jones & Vischi, *Impact of Alcohol, Drug Abuse and Mental Health Treatment on Medical Care Utilization: A Review of the Research Literature*, 17 MED. CARE 1 (1979).

43. Schlesinger, Mumford & Glass, *Mental Health Services and Medical Utilization*, in PSYCHOTHERAPY: PRACTICE, RESEARCH, POLICY 96 (G. VandenBos ed. 1980). One implication of the Schlesinger study is that general health care costs may be increased if mental health services are not provided to those who need them.

44. Regeir, *The Nature and Scope of Mental Health Problems*, in 1 PRIMARY CARE: VARIABILITY AND METHODOLOGY IN MENTAL HEALTH SERVICES IN GENERAL HEALTH CARE (Institute of Medicine, National Academy of Sciences 1979); Yates, *How Psychology Can Improve Effectiveness and Reduce Costs of Health Service*, 21 PSYCHOTHERAPY 439 (1984).

45. Yates, *supra* note 44. *See* Holder & Blose, *Changes in Health Care Costs and Utilization Associated with Mental Health Treatment*, 38 HOSP. & COMMUNITY PSYCHIATRY 1070 (1987).

percent.[46] However, even though covering mental health services increases the resources devoted to these services, the mental health costs are offset by a reduction in general medical utilization. Furthermore, mental health services may significantly reduce other costs (absenteeism and antisocial behavior) that are real industrial or social costs, but are not reflected in health care costs.[47]

There is evidence that medical services utilization may be reduced for virtually all mental health diagnostic groups by providing psychotherapy.[48] The level of this reduction can be significant, perhaps ranging from 25 percent to 60 percent reduction in general medical utilization when general mental health care benefits are available.[49] These data may be considered tentative, but they do suggest the very real possibility that increasing mental health services may reduce total health care costs. Additional studies concerning the effect of mental health services on total health care costs are continuing. If the data reported above are confirmed, it is reasonable to expect that mental health care services could be expanded as a way of reducing total health care costs.

Thus, while it is not yet possible to compare the efficacy or cost effectiveness of various kinds of mental health services, there is significant evidence for the following propositions:

1. In general, mental health care is effective in promoting change or improving the mental condition of patients ("curing") faster than without treatment.

2. Provision of comprehensive mental health services may be less expensive than providing selective (inpatient) mental health services only.

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46. Califano, *Califano Speaks on Health Care Costs at Gracie Square Celebration*, Psychiatric News, Aug. 3, 1984, at 14, *quoted in* Kiesler & Morton, *Psychology and Public Policy in the "Health Care Revolution,"* 43 AM. PSYCHOLOGIST 993, 998 (1988).

47. Kiesler & Morton, *supra* note 46.

48. Rosen & Wiens, *Changes in Medical Problems and Use of Medical Services Following Psychological Intervention*, 34 AM. PSYCHOLOGIST 420 (1979). *See infra* note 49.

49. Schlesinger, Mumford and Glass considered 11 studies involving the use of medical utilization by those receiving psychotherapy. They found that following psychotherapy, patient medical utilization dropped approximately 25 percent. Schlesinger, Mumford & Glass, *Mental Health Services and Medical Utilization*, in PSYCHOTHERAPY: PRACTICE, RESEARCH, POLICY (G. VandenBos ed. 1980). Cummings found that the availability of mental health services reduced general medical utilization for patients by up to 60 percent. Cummings, *The Anatomy of Psychotherapy Under National Health Insurance*, 32 AM. PSYCHOLOGIST 711 (1977). For a review of a number of studies suggesting that mental health services may reduce total medical care usage for a number of conditions, see D. UPTON, MENTAL HEALTH CARE AND NATIONAL HEALTH INSURANCE 113-27 (1983); Mumford, Schlesinger, Glass, Patrick & Cuerdon, *A New Look at Evidence About Reduced Cost of Medical Utilization Following Mental Health Treatment*, 141 AM. J. PSYCHIATRY 1145 (1984).

3. Providing effective mental health services reduces the demand for physical health care and thereby may reduce total health care costs.

Given these propositions it is somewhat surprising that coverage for mental services has been so limited. The explanation may lie in the historical development of private and governmental health care coverage, with its emphasis on hospital care. It may relate to the absence (until recently) of incentives to cut costs and provide efficient services, and it may relate to the fact that only recently have dependable data concerning the benefits of mental health care coverage been available. To the extent that new systems of physical care put an emphasis on keeping patients out of the hospital and reducing total health care costs, coverage for outpatient mental health care may become increasingly important.

PROVIDING MENTAL HEALTH SERVICES

As noted, estimates are that at any time at least 15 percent to 20 percent of the population is in need of mental health services, and that a third of the population has experienced a mental disorder during their lives.[50] Despite this broad need, or perhaps in part because of it, the provision of mental health services has been very limited both in terms of reimbursement for service and in terms of the variety of professionals whose services are covered for reimbursement. This Article now briefly considers the coverage of mental health services by private insurers and the government, and the limitations on the mental health professional whose services will be covered by insurance or government programs.

Insurance and Mental Health Services

Following World War II there was dramatic growth in the health insurance industry. Private health insurance became a standard employment fringe benefit.[51] Although the tendency until the early 1980s was to expand coverage, mental health coverage still lagged behind physical health insurance, with severe limits on coverage for inpatient days and even more limits on outpatient services.[52] By the 1980s, some benefit programs had substan-

50. *See supra* notes 5-7 and accompanying text.

51. *See* Banta & Saxe, *Reimbursement for Psychotherapy*, 38 AM. PSYCHOLOGIST 919 (1983); Ruby, *The Policy Implications of Insurance Coverage for Psychiatric Services*, 7 INT'L J. L. & PSYCHIATRY 269 (1984).

52. *See* R. H. FELIX, MENTAL ILLNESS—PROGRESS AND PROSPECTS (1967); P. MARGO, R. GRIPP & D. MCDOWELL, THE MENTAL HEALTH INDUSTRY: A CULTURAL PHENOMENON (1978); T. MCGUIRE, FINANCING PSYCHOTHERAPY: COSTS, EFFECTS AND PUBLIC POLICY (1981). Regarding alternative financing for certain types of care, see Harris & Bergman, *Capitation Financing for the Chronic Mentally Ill: A Case Management Approach*, 39 HOSP. & COMMUNITY PSYCHIATRY 68 (1988).

tially reduced previous coverage gains.[53] When health maintenance organizations (HMOs) were recognized and protected by Congress, they were required to provide comprehensive health care, with the exception that they could limit inpatient and outpatient services for mental health care.[54]

The reasons for this limitation on benefits may have to do with the difficulty in determining when mental health services are really necessary or when a patient is malingering or a mental health professional is providing unnecessary services. Mental health injuries may seem less real than observable physical injuries. Much mental health treatment is seen as general improvement or growth-oriented rather than curing a disease, and in that sense appears to be elective or even cosmetic. Some forms of therapy, for example, traditional psychoanalysis, are very extended and quite expensive. Psychotherapy is criticized as being "insubstantial care for self-defined illnesses with no clear indication of starting or finishing and no way to judge effectiveness—whether there are results worth paying for." [55] These attitudes may explain why insurance companies and employers who purchase health insurance for their employees may not see mental health coverage as important or attractive.[56]

Despite setbacks in other areas, in some areas coverage for mental illness may be increasing a bit as a result of state legislative action and the changing nature of health care. A number of states have now passed mental health "parity" statutes.[57] These laws require that insurance carriers within the state provide mental health coverage on the same basis or to the same extent as physical coverage. The purpose of these statutes is to prevent unfair discrimination against those with mental illness. The Supreme Court has upheld the constitutionality of such statutes, and their popularity seems to be growing.[58]

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53. The federal government, for example, in 1981 began cutting mental health benefits in its Federal Employees Health Benefits Program through Blue Cross and Blue Shield. Outpatient visits were limited to 50 annually, inpatient days were limited to 60 and co-payments were raised from 20 percent to 30 percent. Regarding the general reduction in mental health benefits, see Rinella, *Ethical Issues and Psychiatric Cost-Containment Strategies*, 9 INT'L J. L. & PSYCHIATRY, 125, 126-131 (1986).

54. Health Maintenance Organization Act of 1973, Pub. L. No. 93-222 (1973). *See* Blonstin & Marclay, *HMOs and Other Employee Health Plans: Coverage and Employee Premiums*, 6 MONTHLY LAB. REV. 28 (1983).

55. McGuire, *Markets for Psychotherapy*, in PSYCHOTHERAPY: PRACTICE, RESEARCH, POLICY 76 (G. R. VandenBos ed. 1980).

56. For some other perspectives on the causes of inadequate mental health care, see F. CHU & S. TROTTER, *supra* note 23; ISSUES IN THE POLITICAL ECONOMY OF HEALTH CARE (J. McKinlay ed. 1985).

57. McGuire & Montgomery, *Mandated Mental Health Benefits in Private Health Insurance*, 7 J. HEALTH POL. POL'Y & L. 380 (1982).

58. Metropolitan Life Insurance Co. v. Massachusetts, 41 U.S. 724 (1985). Heitler, *Man-*

As we shall see, several changes in delivery of health services, such as the emphasis on coverage of all medical care and not just hospital based services (*e.g.*, HMOs), may ultimately encourage greater coverage of some outpatient mental health services.[59] If they can reduce the incidence of physical health problems or hospitalization, then there will be a strong economic incentive to provide them.

State and Local Government Programs

Governments have long accepted some responsibility for dealing with and caring for the mentally ill.[60] It has traditionally fallen to state and local governments to offer mental health facilities through asylums, the involuntary civil commitment process and indigent care programs for some patients unable to pay.[61]

States generally fund a wide variety of mental health programs. The development of private insurance and the reduction in the number and size of state mental hospitals have reduced the relative importance of state services.[62] Further, while state and local governments maintain a major responsibility for providing mental health care to the indigent, since the 1960s the federal government has taken an increasingly larger role.[63] The federal program coverage for mental health services is now a major factor in determining the extent of mental health care available.[64]

The Federal Government

The major federal involvement in efforts to provide mental health services came after World War II. During the war nearly 1.9 million men were re-

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dated Benefits: Their Social, Economic, and Legal Implications, 11 L., MED. & HEALTH CARE 248 (1983).

59. Flinn, McMahon & Collins, *Health Maintenance Organizations and Their Implications for Psychiatry*, 38 HOSP. & COMMUNITY PSYCHIATRY 255 (1987); Marshall, *HMOs and Psychiatry: Could There Be a Silver Lining?*, 10 INT'L J. L. & PSYCHIATRY 35 (1987).

60. M. LEVINE, THE HISTORY AND POLITICS OF COMMUNITY MENTAL HEALTH (1981); D. MECHANIC, MENTAL HEALTH AND SOCIAL POLICY (1969).

61. A state may present significant legal and ethical problems when it provides mental health care. These problems have been especially difficult when the state imposes involuntary services, as in involuntary civil commitment or forced psychiatric treatment. *See* S. SMITH & R. MEYER, LAW, BEHAVIOR, AND MENTAL HEALTH: POLICY AND PRACTICE (1987); Daly, *The Diverse Goals Involved in Treatment of the Mentally Ill: Is a Collision Inevitable?*, 8 J. LEGAL MED. 49 (1987).

62. *See supra* note 15 (changes in the state mental health hospitals). One reason the state responsibility for mental health services decreased was the outrageous conditions that existed in state mental facilities. *See infra* notes 66-67 and accompanying text.

63. Grob, *The Forging of Mental Health Policy in America: World War II to New Frontier*, 42 J. HISTORY MED. & ALLIED SCI. 410 (1987).

64. T. BUTLER, MENTAL HEALTH, SOCIAL POLICY AND THE LAW (1985).

jected for military service because of mental problems.[65] In addition descriptions of state mental hospitals as snake pits, "human warehouses," and "houses of horror"[66] attracted considerable national attention. One account stated that these hospitals rivaled "the horror of the Nazi concentration camps - hundreds of naked mental patients herded into huge, barn-like, filth-infested wards, in all degrees of deterioration."[67]

The National Mental Health Act of 1946 was passed to encourage research and investigation relating to the causes, diagnosis, and treatment of psychiatric disorders through the National Institute of Mental Health (NIMH).[68] In 1955 Congress established the Joint Commission of Mental Health and Illness, which reported its findings in 1961.[69] It noted the need for massive expenditures in the mental health field and argued for comprehensive care centers. President Kennedy, responding to the report, urged a "bold new approach" in the federal response to national mental health problems: reducing the number of institutionalized patients by 50 percent within ten years and replacing large mental hospitals with comprehensive community mental health centers.

The Community Mental Health Center Act of 1963 provided money to construct comprehensive mental health centers, later to be funded through the states.[70] Each community mental health center was to include inpatient, outpatient, and partial hospitalization services; 24-hour emergency services; and consultation and education services. To the extent possible they were also to engage in a broad range of diagnostic services, rehabilitation services, precare and after care services, and education and research. It was hoped that these centers would provide equal access to quality services for the rich and poor alike.[71]

By 1970, 450 community mental health services were in operation, but the growth was reduced as federal funding slowed somewhat and states demonstrated a reluctance to fund the centers as planned. The centers, as well as the development of psychoactive drugs and an emphasis on deinstitutionalization, resulted in dramatic reduction in the number of patients in mental

65. D. MECHANIC, *supra* note 60.

66. F.D. CHU & S. TROTTER, *supra* note 23.

67. A. DEUTSCH, SHAME OF THE STATE (1948).

68. Pub. L. No. 79-487 (1946).

69. The Commission was established through the Mental Health Study Act of 1955. The Commission's report was entitled Action for Mental Health.

70. Pub. L. No. 88-164 (1963). In the act, Congress envisioned the establishment of local or community "catchment areas" of between 75,000 and 200,000 persons.

71. *See* H. FOLEY & S. SHARFSTEIN, MADNESS AND GOVERNMENT: WHO CARES FOR THE MENTALLY ILL? (1983).

institutions.[72] Unfortunately, the release of patients from mental institutions was not accompanied by a sufficient increase in community-based treatment facilities, housing, training, and educational and recreational programs.[73] As a result, deinstitutionalization too often was "a shift of patients from back wards to back alleys."[74]

In the late 1970s another presidential commission recommended a number of new service initiatives to provide mental health treatment for anyone who needed it regardless of income.[75] The commission's report essentially viewed mental health services as a right with a corresponding public responsibility for financing the services. The Mental Health Systems Act of 1980 was arguably the most comprehensive mental health legislation ever passed in the United States.[76] It coordinated a variety of mental health services and continued emphasis on community mental health centers. Special programs were provided for chronically mentally ill, children and adolescents, the elderly, minorities, and rape victims. Before much of this act could be implemented, its sponsor, President Carter, was replaced by President Reagan, and much of the act was repealed. Funds were cut for services and in place of some specific programs, states were given "block grants" covering broad ranges of health services and mental health programs.[77]

The major health care programs of the federal government are Medicare and Medicaid. There are also a variety of specific health service programs directed in part toward mental health care. Medicare is part of the Social Security program that provides health care services for elderly and for the disabled. Funding for mental health services under Medicare has been extremely limited, and it traditionally has been resistant to expanding mental

72. M. LEVINE, THE HISTORY AND POLITICS OF COMMUNITY MENTAL HEALTH (1981).

73. *See* P. SOLOMON, B. GORDON & J. DAVIS, COMMUNITY SERVICES TO DISCHARGED PSYCHIATRIC PATIENTS (1984).

74. Borus, *Issues Critical to the Survival of Community Mental Health*, 135 AM. J. PSYCHIATRY 1029 (1978).

75. President Carter appointed the President's Commission of Mental Health shortly after assuming office in 1977. Mrs. Carter was the honorary chairperson of the commission. It recommended a number of new service initiatives and sought to correct the imbalance between physical and mental health expenditures and services. It also supported reimbursement for mental health services provided by nonmedical professionals. It recommended the establishment of the Mental Patient's Bill of Rights (perhaps its most enduring contribution).

76. Pub. L. No. 96-398 (1980).

77. Omnibus Reconciliation Act of 1981, Pub. L. No. 97-35 (1981). For a discussion of the problems with the mental health system, see Talbott, *The Fate of the Public Psychiatric System*, 36 HOSP. & COMMUNITY PSYCHIATRY 46 (1985). More recently, the Protection and Advocacy for Mentally Ill People Act of 1986 was enacted. It provides limited funds for states to provide advocacy services for people with mental illness and emotional disorders. Among other things, the advocacy is intended to protect these patients from neglect and abuse and to assist them in obtaining benefits. Pub. L. No. 99-319 (1986).

health coverage. In this sense it has followed private health insurance. Although the mental health benefits were expanded by Congress in December 1986, when it authorized direct payment to psychologists through community mental health centers and rural health clinics, there has been little inclination to expand to full mental health coverage.[78]

The traditional means of reimbursement for Medicare hospital expenses (the major portion of the program) has been on a "cost plus" basis so that in effect hospitals were paid on the basis of treatment costs. There was thus little incentive for hospitals and physicians to reduce costs. Medicare has moved toward a "prospective payment system" under which hospitals are reimbursed at a predetermined rate based on the condition or diagnosis of the patient. Medical conditions are placed in diagnostic related groupings (DRGs), and hospitals are paid a flat rate for each admission based on the DRG as adjusted to take limited account of geographical factors.[79] Hospitals receive the same amount for the admission regardless of the actual length of hospital stay or the efficiency or inefficiency of the hospital.[80] The DRG system imposes strong economic incentives for hospitals to operate efficiently and to keep Medicare patient stays as short as possible.[81]

Because of the complexity of psychiatric diagnoses and conditions, DRGs covering psychiatric care in this area have been delayed. Mental health professionals have thus far argued successfully that DRGs should not be applied because the length of mental patient hospital stays is too variable to fit within the DRG system.[82] Initial data supported this contention,[83] although later studies seem to suggest that DRGs could be applied to mental patient

78. DeLeon & VandenBos, *Psychotherapy Reimbursement in Federal Programs: Political Factors* , in PSYCHOTHERAPY: PRACTICE, RESEARCH, POLICY (G. R. VandenBos ed. 1980); Ruby, *The Policy Implications of Insurance Coverage for Psychiatric Services*, 7 INT'L J. L. & PSYCHIATRY 269 (1984).

79. *See* Thienhaus & Simon, *Prospective Payment and Hospital Psychiatry*, 83 HOSP. & COMMUNITY PSYCHIATRY 1041 (1987).

80. Uyeda & Moldawsky, *Prospective Payment and Psychological Services*, 41 AM. PSYCHOLOGIST 60 (1986).

81. Federal programs and private insurers have also endeavored to cut costs by imposing treatment reviews, for example, to avoid unnecessary hospitalization. For example, prior or concurrent review by quality assurance authorities have been used along with "retrospective" reviews to avoid overtreatment. Such programs also monitor the quality of care. G. TISCHLER & B. ASTRACHAN, QUALITY ASSURANCE IN MENTAL HEALTH: PEER AND UTILIZATION REVIEW (1982). Such programs can raise conflicts between therapists' obligations to their patients and the efforts to cut costs. Rinella, *Ethical Issues and Psychiatric Cost-Containment Strategies*, 9 INT'L J. L. & PSYCHIATRY 125 (1986).

82. Kiesler & Morton, *supra* note 46; Schumacher, Namerow, Parker, Fox & Kofie, *Prospective Payment for Psychiatry—Feasibility and Impact*, 315 N. ENG. J. MED. 1331 (1986).

83. English, Sharfstein, Scherl, Astranchan & Muszynski, *Diagnosis-Related Groups and General Hospital Psychiatry: The APA Study*, 143 AM. J. PSYCHIATRY 131 (1986).

hospital stays.[84] In the long run, arguments that DRGs should not be applied to mental health conditions may have the unfortunate consequence of reinforcing the feeling that mental health services are unpredictable and not scientific.

The use of DRGs may influence mental health care in a number of subtle ways.[85] It will encourage hospitals to discharge mental patients as quickly as possible, perhaps thereby promoting deinstitutionalization. In the long run it may also encourage the use of mental health professionals if providing mental health services to those hospitalized for physical ailments promotes early release from the hospital. The incentive toward efficiency also may encourage hospitals to use lower priced professionals (*e.g.*, social workers, or paraprofessionals), instead of higher priced professionals (*e.g.*, psychiatrists) to perform some services. The long-term effects of the prospective payment system and the use of DRG cannot yet be fully calculated.[86]

Medicaid is a cooperative federal-state effort to provide medical services for the indigent.[87] The federal government provides substantial funding and general regulations under which states operate their Medicaid programs. States have some latitude under Medicaid to decide who and what conditions will be covered to provide for the health care costs for the poor. The federal funding for mental health care is extremely limited under Medicaid. For example, it does not cover services to patients under 65 in an "institution for mental diseases."[88] Most states provide few Medicaid mental health services. Because states are permitted to define their programs within federal guidelines, the programs vary somewhat from one state to another.[89]

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84. Kiesler, Simpkins & Morton, *Predicting Hospital Length of Stay for Psychiatric Inpatients: The HDS Data*, (unpublished technical report) *quoted in* Kiesler & Morton, *supra* note 46. For a good review of the issues regarding the use of DRGs in mental health care, see Kiesler & Morton, *Prospective Payment System for Psychiatric Services: The Advantages of Controversy*, 43 AM. PSYCHOLOGIST 141 (1988).

85. Appelbaum, *DRGs and Mental Health Law: A Glimpse of the Future*, 37 HOSP. & COMMUNITY PSYCHIATRY 997 (1986).

86. *See* Binner, *DRGs and the Administration of Mental Health Services*, 41 AM. PSYCHOLOGIST 64 (1986); Taube, Lee & Forthofer, *DRGs in Psychiatry: An Empirical Evaluation*, 22 MED. CARE 597 (1984). *See also* Goldman, Pincus, Taub & Reiger, *Prospective Payment for Psychiatric Hospitalization: Questions and Issues*, 35 HOSP. & COMMUNITY PSYCHIATRY 460 (1984).

87. The legislative purpose of Medicaid is to "enable each State . . . to furnish medical assistance on behalf of families with dependent children and of aged, blind, or permanently disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services and rehabilitation. . . ." 42 U.S.C. § 1396 (1982).

88. The Supreme Court has refused to prohibit this practice. For a discussion of the issues, see Connecticut v. Heckler, 471 U.S. 524 (1985).

89. Somewhat related to Medicaid is the Supplemental Security Income (SSI) program of Social Security. It provides a subsistence allowance to the disabled. 42 U.S.C. § 1381 (1982). Inmates of public institutions do not generally receive SSI payments. When combined with

Budget cuts and reallocations have had the effect of reducing some support for Medicare, Medicaid, and related Social Security programs.[90]

Many view 1978 to 1980 as the high water mark of federal involvement with and concern for funding for mental health services. However, the process of deinstitutionalization was never accompanied by the planned community facilities nor were the promises fulfilled of providing mental health services to all Americans who needed them.[91]

Federal mental health interest has had an element of faddishness.[92] There has been funding for problems of immediate public interest which subsides to be replaced by a new "in" problem, among them child and adolescent care, rape victim counseling, family violence, alcohol and drug dependence, and post-traumatic stress syndrome. Federal mental health services funding has not been consistent or pursued with any form of long-term planning or commitment.[93]

Mental Health Services and Professional Status

When mental health services are covered by government programs or private insurance, the question often remains: which professionals may provide services and be reimbursed for them? In the past, most private insurance provided for billing by or through a psychiatrist.[94] The major medical insurance company (Blue Cross & Blue Shield) strongly favored psychiatrists, perhaps because the company was closely tied to physicians. This process probably tended to increase prices, and decreased the availability of services of psychologists and other independent providers.

Several factors are tending to increase the ability of nonpsychiatric mental health professionals to participate in reimbursement plans. Some states have

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very limited mental health coverage under Medicaid and Medicare, these limitations for inpatient mentally ill can be severe. This practice was challenged but upheld by the Supreme Court in Schweiker v. Wilson, 450 U.S. 221 (1981).

90. The future direction of funding for mental health care related programs is difficult to predict. In general these federal programs have strong political support, but concerns about cost increases may result in increasing resistance to tax increases to pay for the improved services.

91. A number of underserved groups have been identified. *E.g.*, Chiles, *Federal Involvement in Mental Retardation Programs*, 42 AM. PSYCHOLOGIST 792 (1987); Roybal, *Mental Health and Aging: The Need for an Expanded Federal Response*, 43 AM. PSYCHOLOGIST 189 (1988). *See* F. CHU & S. TROTTER, *supra* note 23; H. FOLEY & S. SHARFSTEIN, *supra* note 71; Jansen, *Mental Health Policy: Observation from Europe*, 41 AM. PSYCHOLOGIST 1273 (1986).

92. T. BUTLER, *supra* note 64; Rochefort, *The Political Context of Mental Health Care*, 36 NEW DIRECTIONS FOR MENTAL HEALTH SERVICES 93 (1987).

93. T. BUTLER, *supra* note 64.

94. Dorken & Webb, *Third-Party Reimbursement Experience: An Interstate Comparison by Insurance Carrier*, 35 AM. PSYCHOLOGIST 355 (1980).

passed "freedom of choice" legislation which gives consumers the right to choose from a range of mental health professionals which can be reimbursed by insurance.[95] The threat of antitrust action against reimbursement-only-through-psychiatrist provisions has reduced the number of such provisions in insurance contracts.[96] In addition, a number of new economic considerations provide incentives to use the least costly effective therapy. For example, HMOs, preferred provider organizations (PPOs), and DRGs should encourage the use of psychologists, social workers, and other independently licensed professionals. In HMOs, for example, payment is based on a flat fee for providing all health needs rather than on a straight fee-for-service basis. Therefore, the incentives are to provide effective treatment at the lowest cost possible and this may encourage the use of nonphysician mental health providers whose fees tend to be lower than psychiatrists.[97]

In addition, new trends in health care are tending to deemphasize in-hospital, physician-oriented treatment (which is, of course, the most expensive form of health care) and emphasize services performed, often by nonphysicians, on an outpatient basis. On the other hand, these trends may harm nonpsychiatrist mental health providers, because physicians may increasingly serve as gatekeepers to more and more mental health care.[98] For example, PPOs may require referral through a primary physician and thereby limit the roles of others. If all health care must be initiated through an organization (PPO or HMO) to which only physicians have access, then mental health care *could* increasingly be initiated through physician contact and with some physician supervision. It is too early to determine what the ultimate role of these new forms will be, let alone what effect they will have on the provision of mental health care services.[99]

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95. Cummings, *Mental Health and National Health Insurance: A Case History of the Struggle for Professional Autonomy*, in PSYCHOLOGY AND NATIONAL HEALTH INSURANCE: A SOURCEBOOK (C. Kiesler, N. Cummings & G. VandenBos eds. 1980); Tenney, *Hospital Privileges for Psychologists*, 38 AM. PSYCHOLOGIST 1232 (1983).

96. *E.g.*, Blue Shield of Virginia v. McCready, 457 U.S. 465 (1982); Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia, 624 F.2d 476 (4th Cir.), *on remand*, 501 F. Supp. 1232 (E.D. Va. 1980), *cert. denied*, 450 U.S. 916 (1981). The antitrust aspects of these new forms of delivery are considered in K. WING, THE LAW AND THE PUBLIC'S HEALTH 171-95 (2d ed. 1985); Batavia, *Preferred Provider Organizations: Antitrust Aspects and Implications for the Hospital Industry*, 10 AM. J. L. & MED. 169 (1984); Schmidt, *Health Maintenance Organizations and the McCarran-Ferguson Act*, 7 AM. J. L. & MED. 437 (1984).

97. Wiggins, *The Psychologist as a Health Professional in the Health Maintenance Organization*, 7 PROF. PSYCHOLOGY: RESEARCH AND PRAC. 9 (1976).

98. Turkington, *Preferred Providers Please and Puzzle Private Practitioners*, APA Monitor Feb. 1984, at 18. See Brady & Krizay, *Utilization and Coverage of Mental Health Services in Health Maintenance Organizations*, 142 AM. J. PSYCHIATRY 744 (1985); Cheifetz & Salloway, *Patterns of Mental Health Services Provided by HMOs*, 39 AM. PSYCHOLOGIST 495 (1984).

99. Sank & Shapiro, *Case Examples of the Broadening Role of Psychology in Health Main-*

LICENSING

Licensing is the most elementary form of direct control of mental health delivery. It establishes who will be permitted to deliver certain services, and who will not.[100] Oliver Wendell Holmes once wrote that "if the whole *materia medica* . . . could be sunk to the bottom of the sea, it would be all the better for mankind—and all the worse for the fishes,"[101] a claim also made for the licensing of mental health practitioners.[102]

Purpose of Licensure

Licensing is intended primarily to protect the public from inadequate or dangerous practitioners. Licensing also serves to protect the licensed profession from certain kinds of competition and promotes its respectability;[103] it is a formal recognition of the legitimacy and value of the profession;[104] and it is a step along the route of being included both in a testimonial privilege (which is usually associated with licensed professions)[105] and in third-party reimbursement plans. Licensing is double-edged: it may promote the public interest by improving the quality of care, but it may threaten it because entry into the profession is restricted, so that availability of services is reduced and prices are increased.[106] Whether licensing actually serves the public interest,

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tenance Organizations, 10 PROF. PSYCHOLOGY: RESEARCH & PRAC. 402 (1979) (found very few staff positions for psychologists and fewer still in leadership roles).

100. Christman, *Who Can Do Therapy?*, in THE FUTURE OF MENTAL HEALTH SERVICES: COPING WITH CRISIS (L. Duhl & N. Cummings eds. 1986).

101. O.W. HOLMES, SR., MEDICAL ESSAYS 203 (1892).

102. In fact, one critic of licensing quotes Holmes as part of his argument that professional entry requirements are arbitrary and harmful. D. HOGAN, THE REGULATION OF PSYCHOTHERAPISTS 252 (1979). The four volumes by Hogan on the regulation of psychotherapy is an extraordinarily complete and very useful review of licensure laws affecting psychotherapy. Although somewhat dated, volume 2 of the work, subtitled *A Handbook of State Licensure Laws*, provides a state-by-state and profession-by-profession summary of licensing regulation.

103. C. GILB, HIDDEN HIERARCHIES: THE PROFESSIONS AND GOVERNMENT (1966); Gross, *The Myth of Professional Licensing*, 33 AM. PSYCHOLOGIST 1009 (1978); Wallace, *Occupational Licensing and Certification: Remedies for Denial*, 14 WM. & MARY L. REV. 46 (1972).

104. Ideally, a profession is guided by a high sense of social responsibility. In return for a high level of self-regulation granted by society, the professions should ensure that only reasonably competent and ethical practitioners are permitted to practice, that monopoly-type profits are avoided, that the profession renders service only within its area of expertise, and that it does not restrict licensing for the purpose of promoting its own economic interests. *See* Sanford, *Annual Report of the Executive Secretary*, 6 AM. PSYCHOLOGIST 668 (1951).

105. Smith, *Constitutional Privacy and Psychotherapy*, 49 GEO. WASH. L. REV. 1 (1980); Smith, *Medical and Psychotherapy Privileges and Confidentiality: On Giving With One Hand and Removing With the Other*, 75 KY. L. J. 473 (1987).

106. S. GROSS, OF FOXES AND HENHOUSES: LICENSING AND THE HEALTH PROFESSIONS (1984).

and if so, what form of licensing best serves it, thus continue to be important questions.[107] It is possible that the trend toward increased licensing will be reversed and that "deregulation" could even result in the abandonment of some current licensing statutes.[108]

A philosophical question of autonomy and public protection also exists. On one hand some argue that individuals should be free to seek services from anyone of their choosing, whether or not the professional is approved by the state; the individual takes the risk (if there is one) of being harmed by an incompetent and the risk of not finding out enough about the professional to determine competency. Others argue that it is often unrealistic for a lay person to judge the competence of professionals and that society has a public safety interest in ensuring that those seeking mental health services receive competent treatment. This debate is one of perception (how dangerous an incompetent practitioner is) and one of values (how much the government should intervene to protect us from a very bad choice of practitioners).

State licensing activities take several forms. It may prohibit certain kinds of practice without a license (*e.g.*, using ECT or prescribing drugs). It may also limit the use of certain titles such as "psychologist" or "M.D." or "marriage counselor." Or the state may require registration in order to keep track of who is engaged in practice. It is common for a state that limits practice to licensees to also limit the use of the title associated with that profession. There is no consistent name for these three forms of regulation.[109] To avoid confusion, in this Article: "practice" laws or statutes refer to limitation on practice; "title" laws refer to limitations on the use of title; and "registration" laws to refer to the requirement for registration with the state. "Licensing" generally refers to the first two kinds of regulation.

The purpose served by each of these forms of regulation differs. "Practice" acts are intended to completely prohibit the incompetent from providing services. The theory is that the possibility of harm to the public is so great that it is necessary to prohibit them from practicing. Title laws are

107. For a history of the regulation of the mental health professions, see THE HISTORY OF PSYCHOTHERAPY: FROM HEALING MAGIC TO ENCOUNTER (J. Ehrenwald ed. 1976); H. KENDLER, A HISTORY OF PSYCHOLOGY (1987); Danish, *Considering Professional Licensing from a Social and Historical Context*, 9 COUNSELING PSYCHOLOGIST 35 (1980); Note, *Regulation of Psychological Counseling and Psychotherapy*, 51 COLUM. L. REV. 474 (1951).

108. In a few instances licensing statutes have been repealed or allowed to expire. *See* B. FRETZ & D. MILLS, LICENSING AND CERTIFICATION OF PSYCHOLOGISTS AND COUNSELORS (1980); Hale, *The Illusion of Effective Regulation*, 35 CLINICAL PSYCHOLOGIST 10 (1981); Jackson & Branum, *Licensing is Lovelier the Second Time Around*, 2 PROF. PRAC. PSYCHOLOGY 35 (1981).

109. *See* R.L. SCHWITZGEBEL & R. K. SCHWITZGEBEL, LAW AND PSYCHOLOGICAL PRACTICE 222 (1980). In Kentucky, on the other hand, the state licensure board for a number of years recognized master's-level psychologists as certificants.

intended to provide information in that, by reserving certain titles or labels to those with minimal levels of competence and credentials, people can ascertain whether a practitioner has at least that level of quality. Although registration laws provide no direct consumer service, they do provide a method of monitoring practitioners.

Professional Differences

Mental health professions have approached licensing in various ways. Interestingly, there is virtually no licensing in psychiatry (beyond the M.D. requirement) and psychiatrists as a group have not sought licensing authority. (Licensing must be clearly distinguished from board certification, which is voluntary and not required to practice a specialty or to use a specialty title.) Any physician may claim to be a psychiatrist, without special training or testing. In fact, it appears that less than half of those specializing in psychiatry have obtained certification.[110] The reasons for this are not entirely clear. It is perhaps related to the development of psychiatry within medicine. The medical profession has its own licensing system and a history of specialty practice without specialty licensing. It may also be that there has been little need for physician/psychiatrists to depend upon specialty licensing for recognition and third-party reimbursement.

Psychologists, on the other hand, have actively and successfully sought licensure. Social workers, marriage and family therapists, and counselors have more recently sought licensure statutes.[111] Some states have licensed a wide variety of other mental health professions, including psychiatric technician nurse (Arkansas), psychiatric technicians (*e.g.*, California and Colorado), pastoral counselors (New Hampshire), "drugless healing" (*e.g.*, Illinois and Washington), social psychotherapy (Texas), recreational therapist (Utah), and alcoholism and drug counselors (Virginia).[112]

Among professions, there has been a debate over multi-level licensing. Who should be included within licensing provisions and the qualifications for licensure? In psychology, for example, most states license only those with doctorates. The issue has focused on the potential licensure or certifica-

110. Levit, Sabshin & Meuller, *Trends in Graduate Medical Education and Specialty Certification*, 290 NEW ENG. J. MED. 545 (1974). *See* Taylor & Torrey, *The Pseudo-Regulation of American Psychiatry*, 129 AM. J. PSYCHIATRY 34 (1972); Karson, *Regulating Medical Psychotherapists in Illinois: A Question of Balance*, 11 J. MAR. J. PRAC. & PROC. 601 (1978).

111. *See* Kern, *State Regulation of Social Work*, 10 VAL. U. L. REV. 261 (1976); Rutledge, *State Regulation of Marriage Counseling*, 22 FAM. COORDINATOR 81 (1973); Snow, *Counselor Licensure as Perceived by Counselors and Psychologists*, 60 PERSONNEL & GUIDANCE J. 80 (1981); Swanson, *Moving Toward Counselor Licensure: A Statewide Survey*, 60 PERSONNEL & GUIDANCE J. 78 (1981).

112. 2 D. HOGAN, THE REGULATION OF PSYCHOTHERAPISTS 57-69, 97-110 (1979).

tion of master's-level psychologists.[113] In social work some states have agreed to license social workers with a bachelor's degree.[114] These debates are not generally whether the lower level degree should qualify the professional for the same license as the higher degree, but rather whether a holder of the lower level degree should be recognized by the state at all or permitted to engage in independent practice. Often there is concern that multilevel licensing will confuse the public and weaken the prestige and respect of the higher level license. Such disputes have sometimes defeated licensing for the profession, or required a compromise that essentially provides for multilevel licensing. When it does occur, the lower levels are generally given a different title and are required to work under the supervision of a holder of the higher level license.

The Licensing Process

Licensure is a matter of state law. There is considerable variance from state to state on the professions that are licensed and on the details of the licensing law. Licensure is generally a statutory and regulatory matter and there are relatively few appellate cases dealing with mental health licensing.[115]

Although requirements vary considerably from state-to-state and from profession-to-profession within the same state, there are several common elements.[116] Among these common elements are completion of an academic degree, passage of a licensing examination, completion of supervised work experience or internship, and demonstration of good moral and ethical character.

Professions and states vary concerning the kind of education required for

113. *See* McMillan, *Professional Standards and the Master's Level Psychologist*, 4 PROF. PSYCHOLOGY: RESEARCH & PRAC. 296 (1973); Wayne, *An Examination of Selected Statutory Licensing Requirements for Psychologists in the United States*, 60 PERSONNEL & GUIDANCE J. 420 (1982).

114. *See* Hardcastle, *Public Regulation of Social Work*, 22 SOC. WORK 14 (1977).

115. In the relatively few appellate cases involving licensing, the major issues have been due process (did the state provide a fair hearing or clear standards for discipline) or whether a degree meets the educational requirements for a license. *E.g.*, Aronson v. Hall, 707 F.2d 693 (2d Cir. 1983); Larkin v. Winthrow, 368 F. Supp. 796 (E.D. Wis. 1973), *rev'd*, 421 U.S. 35 (1975); *In re* Partin, 37 N.C. App. 302, 246 S.E.2d 519 (1978).

116. For a discussion of provisions contained in licensing statutes see, B. FRETZ & D. MILLS, LICENSING AND CERTIFICATION OF PSYCHOLOGISTS AND COUNSELORS (1980); 2 D. HOGAN, THE REGULATION OF PSYCHOTHERAPISTS (vol. 2) (1979); Wayne, *An Examination of Selected Statutory Licensing Requirements for Psychologists in the United States*, 60 PERSONNEL & GUIDANCE J. 420 (1982).

licensure.[117] Some type of accreditation is essential if an educational requirement is to have any meaning. Without accreditation, diploma mills could grant meaningless degrees and effectively destroy the education requirement. Professional associations, such as the American Psychological Association or the National Association of Social Workers, usually have some system of educational accreditation.[118] In some states, however, the education requirement for licensure may be met without graduation from a professionally approved school.[119] Regional accreditation may be used to meet the educational requirement. The difficulty with regional accreditation is that it is not oriented toward the needs of one profession but rather toward an entire institution (*e.g.*, a university) and, therefore, does not deal with the quality of the professional training program, and it tends to have relatively low standards for accreditation.[120]

Another issue involving the education requirement is what types of training qualify for training requirement.[121] For example, while the Psy.D. or a Ph.D. in clinical psychology would qualify as training for licensure in psychology, would a Ph.D. in counseling or a Ph.D. or Ed.D. in education psychology qualify? Generally these questions are left to the licensing board and its decisions are accepted so long as the board makes a decision consistent with its own policies and the state statute.[122]

Licensing examinations generally contain a written component which may

117. *See generally* Kiesler, *The Training of Psychiatrists and Psychologists, in Psychology and National Health Insurance* (C. Kiesler, N. Cummings & G. VandenBos eds. 1980).

118. Ensuring rigorous educational requirements through accreditation is a problem for many professions. This occurs because of the failure of the profession to require professional accreditation (some mental health professions), the failure to deal adequately with foreign school graduates (medicine), or the failure of the accrediting agency to implement rigorous standards. *See* Smith, *Accreditation Revisited: ABA Reexamination of Approved Law Schools*, 27 WAYNE L. REV. 95 (1980).

119. Wiens & Menne, *On Disposing of "Straw People," or, An Attempt to Clarify Statutory Recognition and Educational Requirements for Psychologists*, 36 AM. PSYCHOLOGIST 390 (1981). States could choose to require graduation from a fully accredited (professional association) program. Draganosky v. Minnesota Bd. of Psychology, 367 N.W.2d 521 (Minn. 1985).

120. *See generally* Goodstein & Ross, *Accreditation of Graduate Programs in Psychology—An Analysis*, 21 AM. PSYCHOLOGIST 218 (1966); Matarazzo, *Higher Education, Professional Accreditation and Licensure*, 32 AM. PSYCHOLOGIST 856 (1977).

121. Fox & Barclay, *The Foundation of Professional Psychology*, 37 AM. PSYCHOLOGIST 306 (1982); Kayton, *Statutory Regulation of Psychologists: Its Scope and Constitutionality*, 33 ST. JOHN'S L. REV. 249 (1959); Wiens & Menne, *supra* note 119.

122. Smith, *Psychology and the Courts: Some Implications of Recent Decisions for State Licensing Boards*, 9 PROF. PSYCHOLOGY: RESEARCH & PRAC. 489 (1978); Wallace, *Occupational Licensing and Certification: Remedies for Denial*, 14 WM. & MARY L. REV. 46 (1972); Note, *Due Process Limitations on Occupational Licensing*, 59 VA. L. REV. 1097 (1973). The difficulties in adequately assessing competency are reviewed in EVALUATING THE SKILLS OF MEDICAL SPECIALISTS (J. Lloyd & D. Langsley eds. 1983).

be supplemented by an oral examination or practicum exam (patient diagnosis or counseling). These examinations are commonly written or administered by the state board which also provides for scoring them and determines what "passing" scores are.

The supervised work experience or practicum is meant to ensure that during the initial years of practice the professional has the guidance necessary to deal with the complexities of practice. It is a transition period between the intense supervision that is supposed to be part of academic training and the relative lack of supervision of fully licensed practice. In addition, it serves the function of a "probationary" period in that gross incompetence or unethical conduct during the internship might result in the denial of a full license.

The character and fitness aspect of licensing is intended to protect the public from dishonest and unethical behavior. Serious acts of dishonesty, such as crimes of moral turpitude or failure to meet fiduciary responsibility, can be the reason for refusing to license an otherwise fully qualified applicant. But few applicants are denied on this basis, perhaps in part because many educational institutions would not accept such students into training programs,[123] and perhaps because the state licensing boards have not made great efforts to uncover prior dishonest behavior.

Licensing requirements may seem somewhat redundant: what is the need for an educational requirement if there is a licensing exam that could test the applicant's knowledge? Why have an internship when similar experience should have been provided as part of training? In fact, these provisions are intentionally redundant, in part, to provide checks on various parts of the process. Inadequately prepared applicants who somehow get through a training program may be stopped by the exam. In addition, examination results impose restraints on weak training programs; a number of exam failures from one school may indicate a need to increase the academic rigor of that program. The internship may expose seriously incompetent practitioners, or help to compensate for any weaknesses in the training program.

Licensing is done by state licensing boards, generally appointed by the governor, or other state and professional officials. The controlling majority of the boards are usually made up of the members of the regulated profession. In addition to responsibility for the examination and initial licensing function, most boards are charged with the duty of revoking licenses and imposing other forms of discipline (described below).[124]

123. B. FRETZ & D. MILLS, LICENSING AND CERTIFICATION OF PSYCHOLOGISTS AND COUNSELORS (1981).

124. Comment, *Procedural Due Process and the Separation of Functions in State Occupational Licensing Agencies*, 1978 WIS. L. REV. 833. For a general review of licensing and spe-

Practicing without a license is generally a misdemeanor carrying a maximum penalty of a fine and a short jail term. Prosecution for unauthorized mental health practice is very infrequent and, unless there is fraud or a patient is seriously harmed, it often does not result in significant penalties when it does occur.

Licensure is controlled by each state, and generally a license is valid for practice only in the state which has granted it. There commonly are exceptions for emergency or short-term practice. Some states will recognize the license of another state as the basis for granting a license. As with licensing provisions themselves, reciprocity provisions vary widely.

After initial licensure, relicensing essentially becomes a registration procedure. A license holder may be required to provide information about type and location of practice, and to pay a fee. However, there are no license renewal examinations, or any serious review of professional competence. This is similar to the licensing provisions of all types. It means, however, that it is virtually impossible for licensing authorities to assure the continued competence of those relicensed.[125] This absence of reexamination may in part be based on the assumption that once licensed, practitioners increase the level of competence in the areas in which they actually practice and, therefore, reexamination is unnecessary. It may also reflect the political reality that licensing statutes are developed by those in the licensed profession and they generally would not be very enthusiastic about having to take licensing exams throughout their careers.

Continuing education is viewed by some as one way of helping to ensure the continued competence of professionals. In some instances continuing education "credits" or hours are required to maintain a license. Although the success of compulsory continuing education is debatable, these courses should at least provide the opportunity for professionals to stay abreast of some of the latest developments in their areas of practice.[126]

Discipline and License Revocation

Licensing boards generally have an obligation to discipline, or to revoke the licenses of professionals who engage in misconduct or are unfit to con-

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cial certification legal issues, see LEGAL ASPECTS OF CERTIFICATION AND ACCREDITATION (L. Langsley ed. 1983).

125. Small, *Recertification for Psychiatrists: The Time to Act is Now.*, 132 AM. J. PSYCHIATRY 291 (1975).

126. *See* Brown & Uhl, *Mandatory Continuing Education: Sense or Nonsense?*, 213 J.A.M.A. 1660 (1970). The continuing education requirements for a variety of professionals are set out in Jaschik, *More States are Requiring Professionals to Take Continuing-Education Courses*, Chronicle of Higher Ed., May 21, 1986, at 13, 16.

tinue practice. The bases for imposing discipline or revoking a license vary, but generally include incompetence to continue practice, unfitness because of alcohol or drug addiction, illegal activity that reflects on trust or professional standing, and serious unethical misconduct.[127] The board is usually empowered to promulgate regulations that specify the grounds for revoking licenses and to take a variety of disciplinary actions ranging from a private reprimand to suspension or revocation of the license.[128]

Professional discipline involves punitive action on behalf of the state, and the removal of a license is the taking of property. Therefore, a state licensing board must comply with constitutional due process requirements when disciplinary action is taken, which at least requires that the board provide the accused professional an opportunity to present and challenge evidence. To respond to the claims against them, practitioners must be given a fairly clear statement of the claims of misconduct. To avoid inadvertently engaging in prohibited activities, professionals must be given a reasonably clear understanding of the conduct that is prohibited. This does not, of course, require the specificity of a criminal code, but the law must give fair notice of what acts are prohibited.

A disciplinary proceeding is generally a formal hearing, held before the board or a hearing officer appointed by the board. It is common for the professional who is the subject of the hearing to be represented by an attorney, and to present witnesses and evidence to the board. A state attorney, or an attorney hired by the board, generally presents the evidence for discipline. Those seeking to impose discipline generally have the burden of proof.

Disciplinary actions against mental health practitioners are rare.[129] Most state boards are understaffed, many have no full-time professional staff members, and few have full-time investigators trained to discover unethical or incompetent practice. Boards almost always respond only to complaints filed with them, rather than seeking out incompetent practitioners. Most do not have the resources to conduct adequate investigations of complaints.

127. W. VANHOOSE & J. KOTTLER, ETHICAL AND LEGAL ISSUES IN COUNSELING AND PSYCHOLOGY (1977).

128. Smith, *supra* note 122.

129. Hogan reported that a survey of state boards of licensure revealed that on average they received only about one complaint per year per board. From the time of the establishment of state boards until 1972, only five licenses or certificates were revoked. D. HOGAN, *supra* note 116, at 260. During a one-year review, there were only 61 complaints of unethical conduct with the central office of the American Psychiatric Association. *Id.* at 334; Butler & Williams, *Description of Ohio State Board of Psychology Hearings on Ethical Violations from 1972 to the Present*, 16 PROF. PSYCHOLOGY: RESEARCH & PRAC. 502 (1985) (only 11 ethical violations were determined by the Ohio board in 13 years). However, the number of complaints is increasing.

Moreover, professionals are generally unwilling to file complaints against their peers, so patients may become the major source of complaints, and mistreated patients are often reluctant to expose their mental health histories. In addition, because there is no single method of treating many mental health conditions, many patients may not know that they have been harmed or mistreated. The inability or unwillingness of the boards to deal aggressively with inadequate or unethical practitioners is a major weakness of most professional licensure.[130]

Licensing can be an important method of enforcing professional ethics and a serious breach may be the basis for revoking a license. Therefore, ethical codes are more than general statements of professional ideals. They become the basis for the continued right to practice. If codes of ethics are effective in protecting the public from dishonesty, inadequate service, or unfair advantage, then licensing is a method of fulfilling the profession's obligation to protect the public. Unfortunately, many professional codes of ethics are vague and often combine aspirational statements with minimum ethical standards. As a result, the ethical standards generally serve as the basis for board action only in the most outrageous cases of dishonesty (stealing from a patient or making fraudulent insurance claims for services not rendered) or taking advantage of a patient (sexual relations with a patient). It is important that codes of ethics make some clear distinction between the goals or aspirations of the profession, and the minimum level of professional conduct required of all practitioners.

Beyond Licensing

Licensing involves the minimum qualifications necessary to practice a profession. Higher standards may be established by groups for membership or special certification. For example, the American Board of Professional Psychologists (ABPP) and the American Board of Psychiatry and Neurology (ABPN) have requirements for certification that extend well beyond those required by states to practice psychology or medicine. Such forms of certification are not part of the state licensing process.[131]

These forms of credentialing may be useful to other professionals when

130. The reluctance of patients to file licensing complaints probably reflects their reluctance to file mental health malpractice claims. S. SMITH & R. MEYER, LAW, BEHAVIOR, AND MENTAL HEALTH: POLICY AND PRACTICE 8-10 (1987). *See generally* J. CARLIN, LAWYERS' ETHICS: A SURVEY OF THE NEW YORK CITY BAR (1966); Thackrey, *Breakdown in Professional Self-Monitoring: Private Practice Announcement*, 16 PROF. PSYCHOLOGY: RESEARCH & PRAC. 163 (1985).

131. In a few instances membership in a specialty board may be accepted as the basis for licensing. For example, some states will accept ABPP as the basis for licensing.

making referrals. They may also be useful to the public in selecting a therapist and to third-party reimbursement plans. Unfortunately, few people understand the significance of these credentials and even when they do, they may be misled by other groups with similar sounding names that impose much less stringent requirements for certification. Many of the functions of labeling licensing would be better served if the public were more aware of the importance of these special credentialing services, if misleading similar titles were prohibited, and if the professions would make available to the public lists of certification boards with rigorous standards. Such a process might be opposed by those without the certification, but it would encourage practitioners to seek board approval.[132]

Criticism of Licensing

Mental health licensing is criticized for unnecessarily limiting the supply of practitioners and thereby reducing the availability of and increasing the price of mental health services, for stifling innovation, for making it difficult for paraprofessionals to perform effectively, for decreasing geographic mobility and distribution of professionals, and for discriminating against groups that find it most difficult to get the credentials necessary for practice (minorities and women) and that suffer most from an insufficiency of practitioners.[133] At the same time, licensure is criticized for being ineffective in eliminating the incompetent or harmful from practice.[134] Together, these criticisms almost suggest that the licensing process is preventing the competent from practicing, and permitting the incompetent to practice.[135]

The criticisms, while probably overstated, demonstrate some problems. Because the very purpose of licensing is to eliminate from practice those who are not of a minimum level of competence, the licensing process undoubtedly reduces the number of practitioners. This probably tends to increase prices somewhat, and makes services less readily available to some. To the extent it reduces the number of "unnecessary" practitioners, however, it may tend

132. *See* Wellner & Zimet, *The National Register of Health Service Providers in Psychology*, in THE PROFESSIONAL PSYCHOLOGIST'S HANDBOOK 185 (B. Sales ed. 1983). *But see* Clovis, *The Boards—What Price Glory*, 128 AM. J. PSYCHIATRY 784 (1971).

133. *E.g.*, D. Hogan, *supra* note 116, at 39.

134. *E.g.*, S. GROSS, *supra* note 106. Frieberg, *The Song Is Ended but the Malady Lingers On: Legal Regulation of Psychotherapy*, 22 ST. LOUIS U. L. J. 519 (1978).

135. M. GROSS, THE PSYCHOLOGICAL SOCIETY: A CRITICAL ANALYSIS OF PSYCHIATRY, PSYCHOTHERAPY, PSYCHOANALYSIS AND THE PSYCHOLOGICAL REVOLUTION (1978); R. REINEHR, THE MACHINE THAT OILS ITSELF: A CRITICAL LOOK AT THE MENTAL HEALTH ESTABLISHMENT (1975); Somers, *Accountability, Public Policy, and Psychiatry*, 134 AM. J. PSYCHIATRY 959 (1977).

to reduce treatment that is not necessary or desirable.[136] Licensing may also somewhat inhibit innovation. On the other hand, claims of innovation may be an excuse for quackery. The real question is whether licensing reduces *effective* innovations more than it protects against ineffective or even dangerous ones. If licensing discourages the use of paraprofessionals, that is undesirable only if it prevents them from doing things that need not be done by professionals.

There are undesirable consequences of licensing, whether or not one agrees with all of the criticisms described above. The process is time-consuming, requires state resources, may suggest to the public greater competency than it actually assures, and will result in some incorrect decisions. The primary question is whether these costs are worth the benefits in improved mental health care and in the avoidance of quackery and fraud. This is a calculation that cannot be performed with precision, and trying to guess about it is the major source of debate about the desirability of mental health licensing.

Another question is whether licensing is successful in ensuring minimum levels of competence. An argument can be made that it does not. Few applicants are denied licenses because they are never able to pass the examination or because of character and fitness considerations. In reality, the educational requirement is probably the major requirement limiting licensure, and it may become even less effective if there are no rigorous accreditation standards. Another weakness in ensuring minimum competency—one shared with other professions—is that very few practitioners have their licenses revoked. There are few efforts to seek out unethical professionals and remove them from practice. Furthermore, the absence of relicensing provisions makes it unlikely that practitioners who become incompetent will be detected and their licenses revoked.[137]

Some form of mental health licensure is desirable. In the absence of label licensing, mistakes about the quality of the professionals would be common. There are undoubtedly some procedures that are sufficiently dangerous that they should be undertaken only by qualified experts. There is a social, as well as an individual, interest in ensuring that mental health services are

136. The story is told of the therapist who denied that he provided any unnecessary therapy. He reported, "I don't put someone in therapy unless I absolutely need the money." There exists a danger that if there are too many professionals they may unnecessarily place some people in extended treatment programs or extend treatment longer than necessary. Because much mental health treatment does not have clear, standard protocols, overtreatment is particularly a potential problem in psychotherapy.

137. Bernstein & LeComte, *Licensure in Psychology: Alternative Directions*, 12 PROF. PSYCHOLOGY: RESEARCH & PRAC. 200 (1981).

performed by competent professionals. The personal interest is clear—the individual wants effective treatment. Others also have an interest in ensuring competent mental health activities. For example, if the services are paid for by insurance or Medicare or Medicaid, there is a social interest in ensuring that reasonably competent services are provided. There is also a broad social interest in reducing antisocial activity, and to the extent that effective treatment may reduce it, competent treatment ought to be ensured.

Improving Mental Health Licensing

The current state of licensing has caused some to urge that mental health licensing in its present form be eliminated. Hogan has proposed that the state register mental health professionals and require that they make information, including experience and academic training, statement of ethical beliefs, proposed length of treatment, and results that are to be expected available to the public.[138] Such a proposal has the advantage of making available a maximum amount of information about a therapist, while allowing a significant form of competition to exist. However, it is certainly not realistic to expect most patients who need medical or mental health services to be able to carefully study the various therapists in order to choose the right or qualified ones. Certainly an argument can be made that in such times of need, many patients cannot conduct a "Consumer Report" review of the options available to them. Nor is it reasonable to expect that states could enforce compliance with claims made by therapists in these reports to the public. As a result fraud could easily become a significant problem.

A system of licensing that works well may serve both the professions and the public. The problem with the current system may be that it works neither in eliminating the incompetent and unethical, nor in providing the advantages of a freely competitive market. The compromises that have produced licensing laws have resulted in the worst of both worlds for the public; many of the costs of regulation are present but the potential benefits of licensure regulation are reduced by the weak licensing provisions currently enforced. To best serve the public, licensing procedures should be significantly strengthened and restructured as described below.

1. If practice licensing (limits on who can perform services) is to be undertaken, the services within the definition of the practice must be much more clearly set out either by statute or by regulation. The definitions now used are extremely broad and often worthless. For example, a proposed model licensing act for psychology defines the practice of psychology as "rendering any psychological service involving the application of principles,

138. D. HOGAN, *supra* note 116, at 361-62.

methods, and procedures of understanding, predicting and influencing behavior . . . , the methods and procedures of interviewing, counseling, and psychotherapy; of constructing, administering and interpreting tests of mental abilities . . . , and of assessing public opinion."[139] A model social work act defines the practice of social work as "service and action to affect changes in human behavior, a person's or persons emotional responses, and the social conditions of individuals, families, groups, organizations, and communities, which are influenced by the interaction of social, cultural, political, and economic systems."[140] These definitions apply to the activities of much of the population. They are so broad as to be worthless.

2. The educational requirements should be more clearly defined. For example, whether a counseling doctoral degree is sufficient for one to be licensed as a clinical psychologist should be rather clearly determined. This should be based not on labeling, but on content, and, therefore, could be most efficiently performed through rigorous accreditation.

3. The accreditation of educational programs should be strengthened. In the long run, maintaining an effective education requirement requires a dependable accreditation process that prevents diploma-mill operations. Most states do not depend on rigorous national professional accreditation to determine which educational programs provide sufficiently sound educational programs to fulfill licensing requirements. Few state boards are equipped to conduct full and adequate accreditation reviews within their own state, and none is able to conduct adequate reviews of programs outside their own states. As a result, education accreditation for licensure tends to be haphazard and without very high standards and this seriously weakens licensing educational requirements. Licensing should require graduation from an educational program accredited by the nationally recognized professional body.

4. The use of titles that are similar to other licensing titles should be prohibited. Thus, if use of the title "psychologist" requires a license, the use of terms such as "psychotherapist" or "psychocounselor" by those not licensed should also be prohibited. States should be particularly careful to avoid using similar titles for different, licensed professionals. For example, "certified psychologist" should not be used to designate a master's-level professional (required to practice under supervision) if "licensed psychologist"

139. American Psychological Association (Committee on State Legislation), *A Model for State Legislation Affecting the Practice of Psychology* 1967, 22 AM. PSYCHOLOGIST 1095 (1977) (later revised).

140. NATIONAL ASSOCIATION OF SOCIAL WORKERS, LEGAL REGULATION OF SOCIAL WORK PRACTICE (1973). *See also* NICHOLS, MARRIAGE AND FAMILY COUNSELING: A LEGISLATIVE HANDBOOK (1974).

indicates a doctoral-level, independent practitioner. The similarity is likely to be confusing to the public and thereby defeat the purpose of title licensing.

5. The label "psychiatrist" should be limited to those with special training and recognized ability in psychiatry. It is likely that the public is currently misled about the qualifications of some claiming to practice psychiatry. At a minimum, title licensing of psychiatrists should be undertaken.

6. Character and fitness reviews should be more thoroughly conducted, and boards should be less reluctant to use past dishonesty as the basis for denying state licenses. Licensure discipline in one state should generally be a disqualification for licensure in another state. Each profession should establish a central national registry of disciplinary action and complaints to detect the unethical practitioner who moves from one state to another.

7. State boards should be much more aggressive in seeking out the unethical or incompetent practitioner for discipline. Complaints to the board should be thoroughly investigated by experienced staff. The public should be reminded that the licensure board is available to receive complaints and the board should actively seek information from those who might have complaints. To the extent possible consistent with due process, the confidentiality of patients and clients with complaints should be recognized. This recommendation would unquestionably require the addition of staff and funding for state boards.

8. State boards should be more inclined to impose significant penalties for any serious breach of ethical rules and for incompetency.

9. Some form of relicensing should be required to demonstrate continued competency in the area of practice or subspecialization.

10. Efforts should be made to inform the public of various levels of certification that go beyond licensing. Professionally recognized diplomate or certification status should be explained to the public.

11. If clearly defined practice licensing is used, states should more vigorously prosecute the unauthorized or unlicensed practice of the profession. Such prosecutions now are extremely unusual.

Other Limitations on Practice

Mental health practice is also controlled by the regulation of hospital privileges and authority to prescribe drugs. Because services will ordinarily be provided only if they can be paid for, the reimbursement issue, described in earlier sections, is also an important form of indirect mental health care

regulation.[141]

Hospital Privileges

Traditionally, authority to practice independently in hospitals and to admit patients to hospitals has been limited to physicians. Therefore, psychiatrists have been the only mental health professionals with hospital privileges. While other mental professionals can be called upon to assist in a hospital, they operate at least in theory under the direction of a physician. A mental health professional seeing a patient who needs hospitalization, of course, must refer the patient to a physician for admission. In a few areas of the country, however, limited hospital privileges have been granted to some nonphysician mental health professionals, while elsewhere the issue is a matter of hot debate.

Staff privileges are granted by each hospital according to its own criteria. However, hospital accreditation standards play a significant role in the process. Since 1951, the Joint Commission on Accreditation of Hospitals (JCAH) has been the major accrediting body for hospitals.[142] Although it is a voluntary accrediting body, many third-party payers (including federal health programs) depend upon JCAH accreditation. The JCAH regulations have reflected the physicians' control of the policies of that organization. Until recently, the accreditation standards permitted hospitals to grant staff privileges only to physicians. Recently, however, the medical staff of the hospital has been redefined to include in addition "licensed individuals permitted by law and the hospital to provide patient care services independently in the hospital."[143] Several states have by statute provided that licensed psychologists and others may be granted staff privileges.[144]

Even without such specific statutory authority hospitals may be able to grant staff privileges to such professions. Not surprisingly, however, most hospitals have not immediately started to grant privileges to nonphysician

141. *See supra* notes 50-99 and accompanying text.

142. *See* Zaro, Batchelor, Ginsberg & Pallak, *Psychology and the JCAH: Reflections of a Decade of Struggle*, 37 AM. PSYCHOLOGIST 1342 (1982). The JCAH was developed by the American Medical Association, the American Hospital Association, the American College of Surgeons and the American College of Physicians. The American Dental Association is now part of the JCAH structure. Lieberman & Astrachan, *The JCAH and Psychiatry: Current Issues and Implications for Practice*, 35 HOSP. & COMMUNITY PSYCHIATRY 1205 (1984).

143. JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, ACCREDITATION MANUAL FOR HOSPITALS (1984).

144. California, Georgia, and the District of Columbia have led in the development of a statutory authority for psychologists to be given staff privileges. Currie, *Legislative Initiatives in Hospital Practice* (paper presented to American Psychological Association 1983)). *See* Copeland, *Hospital Privileges and Staff Membership for Psychologists*, 11 PROF. PSYCHOLOGY: RESEARCH & PRAC. 676 (1983).

mental health professionals. Threats of antitrust lawsuits have in some cases encouraged the hospitals to consider it. One basis for the antitrust claim is that refusal of privileges is a conspiracy to restrain trade by reducing competition through the refusal to let qualified professionals into the hospital "market." Indeed, the threat of antitrust action probably played an instrumental role in the JCAH decision to amend its criteria.[145]

There are several reasons for these efforts to expand privileges. Without them, some mental health professionals claim that treatment may be disrupted or interrupted when a patient enters the hospital. It is argued that if they could admit the patient to the hospital and continue to direct their care, treatment would improve. Others argue that the refusal to grant staff privileges reduces competition and thereby economically harms both patients and nonphysician mental health professionals.[146] At the same time, mental health training programs are now sufficiently complete to ensure adequate knowledge to direct the hospital treatment programs of some mental patients. Therefore, it is argued, it is unnecessary for a licensing physician to further ensure the qualifications of those trained for independent practice.

The nature of hospital practice, at least in larger hospitals, has changed. Physicians are now commonly limited to practicing only in their specialties. New methods of health care delivery may rely heavily on those with staff privileges and care providers. For example, preferred provider organizations (PPOs) may be structured around professionals with privileges at a particular hospital or set of hospitals.[147] Without being part of the staff, mental health professionals may be excluded from these important new forms of health care. In addition, the hospital staff plays an important role in the governance of hospitals and in the assurance of quality care.[148] Without staff privileges, mental health professionals cannot fully participate in this process.

There are also numerous arguments against permitting nonphysician staff privileges. For one, they are not licensed to perform a full range of services;

145. Bershoff, *Hospital Privileges and the Antitrust Laws*, 38 AM. PSYCHOLOGIST 1238 (1983). *See generally* Virginia Academy of Clinical Psychologists v. Blue Shield, 624 F.2d 476 (4th Cir.), *on remand*, 501 F. Supp. 1232 (E.D. Va. 1980), *cert. denied*, 450 U.S. 916 (1981); Dolan & Ralston, *Hospital Admitting Privileges and the Sherman Act*, 18 HOUS. L. REV. 707 (1981); Drexel, *The Antitrust Implications of the Denial of Hospital Staff Privileges*, 36 U. MIAMI L. REV. 207 (1982); Kissam, *Government Policy Toward Medical Accreditation and Certification: The Antitrust Laws and Other Procompetitive Strategies*, 1983 WIS. L. REV. 1.

146. Bershoff, *supra* note 145; Tanney, *Hospital Privileges for Psychologists*, 38 AM. PSYCHOLOGIST 1232 (1983).

147. Altman & Frisman, *Preferred Provider Organizations and Mental Health Care*, 38 HOSP. & COMMUNITY PSYCHIATRY 359 (1987).

148. *See* G. TISCHLER & B. ASTRANCHAN, QUALITY ASSURANCE IN MENTAL HEALTH: PEER AND UTILIZATION REVIEW (1982).

for another, their philosophy of treatment may not be consistent with the medical models on which hospitals are typically structured. Others argue that their training programs are inadequate to prepare them for independent work in a hospital setting and, therefore, the quality of care may be inferior to that which could be provided by physicians.[149] Physician control over staff admission policies is, of course, one practical reason that privileges have been rejected.

There is by no means complete agreement within the nonphysician mental health professions that staff privileges are desirable. Some claim such status would increase the public esteem and recognition of the professions, while others suggest that they would change the nature and focus of professional practice, education, and treatment approaches. Still others fear a continuing adversarial relationship with psychiatrists and other physicians within the hospitals.

JCAH accepting nonphysician practitioners, the developing concept of limited staff privileges, and the increasing respect and public acknowledgment of a variety of mental health practitioners all suggest that the move toward hospital staff privileges for mental health professionals will probably continue at a slow pace. Hospitals will still be able to restrict staff privileges. They need not admit everyone with the licensing or academic credentials necessary for practice. They may require special levels of education, experience, and quality of practice; they may impose very high standards for nonphysicians; and they may narrowly define the kinds of activities that mental health professionals may perform, require substantial consultation with the physicians, and limit the participation of mental health professionals in staff governance.

Prescription Drugs

Currently, psychiatrists are the only mental health practitioners permitted to order prescription drugs for patients. All other physicians are also licensed to prescribe psychoactive drugs to patients whether or not those physicians have specialized training in psychiatry or neurology.

The control of prescription drugs is a matter of both federal and state law. Federal law establishes the basic regulation and approval of medication (including the classification of compounds as over-the-counter or prescription

149. *See generally American Psychiatric Statement, Position Statement on Hospital Privileges for Psychologists*, 125 AM. J. PSYCHIATRY 1458 (1981). *See also* Elfant, *Psychotherapy and Assessment in Hospital Settings: Ideological and Professional Conflicts*, 16 PROF. PSYCHOLOGY: RESEARCH & PRAC. 55 (1985) (involvement in hospitals may lead to "implicit identification with values and principles alien to the discipline of psychology").

drugs); state law deals with the licensing of specific individuals permitted to prescribe medication.

In many ways, issues concerning the authority to prescribe drugs are similar to those raised about hospital staff privileges. The arguments for authorizing some nonphysician mental health professionals to prescribe psychopharmacological agents are that drugs have become an important part of psychotherapy; restrictions on the professionals permitted to prescribe drugs increases costs; and psychologists, social workers, and others should be able to integrate drug therapy with other forms of psychotherapy. Those in favor of limited prescription authority point to the authority granted to dentists and optometrists to use some prescription drugs and devices. Yet, it is also argued that most current mental health education programs lack adequate training in pharmacology to justify such authority and that most of these programs would find it philosophically contrary to their treatment approaches. Others claim that prescription authority might encourage mental health professionals to rely too heavily on drugs. Again, the political reality is that expansion of prescribing authority would face considerable opposition from physicians.

To date, there has not been much professional effort to obtain prescribing authority, in part because there is little likelihood of success in the near future. Unless there is a considerable increase in conditions for which there is a clearly effective drug therapy, it is unlikely that nonpsychiatric professions will seek authority to prescribe drugs.

THE PHILOSOPHY AND FUTURE OF MENTAL HEALTH CARE DELIVERY

The current story of the mental health delivery system is not a very happy one. The direct controls (licensing and, to some degree other limitations on practice) have not ensured quality of care. Furthermore, the current substantial unmet need for services reflects the absence of adequate reimbursement schemes. Government programs have provided some services for the indigent with serious mental problems and limited services for others.[150] Private health insurance, usually provided through employers, has generally provided only minimal mental health benefits. Other services have been purchased directly by those needing them. Thus, the determination of how much service will be available and who will get the services has depended on political considerations (government programs), employee benefits, and ability to pay for services. The medically indigent, middle and lower socioeconomic groups, often do not fare well under such a system because of the

150. Frazier & Parron, *The Federal Mental Health Agenda*, in THE FUTURE OF MENTAL HEALTH SERVICES: COPING WITH CRISIS (L. Duhl & N. Cummings eds. 1986).

inability to privately purchase mental health services. The goal of making mental health services available to all Americans regardless of the ability to pay has largely gone unfulfilled.

Competition and Mental Health Care

Until recently, health care was becoming an increasingly regulated part of the economy. During the last few years this trend has been reversed and there are now efforts to impose market-like discipline, intended to improve efficiency by reducing costs while maintaining service. The increased applicability of antitrust laws, the use of DRGs for Medicare reimbursement, and the development of PPOs and HMOs have added elements of competition. The consequences of these changes, while far from certain, have the potential for substantially increasing the use of outpatient mental health services.[151]

Efforts to reduce health care costs have sometimes resulted in the loss of mental health care services from insurance,[152] but the potential for mental health care services to reduce total health care cost may ultimately encourage the provision of these services to the poor, and medically indigent lower and middle income families.[153] In the absence of proof that one form of therapy is more effective than another, or that one class of mental health professionals is more effective than another, there may be a trend toward providing services through lower-cost rather than higher-cost professionals. The incentives to avoid inpatient care will undoubtedly increase.

There is a risk, however, that mental health services may become less available in the push to cut costs. If mental health care continues to be viewed as a nonessential extra and unrelated to physical health care costs, then these will be among the first services to be cut. The reduction in government-funded mental health services and private insurance contracts suggests that mental health may be viewed as desirable but not essential or even

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151. *Compare* Flinn, McMahon & Collins, *Health Maintenance Organizations and Their Implications for Psychiatry*, 38 HOSP. & COMMUNITY PSYCHIATRY 255 (1987); Marshall, *HMOs and Psychiatry: Could There Be a Silver Lining?*, 10 INT'L J. L. & PSYCHIATRY 35 (1987) *with* Altman & Frisman, *Preferred Provider Organizations and Mental Health Care*, 38 HOSP. & COMMUNITY PSYCHIATRY 359 (1987); Martinsons, *Are HMOs Slamming the Door on Psychiatric Treatment?*, 62 HOSPITALS 50 (1988).

152. Rinella, *Ethical Issues and Psychiatric Cost-containment Strategies*, 9 INT'L J. L. & PSYCHIATRY 125 (1986).

153. Marshall, *supra* note 151. *See* Flinn, McMahon & Collins, *Health Maintenance Organizations and Their Implications for Psychiatry*, 38 HOSP. & COMMUNITY PSYCHIATRY 255 (1987); Feldman & Goldman, *Mental Health in HMOs: Practice and Potential*, in THE FUTURE OF MENTAL HEALTH SERVICES: COPING WITH CRISIS (L. Duhl & N. Cummings eds. 1986).

important. Evidence concerning the overall health care cost with and without the inclusion of mental health care services suggests that cutting mental health services may be costly in the long run. The challenge to those promoting mental health benefits is to continue to develop data demonstrating the cost-effectiveness of mental health services generally and of specific forms of therapy.[154]

National Health Insurance

The most comprehensive form of government regulation of health care is national health insurance. The United States is the only major industrial country without such a program.[155] Depending on one's point of view, this either represents one reason for the high level of quality of medical services available within the country or the reason for the high percentage of gross national product devoted to them. The United States has some elements of national health insurance.[156] The Medicare system, for example, provides general health coverage for the elderly; Medicaid for the indigent has similar elements. The expansion of catastrophic care will expand the federal portion of health care. Government expenditures for health care may represent 40 percent to 50 percent of health care services.[157]

Although the broad universal coverage of national health insurance does not appear to be imminent in the United States, it is likely that the debate about it will continue. In addition, discussion continues about the desirability of expanding current federal health programs in ways that would, in effect, move the country closer to universal coverage.

National health insurance would not necessarily be comprehensive in

154. Cummings & Duhl, *The New Delivery System*, in THE FUTURE OF MENTAL HEALTH SERVICES: COPING WITH CRISIS (L. Duhl & N. Cummings eds. 1986); Schlefer, *The Economics of Mental Health Care in a Changing Economics and Health Care Environment*, in THE FUTURE OF MENTAL HEALTH SERVICES: COPING WITH CRISIS (L. Duhl & N. Cummings ed. 1986).

155. Not all mental health delivery problems are solved under national health insurance programs as mental health programs in Europe demonstrate. *See* L. GOSTIN, MENTAL HEALTH SERVICES: LAW AND PRACTICE (1986); Hoyer, *The Control-Commissions in Norwegian Mental Health Care*, 9 INT'L J. L. & PSYCHIATRY 469 (1987); Jansen, *Mental Health Policy: Observations from Europe*, 41 AM. PSYCHOLOGIST 1273 (1986); Williams & Shapland, *The Code of Practice: Strengthening the Legalist Philosophy?*, 11 INT'L J. L. & PSYCHIATRY 1 (1988).

156. *See generally* K. DAVIS, NATIONAL HEALTH INSURANCE (1975); NATIONAL HEALTH INSURANCE: CONFLICTING GOALS AND POLICY CHOICES (J. Feder, J. Holahan & T. Marmor eds. 1980); PSYCHOLOGY AND NATIONAL HEALTH INSURANCE (C. Kiesler, N. Cummings, G. VandenBos eds. 1980); D. UPTON, MENTAL HEALTH CARE AND NATIONAL HEALTH INSURANCE (1983).

157. DeLeon & VandenBos, *Psychotherapy Reimbursement in Federal Programs: Political Factors*, in PSYCHOTHERAPY: PRACTICE, RESEARCH, POLICY (G. VandenBos ed. 1980).

terms of providing complete mental health coverage. In fact, some legislative proposals have provided for very limited mental health coverage within a national health insurance program. The reasons for this exclusion are the same as those for limited coverage: it is difficult to define what conditions should be covered by the insurance or to determine when the patient is "cured" or no longer needs treatment; there traditionally has been relatively limited consumer demand for mental health coverage and thus mental health may appear to be optional or elective rather than essential; some mental health care is aimed at personal growth or education rather than "real" health care; and mental health care is commonly provided outside the hospital and, therefore, does not fit neatly within hospital-based insurance plans.

The arguments in favor of including mental health care within national health insurance are that mental health problems are as real and as painful as physical disease and those with mental conditions as surely deserve treatment as do those with physical conditions; the failure to provide for outpatient mental health services is likely to result in more expensive hospital treatment; providing good mental health services (especially outpatient care) apparently lowers total health care costs; and physical and mental conditions are related and should be considered together in treating the whole person.[158] If comprehensive mental health coverage proves to be an effective means of reducing total health care costs, then those services will probably be covered by future comprehensive national health insurance proposals. Otherwise the prospect for including broad mental health benefits under national health insurance will remain bleak.

If mental health coverage is to be included in government programs, mental health benefits will have to be narrowly and precisely defined. They should be defined in terms of the treatment of relatively significant mental distress or conditions and the prevention of these conditions when their development is likely. This definition, although imprecise, excludes general growth therapy, encounter groups, and education. While such activities may be worthwhile, classifying them as mental health care tends to trivialize the importance of serious mental health needs. Clearly defined treatment plans against which individual treatment can be measured or considered are also needed. Such an approach obviously has problems in terms of failure to recognize the individual differences among patients, but it is probably neces-

158. *See* Burns, *National Health Insurance: Inclusion of Mental Health Care and Clinical Psychology*, 9 PROF. PSYCHOLOGY: RESEARCH & PRAC. 723 (1978); Cummings, *The Anatomy of Psychotherapy Under National Health Insurance*, 32 AM. PSYCHOLOGIST 711 (1977); McSweeney, *Including Psychotherapy in National Health Insurance*, 32 AM. PSYCHOLOGIST 722 (1977).

sary for third-party payers to be assured that they are not being billed for unnecessary or experimental treatment.

CONCLUSION

It is estimated that at any given time between 15 percent and 20 percent of the population is in need of mental health services. Only a small portion of those needing the services will receive them. Private insurance and government programs such as Medicare and Medicaid generally provide only very limited coverage for mental health services. Even "comprehensive" health plans such as health maintenance organizations often do not provide full coverage for mental health services. The federal government as well as state and local governments directly provide some mental health services. A major effort to make mental health services available to everyone has been the community mental health center program. These programs were never funded as planned and the goal of making mental health care a right remains unfulfilled.

Limiting coverage for mental health services, particularly for outpatient services, may prove to be counterproductive. There is reason to believe that the availability of good outpatient services may reduce mental health hospitalization. It may also be that providing mental health services reduces the demand for physical health services, thereby reducing the total cost of health care. It has been difficult to demonstrate the efficacy of one form of psychotherapy over other forms. However, data do suggest that mental health care in general is effective.

The purpose of licensing is to protect the public from incompetent, and, therefore, dangerous, practitioners and from quacks. In practice, licensing also provides a formal recognition of the profession, tends to reduce the number of people admitted to practice, and protects professions from competition. Thus, while licensing has a potential for protecting the public, it also has a potential for harming it. State licensure laws may prohibit the performing of certain services without a license (practice laws), prohibit the use of a title or label without a license (title laws) or require the licensee to register with the state (registration laws).

There are substantial differences among mental health professions concerning the nature of licensing laws. Psychiatry is essentially without a license requirement, other than that of a Medical Doctor, and any physician can claim to be a psychiatrist. Psychology licensing varies considerably from state-to-state, but most states license doctoral-level physiologists, while a significant minority also provide some licensing or certification for masters-level psychologists. Social work generally recognizes various levels of

licensing depending on educational level. In some states there are also licensing laws for marriage or family counseling.

The requirements for licensing ordinarily include the completion of an academic degree, passage of licensing examination, completion of supervised work experience, and demonstration of good moral or ethical character. Once a license is granted, it is fairly uncommon for it to be revoked. There is generally no requirement for periodic retesting or recertification. State licensure boards are authorized, following appropriate hearings, to remove a license if they find a professional is incompetent to continue practice, or otherwise unfit, it is unusual for a state board to take strong disciplinary action against the holder of a license.

A number of criticisms are leveled against licensing, including that it unnecessarily limits the supply of practitioners resulting in fewer services at higher prices, that it stifles innovation, and that it limits the geographical distribution of mental health services. There is a basis for some of these criticisms, and a number of reforms would strengthen licensing and help protect the public.

In addition to licensing there are a number of other limitations on mental health practice. These include the availability of hospital privileges and authority to prescribe medicines. Both have traditionally been the exclusive province of physicians, although in some areas of the country other mental health practitioners have gained limited hospital staff privileges. Recent revisions in the accreditation standards for hospitals permit hospitals to grant staff privileges to nonphysicians under some circumstances. The debate over hospital staff privileges for nonphysician mental health professionals is likely to continue, with the trend likely to be toward expansion of privileges. Less debate has occurred on the desirability of authorizing mental health professionals with appropriate training to prescribe medicines, but similar arguments can be anticipated.

Major proposals for national health insurance have provided relatively limited coverage for mental health, consistent with current government policies in Medicare and Medicaid.

The immediate future for adequate mental health care is not bright. The long-term outlook is somewhat brighter, although far from certain. To encourage adequate care, essential mental health services should be separated from individual growth or education goals, the efficacy of various forms of treatment should be demonstrated, treatment plans for various conditions should be articulated by the professions, the ability of mental health care to reduce total health care cost should be more clearly established, and the

public should be made aware of the need for and benefits of mental health care.