Coping with the Toll of COVID-19: An Overview of Temporary Changes in Scope of Practice of Mental Health Providers

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COVID-19 led to the untimely death of nearly one million Americans during the first two years of the pandemic. Since the beginning of the pandemic, there has been a twenty-five percent increase in anxiety and depression among both adults and adolescents.[v] The Center for Disease Control and Prevention has documented that these effects are particularly large among women and high school students.[vi] There has additionally been pronounced negative effects on mental health for people of color, including a forty-two percent increase in emergency room visits for stress-related incidents within Alaskan and Native American communities.[vii] With the economic and mental toll that this caused, some states responded by expanding access to mental and behavioral healthcare services provided by psychologists, psychiatrists, and nurse practitioners. State governors used their executive order powers during the pandemic to address the concern of mental healthcare access through immediate policy action, to either expand the states from which they accepted practitioner licenses, allow practitioners to provide patient care through telehealth, or expand the set of tasks and duties a practitioner is allowed to perform without physician supervision.

The accompanying dataset documents the scope of practice expansions for mental healthcare services that were enacted during the COVID-19 pandemic and their status as of June 2021. This does not include expansion orders made by individual hospitals or public health groups but is instead limited to the actions of state governors. The first dataset lists the executive orders related to expanded recognition and license endorsement for out-of-state psychologists, psychiatrists, and nurse practitioners. Most orders were enacted during the third week of March in 2020, but some were enacted as late as December 2020.

Psychologists are often the first point of care for individuals who are experiencing a mental or behavioral health episode. Prior to the pandemic, psychologists would meet with new or existing patients and if a pharmacological intervention was deemed necessary, the patient was referred to a psychiatrist which may take six to eight weeks on average to diagnose the patient, develop a treatment plan, and determine the dosage of medication.[viii] In five states (Louisiana, New Mexico, Indiana, Iowa, and Illinois), psychologists can directly prescribe medication to patients within their states which leads to decreased mental and behavioral distress and suicide.[ix] Prior to the pandemic, many states limited the ability for psychologists to treat patients across state lines or provide telehealth. Since the start of the pandemic, twenty-nine states and the District of Columbia have enacted executive orders that allow for recognition of psychologist licenses from other states. Five of these additionally allowed for expanded telehealth services by psychologists. Connecticut did not expand interstate license recognition, but did allow psychologists to meet with patients through telehealth systems when receiving talk therapy.

Even prior to the pandemic, psychiatrists have been facing a large provider shortage with a national average of 16.6 psychiatrists per 100,000 residents and over 38 percent of the U.S. population residing in a designated mental health professional shortage area.[x] Psychiatrists are a type of physician and are thus eligible to participate in the Interstate Medical Licensure Compact (IMLC). The IMLC provides all physicians a shorter pathway to multi-state licensing across all 30 participating states. While the compact allows for easier pathways to interstate licensing, it does not allow for immediate license recognition. This was particularly problematic during the COVID-19 pandemic when states were aiming to increase the number of available practitioners in a few days, not months. Forty governors signed executive orders to expand the recognition and reciprocity of psychiatrist licensing, while nine states additionally allowed for psychiatrists to begin servicing patients through telepsychiatry. Telepsychiatry includes Zoom, Skype, or other services that allow for patients and providers to maintain an at-distance visual discussion when considering treatment options.

Nurse practitioners are also an important provider of mental health care. Eighty-five percent of nurse practitioners focus on providing primary care and general wellness. While the overwhelming majority of nurse practitioners work within primary care, some nurse practitioners do specialize in providing mental and behavioral healthcare that includes talk therapy, counseling, and in some states even prescribe medications for patients with the appropriate diagnoses. During the COVID-19 pandemic 37 states and the District of Columbia further expanded the recognition of out of state licenses, beyond the shorter path to interstate licensing reciprocity provided through the Nurse Licensure Compact. Three of these executive orders specifically address expanding telehealth services. It is important to note that the ability to provide telehealth services was already common practice for nurse practitioners prior to the COVID-19 pandemic, but the ability to bill for telehealth services was severely limited for psychologists and psychiatrists.

Several of the executive order expansions in telehealth services and interstate license recognition ended between mid-2020 and late 2021. It is now important for states to evaluate the benefits of maintaining or reinstating expanded scope of practice for psychologists, psychiatrists, and nurse practitioners. Since these executive orders have been put in place, individuals have developed care plans and trust with providers. Removing these expansions not only limits the services that can be provided, but also forces current patient-provider relationships to end during patient treatment. Abrupt ends to these relationships can result in detrimental mental health outcomes for patients receiving care from out-of-state practitioners or through telehealth resources. The data provided here is meant to serve as a tool for further policy research investigating the effects of expanded mental health access during the COVID-19 pandemic, in the hopes that the policy expansions and their potential effect (or lack of effect) on quality and safety of patient care may be better understood.

Note: Information from executive orders were hand-collected and verified by students at the University of South Carolina. We thank them for their diligence and any remaining mistakes are those of the authors.

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[v] https://www.who.int/news/item/02-03-2022-covid-19-pandemic-triggers-25-increase-in-prevalence-of-anxiety-and-depression-worldwide
[vi] https://www.cdc.gov/media/releases/2022/p0331-youth-mental-health-covid-19.html
[vii] https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2790337
[viii] Thomas, Kathleen, Alan Ellis, Thomas Konrad, Charles Holzer, and Joseph Morrissey. (2009). County-Level Estimates of Mental Health Professional Shortage in the United States. Psychiatric Services, 60(10):1323-1328.
[ix] Roy Choudhury, Agnitra and Alicia Plemmons. (2021). Deaths of Despair: Prescriptive Authority of Psychologists and Suicides. Working Paper August 2021, Center for Growth and Opportunity.
[x] Mental Health Shortage Areas are designated by the Department of Health Resources & Service Administration. The list of shortage areas and associated data may be found at https://data.hrsa.gov/topics/health-workforce/shortage-areas.