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## MEETING NOTICE

### LCSW Education Committee October 27, 2008

Embassy Suites  
Mendocino/Burlingame Room  
150 Anza Boulevard  
Burlingame, CA  
(650) 342-4600

#### By Teleconference From:

12 Clear Creek  
Irvine, CA 92620

**9:30 a.m. to 2:30 p.m.**

- I. Introductions
- II. Purpose of the Committee
- III. Review and approval of the May 5, 2008 meeting minutes
- IV. Review and approval of the June 23, 2008 meeting minutes
- V. Statistics Related to Outcomes in the LCSW Licensing Process
- VI. Minnesota Report on Baseline Competencies for Mental Health Professionals
- VII. Discussion of Desired Skills in Public Mental Health Agencies
- VIII. Review of Foundation Year Curricula, Concentrations and Specializations in Master's Level Social Work Programs
- IX. Future Meeting Dates
- X. Suggestions for Future Agenda Items
- XI. Public Comment for Items Not on the Agenda

*Public Comment on items of discussion will be taken during each item. Time limitations will be determined by the Chairperson. Items will be considered in the order listed. Times are approximate and subject to change. Action may be taken on any item listed on the Agenda.*

THIS AGENDA AS WELL AS BOARD MEETING MINUTES CAN BE FOUND ON THE BOARD OF BEHAVIORAL SCIENCES WEBSITE AT [www.bbs.ca.gov](http://www.bbs.ca.gov)

NOTICE: The meeting facilities are accessible to persons with disabilities. Please make requests for accommodations to the attention of Christina Kitamura at the Board of Behavioral Sciences, 1625 N. Market Boulevard, Suite S-200, Sacramento, CA 95834, or by phone at 916-574-7835, no later than one week prior to the meeting. If you have any questions, please contact the Board at (916) 574-7830.



Arnold Schwarzenegger  
Governor  
State of California  
State and Consumer  
Services Agency  
Department of  
Consumer Affairs

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## DRAFT MEETING MINUTES

### LCSW Education Committee May 5, 2008

Department of Consumer Affairs  
1625 N. Market Blvd.  
Hearing Room, First Floor  
Sacramento, CA 95834

**Committee Members Present:**

Renee Lonner, LCSW Member, Chair  
Gordonna DiGiorgio, Public Member  
Joan Walmsley, LCSW Member

**Staff Present:**

Paul Riches, Executive Officer  
Mona Maggio, Assistant Executive Officer  
Christy Berger, MHSA Coordinator  
Sean O'Connor, Outreach Coordinator  
Christina Kitamura, Administrative Assistant

**Committee Members Absent:**

None

**Guest List:**

On File

Renee Lonner, Chair, called the meeting to order at 10:06 a.m.

#### I. Introductions

The Committee introduced themselves in place of roll. A quorum was established. Staff and audience members also introduced themselves.

#### II. Purpose of the Committee

Ms. Lonner explained that the LCSW Education Committee (Committee) will be looking at the landscape in terms of how Licensed Clinical Social Workers (LCSWs) are prepared to face today's workplace which includes many different types of settings. In terms of education, the Committee is concerned with those MSWs who are interested in obtaining a clinical license. The first question is what do LCSWs need as an educational foundation in order to be able to land on their feet in this complex environment and in workplaces where the level of demand is typically very high. We need to look at the core competencies required for licensed independent practice.

The Committee's role is information gathering and data collecting, and the Committee hopes for a great deal of feedback from stakeholders. This is an open-ended inquiry, and the Committee does not know where it will lead. This process will take many months, and

the Committee will travel around the state and talk with people. Ms. Lonner expressed her appreciation to all of those who took the time to attend the meeting.

### **III. Review of Information Sources and Key Stakeholders**

Christy Berger listed the sources of information and key stakeholders that staff and the Committee members have identified. Ms. Berger asked audience members to provide additional sources of information.

Janlee Wong, Executive Director of the National Association of Social Workers (NASW) California Division, pointed out that it would be helpful to understand the distinction between social work as a vocation versus social work as a profession. He suggested some informational sources: the NASW clinical standards, the NASW code of ethics, and NASW statistics and demographics that are on its website under the Center for Workforce Studies. He pointed out that because California only has one license it has become the catchall license, and it is being used by the outside world in many different ways. He knows the Board can't control that but it does affect social work education and the public's perception of what social workers do. He applauded the Committee for its effort for taking this on because it will be a chance to describe and talk about the full breadth of social work.

Paul Riches stated that we should obtain some job descriptions from around the state that carry the social worker title and require the LCSW license. This will give the Committee and staff a better idea of which workplaces and settings require the license.

Ms. Walmsley asked if there was any title protection for social workers. She believes this is hugely impacting the profession. She doesn't know if it is appropriate for this Committee to address, but it is a valid issue.

Mr. Riches stated that he received additional feedback on data sources, and asked others for suggestions on identifying other stakeholders and to provide that information.

### **IV. Review of LCSW Occupational Analysis**

Ms. Berger explained that an occupational analysis is a method a method for identifying the tasks performed in a profession or on a job and the knowledge, skills, and abilities required to perform that job safely and competently. It provides a comprehensive description of current practice, and is a snapshot in time. The results of an occupational analysis are used to form the basis of an examination program. It is used in other ways also, and there is a lot of information the Committee can take from it.

Ms. Berger explained that the most recent LCSW occupational analysis was performed in 2004, and that the Board contracts with the Department of Consumer Affairs' Office of Examination Resources (OER) to perform the analysis. The analysis involves interviewing and surveying LCSWs who are working in different practice settings and different parts of the state to obtain information and survey them about what they do. The results of the analysis are used to form the LCSW examination outline.

Mr. Riches stated that one of the central issues is that occupational analyses are evolutionary documents, fundamentally grounded in what came before them, that is, there is a baseline they work from. There may be a significant disjuncture due to intervening events such as MHSA and changes in funding and programmatic structure. Given this occupational analysis, absent any input this is the blueprint as it relates to licensed

practice about the totality of knowledge we expect from our licensees: 1) Does it still make sense? 2) Are there big things we're missing? 3) How does this address the actual workplace as it relates to doing clinical social work in California? We are hoping for some feedback on that because it is a starting place for the Committee's work.

Mr. Wong referred to the demographic data in the occupational analysis. He stated that statistics on the incoming social workers show that whites are a minority and will be so increasingly. The occupational analysis is done on a random sample, and it is developed to try to be inclusive to minority groups. But there is a gap between the incoming social workers and the licensees who get surveyed. It is important because those new social workers will be taking the exam and will be culturally different than those who were surveyed for the analysis. This may impact who passes and who fails the exam. If we have a whole new population of social workers who are very ethnically diverse, how is that accounted for in the sampling of persons to receive the survey?

Inna Tysoe from the Department of Mental Health asked when the current exam was constructed. Mr. Riches responded that the occupational analysis resulted in a content outline that is the basis for all of the examinations, and this was last done in 2003. The Board develops two new forms of the examination each year based on that same content outline.

Heather Halperin from the University of Southern California's (USC) School of Social Work stated that she noticed that the examination outline seems to lack the influence of culture and the tremendous movement toward evidence-based practice. So there are interventions included but they are not based on theoretical knowledge.

Mr. Riches summarized the issues raised that the committee should include on future agendas: the influence of culture, bringing someone in to speak on evidence based practices, and demographics in occupational analyses (historically and what projections might look like). The Board is at a point of opportunity where it will conduct the next occupational analysis in about 18 months so if there are gaps we can work with OER to address those gaps.

Mr. Wong suggested bringing in presenters on recovery-oriented practice. He suggested that they prepare by looking at the occupational analysis and content areas and commenting on what fits and what doesn't fit that type of practice. Ms. Lonner responded that recovery oriented care is a huge effort going on all over the country. Mr. Riches stated that the California Association of Social Rehabilitation Agencies (CASRA) and the National Mental Health Association of Los Angeles have provided great information in the past but the Committee and staff are open to other ideas.

Mr. Wong stated that the federal Substance Abuse and Mental Health Services Administration (SAMHSA) have some consultants, speakers and presenters on this subject, and they often come to California. He offered to contact Mr. Riches the next time they come to California. This is a national movement, and it is being recommended by the federal government. While we have good experts in California, it would be interesting to hear about it from a federal level. Mr. Riches asked if anyone has a contact at SAMHSA. Geri Esposito, Executive Director of the California Society for Clinical Social Work (CSCSW), stated she would check.

Mr. Lonner stated that mental illness is debilitating and recently read an article stating that it is second only to cardiovascular disease in terms of how debilitating it is.

Mr. Wong suggested we involve the Veterans Administration and military, because there are a huge number of injured soldiers. The VA is a federal agency so their standards require social workers to have taken the Association of Social Work Boards (ASWB) examination. It would be important to get their perspective on what kind of training LCSWs should get and what examinations they should take. These are key agencies that we would benefit a lot from involving in this process.

Mr. Riches asked about bringing in someone to talk about trauma and disaster response, as the government is looking for licensees to perform that kind of work. It would be worth giving some attention to because it is basic to public protection. He asked if someone could provide information on who to contact for more information. Mr. Wong suggested that we also address school violence, related yet a little different because it is on a campus. He stated he would email Mr. Riches with some contact information.

Ms. Walmsley suggested looking at medical social work. She may know someone, and asked Ms. Halperin if she knows anyone. Ms. Halperin stated that she knows Sharon Massey from Cedars Sinai and June Simmons from Huntington Hospital. She also suggested Marlene Wong, who does disaster work nationwide and in Los Angeles schools, and Ron Aster from USC who would be a resource on school violence.

Ms. Esposito stated that one of their members, Lou Monet, was hired by the military and he debriefs troops coming back from Middle East. He may be a good first-person speaker about this topic. She believes it is good to have organizational overviews, but it is better to hear from the individuals actively doing the work when possible because they can talk about their learning curve, and how easy or hard it was to adapt to these settings. Ms. Lonner stated that she knows someone who works with military families that may be of assistance.

Mr. Wong stated that the California Department of Corrections and Rehabilitation is trying to forecast their need for social workers and are doing a lot of recruiting. The parallel agency is the state Department of Mental Health, and they have a lot of forensic facilities. Key people could be the chiefs of social work at each of these institutions. This is so important because they are actively seeking out new young social workers, and we need to know how well these social workers prepared for these types of agencies.

Ms. Walmsley stated that she and Ms. Lonner have both practiced in many different types of settings and would be able to help provide that perspective. Ms. Lonner stated that one of the unique things about social work is the variety of work settings, and the person in the environment perspective.

## **VI. Future Meeting Dates**

This agenda item was taken before the presentation from the California State University at Sacramento (CSUS) in order to allow time for the guest presenter to arrive, since the prior topics finished early.

The next two meetings will be held on June 30 and September 15, 2008. The Board is trying to find locations that are accessible and will maximize participation, and would like to meet at schools, but the logistics can be complicated.

Ms. Halperin stated that she may be able to help, and suggested holding meetings at USC or Hebrew Union College. An audience member suggested the Center for Child Welfare.

Mr. Riches stated that we want to encourage participation but know that summer months are absent of faculty and the student base. Ms. Halperin stated that September can be difficult for schools also. Mr. Riches asked for any other suggestions for locations. Charlene Gonzalez suggested the California Endowment in Los Angeles; it may be available at no cost.

Mr. Riches asked Ms. Jensen if there would be meeting space available at CSU Chico. Ms. Jensen responded yes, but cautioned that it is not the most accessible as far as flying. Mr. Riches stated that we would keep Chico in mind.

Mr. Wong suggested meeting at The Village in Long Beach, the program that is nationally known for their use of the recovery model. Mr. Riches stated that the Board hopes to visit The Village, possibly in conjunction with our November board meeting, as it would be highly educational.

Ms. Lonner received a special request to change June meeting from 30<sup>th</sup> to 23<sup>rd</sup>, which the committee agreed to do.

#### **V. Presentation about Graduate Social Work Education from the California State University at Sacramento, Division of Social Work**

Mr. Riches introduced Dr. Robin Carter, Director of the Division of Social Work at California State University of Sacramento (CSUS). Dr. Carter provided some background about the national accrediting standards for social work education from the Council on Social Work Education (CSWE), and handed out a copy of the accrediting standards. She stated that the standards provide some sense of how programs are structured, but to get a better sense you would have to look at individual programs. Accreditation is required for any school that wants the degree to be transferable, qualify for licensure, and be credible. There have been some revisions in the policy standards, which may have been released recently, but they are not radically different. All of the current programs are based on this version of the accreditation standards.

She explained that accreditation is important because the Board focuses on consumer protection, and there are many elements of accreditation that are in line with consumer protection. It is not just about designing content, and there are a lot of requirements that help promote quality programs.

Dr. Carter referred to page six which talks about the structure of social work education. Each program has a different mission and is designed around that mission and its particular objectives. Programs can be very different. Mr. Riches asked in terms of formulating a mission, do schools consider the regional needs, or are there some that have a national focus? Dr. Carter stated that the programs in urban areas, for example, would typically have part of their mission as serving that community. Some programs are much more focused on preparing people for a certain kind of social work. CSWE requires the content of the curriculum to reflect the mission and objectives. CSUS advises students who are looking for a program to think about the type of social work they want to do or what community they want to serve to help them make that decision.

Mr. Riches asked when formulating a mission is that something that the faculty does or is it from the school on a larger basis. Dr. Carter responded that it tends to be layered, the universities have a broad mission and her program is under a college, but some are standalone schools of social work. For CSUS, the university has a mission, the college has a mission and the program has a mission. The mission is formulated by the faculty.

She stated that CSUS is going through a reaffirmation of their accreditation, which has to be done every eight years. It takes about two years to prepare for reaffirmation.

Dr. Carter next referred the committee to page seven which states that all programs must have a professional foundation, which basically means in order for a program to have transferability or uniformity across the degree, there are certain things every program must contain. This speaks to the objectives of the foundation curriculum content, what must come first in the graduate program and the concentration curriculum and objectives.

She next referred to the bottom of page eight, which states that the foundation curriculum must have the following content: values and ethics, diversity, populations at risk, social work practice/theory, social welfare policy and services, research and field education. This content must be completed before moving on to the advanced curriculum. The foundation curriculum will look pretty much the same across MSW programs although some may have a different number of classes or the course names might be different but they all must have this content.

Dr. Carter continued to explain about the advanced content in the second year, which is where the concentration content is delivered. She explained that in general, all of the programs are set up this way. Some deliver the program in two years and some in four years for part time students. The programs tend to require about 60 units.

The advanced concentration content is not specified in the CSWE standards, and that is why programs look very different. She clarified that a concentration means there has to be a focus to the advanced curriculum. The focus could be a generalist perspective, but many programs have specific concentrations such as child welfare, mental health, school social work, etc.

Mr. Riches asked if most programs have a variety of concentrations available, and how many choices are generally available. Dr. Carter stated that CSUS has one advanced multi-level concentration. However, it ranges because some schools have two concentrations, larger schools may have four. It depends on the mission of the school and what they are attempting to do. Ms. Walmsley asked whether a school could have only one concentration, for example in mental health. Dr. Carter responded that this is a possibility.

Dr. Carter explained that there are also opportunities for specializations. For example, CSUS though it only has one concentration, which is multi-level practice, offers a number of different specializations. This means that all students get an advanced curriculum that introduces them to social work in all levels of practice (micro, mid level and macro), and on top of that there are opportunities for specialization, especially with the Mental Health Services Act (MHSA) and the stipend programs. Students are not locked in during their second year, but they can choose a set of courses and an internship that allows them to specialize.

Dr. Walmsley asked if CSUS has a medical social work specialization. Dr. Carter stated they do not, but they are also developing an aging specialization. Dr. Carter offered to have other schools represented in the audience come up and talk about how their programs are structured.

Mr. Riches asked at what point students select their concentrations. Ms. Halperin from University of Southern California (USC) stated that students are given an overview of their choices in January of their first year. During the spring, students choose three agencies

specific to their concentration and meet with concentration coordinators. Students will interview in May and will know their placement by July 1. Mr. Riches asked if this process is competitive. Ms. Halperin responded that it is, and is becoming more and more so. The second-year students are interviewing and competing with students at other schools. Mr. Riches asked if the student does not get the placement, could they still do that concentration. Ms. Halperin responded that they will still be able to do that concentration but their placement will be in the second round, which takes them to three other placement choices. USC offers five concentrations and also sub-concentrations.

Ms. Hunter from CSU Chico stated that their structure is similar to CSUS, they have one concentration with specializations in children, family and youth and mental health. She explained that students have the same curriculum in the concentration year, such as everyone has to take a policy class but they would take a mental health policy class if their specialization was mental health. So coursework looks a little different based on the specialization.

Ms. DiGiorgio asked what if a student chooses a specialization and discovers that they don't like it. Do they have to go back and take another specialization? Ms. Halperin responded no, they just work in the field until someone hires them for what they want to do. Dr. Carter responded that CSUS is a little different, as everyone takes the same curriculum in the second year except for the seminar, electives and field placement. They moved away from offering concentrations because students would choose a concentration but then get a job in another area, or decide they wanted to do something different, or their agency needs them to do something different. She explained that there is no perfect curriculum, but CSUS tries to address that by giving everyone a concentrated focus across the board and an opportunity to specialize. There are advantages and disadvantages to both ways.

Ms. Halperin stated that USC is structured a little differently in the second year than CSUS. Previously, the second year curriculum was very specified and tight with only one elective. They did a curriculum revision, and now there are core courses that all students are required to take but they get to choose four electives that are linked to their concentration. They have more flexibility, but the core is very concentration-focused.

Mr. Riches asked about field training. Dr. Carter stated that all MSW programs have 900 hours of supervised fieldwork during the two-year period. She reiterated that accreditation standards specify the minimum everyone must have, but most programs have more than the minimum. Everyone does it differently, some in blocks, some within a semester. Some, such as CSUS requires, spread it out over the course of the four semesters. CSUS screens and closely monitors the field training to make sure the people who supervise have the right credentials and that it is truly an educational experience. The most significant part of the learning experience happens in the field.

Mr. Riches asked if the field placement hours are all tied into the academic calendar or can it be done during the summer or off periods. School representatives responded that it varies. For example, CSU Chico does it only during the academic year, and Long Beach has a summer unit. Mr. Riches asked when someone is placed do they stay at that agency for the whole time or do they move around. At CSU Chico they typically have one placement in the first year and another in the second year.

Mr. Riches asked if there is an on-campus fieldwork course offered that is tied to the field placement. Ms. Hunter stated that it varies from school to school, but they have an integrated seminar where students meet every other week with the seminar instructor to

process their experience and that instructor is also the field liaison that goes out to the agencies to monitor how those placements are going. She explained that CSU Chico also has a three-year program that uses a hybrid model, which is an internet based seminar and meeting face to face two times on campus. Some schools do not have the seminar separated out; they may have that as part of their practice course. Dr. Carter stated that CSUS' program's fieldwork course is part of the practice course. The practice instructor is also the liaison to the agency. However CSUS is considering going back to integrated seminar. USC has an integrated seminar, which is a two-unit pass/fail class and is changing to become a graded class. It meets on a weekly basis for the foundation year only.

Ms. Halperin stated that CSWE does not require field instructors to have a MSW. The reason is that other areas of the country have a limited number of MSWs so it could cause difficulties in finding placements. Dr. Carter stated that CSWE requires a social work focus, so CSUS allows people other with similar degrees to supervise the student on a day-to-day basis but an MSW must spend time with them to assure the social work focus. Ms. Hunter stated that CSU Chico students have a task supervisor that is not a MSW but they also meet for an hour a week with a MSW for individual supervision. It is very challenging to find MSW-level social workers to act as supervisors in their area of the state.

Mr. Wong asked whether there are any field placements in a private independent practice setting, and if there are any non-private practice settings that approximate a 50-minute hour. Dr. Carter replied that CSUS does not place students in private practice. They tend to focus more on non-profits, and if they use a for-profit agency they expect them to pay the student a stipend. They do have students doing the traditional 50-minute hour. Ms. Hunter responded that CSU Chico does not have field placements in private practice, but do occasionally in a for-profit agency. Ms. Halperin stated that they will use any agency that will take their students, and they have students who do 50 hours in a family service agency or in county mental health.

Ms. Walmsley clarified whether schools really do place students in a private practice setting. The school representatives all responded no. Ms. Halperin mentioned that it is a more well rounded experience to work in non-profit and county agencies.

Mr. Riches asked if the site-based supervision provided to students is done individually or in groups. Ms. Halperin responded that USC requires 1.5 hours of individual supervision per student per week. They also ask, if the agency has more than one student, to do one hour of group every other week. If it is a large agency with many trainees they probably have group supervision built into it, usually weekly. They must have individual supervision too. In reality it often gets dropped to an hour per week. Dr. Carter and Ms. Hunter stated that it is the same for their schools.

Ms. Esposito asked Ms. Halperin if USC actually uses a private practice setting for a pre-MSW student. Ms. Halperin responded no, they do not. Ms. Esposito stated that CSCSW would be against such a thing. Since the advent of managed care the resources available to nonprofits has dwindled and it is inconceivable to place a pre-MSW student in private practice.

Dr. Carter stated that it is assumed that when students graduate that they have the opportunity to work in that type of setting. She would find it hard to supervise and would be concerned about the opportunity for exploitation.

Ms. Halperin stated that USC tries not to have students in placements where the student already works, although students would really like that. She tells them that they can only stay there if it is a large enough agency to be in a different location doing something they have not done before. Dr. Carter stated that CSUS does the same thing.

Mr. Riches asked how many full-time equivalent students are in the programs. Dr. Carter stated that CSUS has over 300. Ms. Halperin stated that USC has over 600, but that includes about 100 part-time students. CSU Chico has about 75 full-time and about 30 or 35 part-time students.

Ms. Hunter clarified that the field placement is often where students can get more of a clinical focus if they plan to get licensed, but it is important to remember that not all MSW students plan to get licensed. The curriculum must be able to meet the needs of all of those students. When they have a student who wants to work toward licensure they have that discussion in the placement process, which helps them find the right agency. It is becoming more and more difficult to find because agencies are cutting back and may not want to take students on. To fit more clinical training in the curriculum would be very difficult.

Mona Maggio asked if someone selects a concentration and doesn't want to go down the licensure path, do they ever later find out that their agency will require them to get a license? The school representatives responded yes. Ms. Maggio asked how they would then gain the knowledge to be successful in the licensure process. Ms. Hunter said there is a two-year period in which they are required gain hours of experience toward licensure so it is important to look there to see what is happening.

Dr. Carter stated it is important to remember that unlike other licenses, MSWs can't accumulate their hours until post-graduation. So they get the 900 hours of fieldwork and then the additional 3200 hours. Even if we have students who are clinically focused, do that specialization and placement in that area, most feel they are not ready even with the MSW. They still need experience in the field, that's why the 3200 hours is required. She stated that she couldn't imagine any student leaving an MSW program ready to sit for the LCSW exam, that two-year period is critical.

Dr. Carter stated that she is a perfect example of that. She did a health concentration, worked in hospitals and did not plan to get licensed. But then medical settings began to require a license and she didn't feel able to compete for those kinds of positions. She went back and chose settings where she could get clinical experience. She felt her degree preparation was adequate, and she just needed more experience. Ms. Halperin stated that USC focuses on creating a solid foundation and the students have to build upon that and learn about the different phases of social work and what they want to do.

Dr. Carter moved on to discuss expectations around quality social work programs and referred to page 13. CSWE looks at how programs are governed, such as whether they have adequate resources, the ratios of student to faculty, and the administrative structure. For the most part schools offer small classes and small seminars to promote quality education. CSWE also requires administrative people in place to run program, expectations for the faculty as indicated on page 15. It is expected that the level of diversity in the content of the programs based on local demographics, and diversity is also expected in students and faculty. They look at admissions policies, student admission and retention policies, and a number of other things to ensure quality programs.

Mr. Wong asked if the school representatives could explain how much direct services, clinical social work, and psychotherapy that MSW students perform. Dr. Carter replied that this is not specified in CSWE standards. CSUS does require all students to have at least one field placement in direct service, even if that student only wants to do policy level social work. Because CSUS has a specialization in mental health they know those students have an interest in clinical social work, but it is their belief that clinical social work belongs to all MSW students in every specialization. For example child welfare students need to know psychopathology, good assessment skills, etc. It is important that content in clinical social work is woven throughout the program. As far as psychotherapy, CSUS has classes where it is taught but it is more likely they will get to practice this in the right placement. Everybody gets to perform direct services, everyone gets to do some clinical content, and fewer get to do psychotherapy.

Ms. Hunter stated that CSU Chico is very similar to CSUS in that regard, and that it depends on the student and the agency. The agency is very mindful of when a student is ready to offer psychotherapy students. Ms. Halperin stated that USC is also a little different. Every student gets to perform direct services. Students are required to have 50% of their hours in direct services by January of the foundation year. Direct services may include clinical work, case management and psychotherapy. Many of their students are doing psychotherapy in the first year, even in the first month. It depends on the student, some come in with a lot of experience.

Ms. Hunter stated that there may be some variation in peoples' definition of psychotherapy. Her students get good clinical exposure but they are not doing much intensive psychotherapy. The agencies carefully select a few clients for each student to work with and would choose those clients with a lesser degree of pathology.

Ms. Walmsley stated she went to University of Chicago and in her first year was doing psychotherapy. She stated her opinion is that clinical work includes any face-to-face contact with people. Psychotherapy takes on a meaning of its own.

Ms. Halperin stated that every student is required to do process recordings that their field instructor reviews, at least one per week while in placement. Dr. Carter said CSUS requires journals unless the field instructor specifically requires process recordings. Ms. Hunter said that it would not be possible for the field instructors to review these every week. The field instructors do not have the time to review the process recordings so they moved away from that requirement. Dr. Carter said that the other part of the curriculum design is a concurrent model. They must be in a practice class that compliments field experience.

Mr. Riches asked for the difference between a field class and a practice class. Dr. Carter defined field as internship, but they register for it and receive a grade for it. Ms. Hunter stated they may also have a seminar that accompanies the field class, where they are processing cases.

Mr. Riches asked what is learned in practice class. Ms. Halperin responded that they are learning practice theory; they are applying practice theory in integrated seminar; and they are utilizing practice theory in placement. Dr. Carter stated the bridge between theory and application occurs in practice.

Ms. Jensen stated social work practice is an ambiguous term. It is not truly reflective of what is involved in school curriculum as far as theoretical frameworks and interventions,

and human behavior of social environment. Sometimes course titles do not reflect the nature of what is taught.

Mr. Wong referred to the LCSW exam outline. He stated that being prepared for the exam is based on the coursework that is taught in the MSW program. The outline includes biopsychosocial assessment, diagnostic formulation, treatment plan development, resource coordination, therapeutic intervention, legal mandates and obligations, and ethical standards. The exam is currently structured this way. Are these content areas covered in the curriculum?

Dr. Carter responded yes, there is exposure to that content, but not well enough to sit for the exam once they finish their MSW. Ms. Hunter responded yes, they take a series of practice classes in which the diagnostic and treatment planning is looked at, and they take an assessment course for one semester that focuses on crisis assessment as well as DSM-IV category. In the first foundation of the practice class, they are writing biopsychosocial assessment. Ms. Halperin responded that they cover everything except for diagnostic. USC does not have a required class for DSM. It is offered as a one-credit class elective. Not every placement requires them to have an understanding of diagnostic in a DSM focus.

Ms. Walmsley asked why DSM was not included. Ms. Halperin responded that DSM is considered a specialty of mental health. She stated that it is not included during the foundation year, but it is included during the second year under the mental health tract. Dr. Carter stated that CSUS requires the DSM course. The practice class has a community mental health focus so that they can get that exposure.

Ms. Walmsley asked how field instructors in supervision are evaluated in their skills and their ability to prepare students to practice. Dr. Carter responded that they have an application process for field instructors and take the initial class. There is no interview process. Students and faculty liaisons conduct an evaluation of the field instructor at the end of each semester. Each student has a liaison whose responsibility is to develop the agency and the field instructor. If field instructors do not provide the educational experience that affects the students, then those agencies are not used. Ms. Hunter stated that CSU Chico has a similar process. Feedback is provided from students and liaisons at the end of the year. From that, it is sometimes decided not to utilize certain field instructors. Ms. Halperin responded that USC has an application process. They commit to meeting with field instructors and assess them. However, they do not truly know what it is they are assessing. At the end of the year, students evaluate the field instructors. If field instructors are not doing well, USC tries to not utilize them. Sometimes, however, those field instructors are used when they are finding placement for 2,000 students.

Mr. Wong asked the school representatives to talk about how practice informs education. Is faculty in touch with what happens in the field, in practice and vice versa? Dr. Carter responded that faculty is evaluated at the 10-year and post 10-year. One component of the evaluation is community service. There is an expectation that faculty will continue to be involved in community service. Ms. Hunter stated that CSU Chico is similar to CSUS in that respect. She tries to bring in a panel of field instructors at least once a year to meet with faculty and have a discussion regarding their agencies, trends from the agency perspective, skills and knowledge that students need. They have an advisory board that takes this information and feeds it back into the curriculum. The MHSA Stipend Coordinator on the faculty has been a valuable resource to the faculty. Ms. Halperin stated that every practice faculty at USC is directly involved in the community. One research faculty joined a large Los Angeles organization to do a research study of

evidence-based practice with students in the agency, and put together a conference informing the academic world about what is happening in practice and vice versa.

Mr. Riches asked to what degree is online education being taken up in the social work programs. Are schools offering online courses? If so what courses seem to run best to the online format versus other courses that are not well suited for it. Dr. Carter responded that she is not aware of CSUS delivering a complete program online. CSUS has only offered electives online. They offered a research class once, and it did not have good results. CSUS and CSU Chico are looking at offering some programming for the small northern counties that are most interested in getting people into social work degree programs because they don't have access to the institutions. Ms. Hunter responded that CSU Chico has offered electives and the human behavior course online, and those have done well. They have not offered the practice classed online. This is their first year in offering the hybrid field seminar.

Ms. Jensen stated that there are two complete online social work programs in the nation: Florida State and North Dakota, fully accredited by CSWE. CSU Chico has a 3-year weekend program where students come to campus once a month. CSU Chico wanted to do more frequent field seminars. Many students are in employment-based internships, so there are more critical needs, and CSU Chico wanted to be sure the students were not doing the same jobs and caseloads; they wanted to have more contact with the students. They developed a series of modules where all the students do not have to be online at the same time, but have to complete very two weeks. The modules consist of discussions, both written and verbal. They do verbal case presentation on a case in their agency, and everybody has to respond. There are discussion questions that address a variety of issues. Students are shown what professional social work education looks like; a cultururation to professional social work is what is focused on all the way through practical documentation, counter transference, secondary trauma, and topics that might come up in a face-to-face seminar. Students either love it or hate it. As an instructor, Ms. Jensen noticed that students go deeper due to the ability to process the information and think about what they write; there is a richness to how the students interact online.

Ms. Halperin stated that the only course that she knows of that is offered online is the DSM.

Ms. Esposito asked the school representatives find that there are political problems with the DSM as an instrument, and if they have a sense from their faculty where there are feeling about the DSM as an instrument. The feedback that Ms. Esposito receives is that the DSM is disliked because it is a labeling instrument.

Dr. Carter responded that a former faculty member at CSU Sacramento wrote a book against the DSM, and the faculty shared that feeling for a long time. Dr. Carter stated that they teach it in the context of the person environment. It's become a bigger challenge with the introduction of the MHSA and putting recovery at the forefront. There was a lot of discussion in the DSM course regarding content. Most of the faculty is now onboard and agrees that this is critical content especially if students are going into a mental health setting. Knowing how to use it, when to use it, how it can be abused and misused along with all the layers is important. About 100 students each year take the DSM course.

Ms. Esposito stated that it concerns her that MHSA students probably have more knowledge of the recovery model than many of the people they are working because those cultures have not changed yet. Without supplying them with the language of mental health as it is now – which is a medical model - they are being put in a disadvantage.

Dr. Carter stated that they have certain field placements that require the DSM course. Ms. Hunter added that it is the tool of the trade for mental health diagnostics and billing. There is an obligation to teach the knowledge of the DSM as well as the limitations, evidence-based practice, and the how the diagnostic clusters are formulated. There is a struggle within the profession, and there will be struggle amongst students, regarding the movement towards the recovery treatment and the varying levels of acceptability in the clinical world.

Mr. Wong asked the school representatives feel that the recovery-oriented model is taught in social work education now, and how they felt about recovery being taught in social work education?

Dr. Carter responded that all of the programs in California that are receiving the MHSA funding have done a great job implementing the competencies into the curriculum. Ms. Hunter responded that some of the faculty members are more traditional psychopathology-oriented medical model driven folks. The school has accepted the charge into making the transformation into a more recovery-oriented language and treatment. They are incorporating those curriculum competencies, but all faculty members incorporate it differently based on their beliefs and orientations. Each university is incorporating it differently, but it is happening.

Dr. Carter added that students are excited about the recovery training. But once they get to the agencies, they discover that the agencies are not there yet.

Dr. Carter asked if the Committee will have dialogue with CSWE. Mr. Riches responded that staff is having a conference call with CSWE representatives in the next week, and will invite them to attend a Committee meeting to join in the discussions.

## **VII. Suggestions for Future Agenda Items**

Suggestions for future agenda items were discussed under agenda item IV.

## **VIII. Public Comment for Items Not on the Agenda**

Ms. Esposito stated that recently the BBS created a chart that compared the licensed professional counselors (LPC) with the MFTs and LCSWs. She was appalled at what was listed on the LCSW column – it was not reflective of what the students get in the curriculum. Ms. Esposito asked the school representatives if they could suggest how we might look at the schools and the education process for the purposes of legitimizing the LCSWs, who they are and what they do in the marketplace - the public marketplace, not just the private marketplace – when there is nothing to hang a hat on. How do LCSWs justify what they do and how they are educated?

Dr. Carter agreed that the chart created by BBS was not reflective of what the students get in the curriculum. Schools do have this foundation and standards, but it doesn't all look alike. There is nowhere you can go where it states that all schools of social work has a DSM course unless you go to each school and go through their course catalogues. It would be important to attend a CalSWEC meeting and have that conversation. There's an assumption that social work is not willing to put the curriculum in statute, but there has not been a dialogue about it. There is a strong belief that social work is a lot of things, and social workers do not want to be defined as one thing, and assumed to be nothing else.

Ms. Hunter stated that CSWE came out with field education as being the new signature pedagogy, which is a piece that social workers can hang their hat on. The number of hours completed in the graduate program, the hours completed before licensure, the amount of supervision, and the breadth and depth of field placements all present the case of how skilled and knowledgeable social workers are in a variety of areas.

Dr. Carter stated the social workers have to protect themselves. Ms. Halperin stated that social work is very broad, and it's difficult to protect it if others are saying that there is nothing defining social work as one thing. Ms. Esposito responded that social workers are protected by the bachelor or masters degree in social work, and that justifies the social worker.

Ms. Gonzales asked if it is the responsibility of the Board to protect the integrity of the social work profession or just the title. Ms. Lonner responded that the Board only has jurisdiction over licensees. The Committee's charge is competency as it relates to people sitting for their license.

Ms. Jensen asked if the Board is looking at BSW licensure certification. Mr. Riches responded no, but it has been a discussion over the last 3-½ years. He explained that the Board's charge is public protection. With a new licensing proposal, public harm must be addressed, and the proposed licensing act needs to show how it is going to prevent or reduce the threat of public harm. The profession needs to define that and answer those questions for themselves. Most licensing programs originate from the professional communities that they impact.

The meeting was adjourned at 1:14 p.m.

## **DRAFT MEETING MINUTES**

### **LCSW Education Committee June 23, 2008**

CSU Long Beach  
"The Pointe" at the Pyramid  
1250 Bellflower Blvd.  
Long Beach, CA 90840

**Committee Members Present:**

Renee Lonner, LCSW Member, Chair  
Gordonna DiGiorgio, Public Member

**Staff Present:**

Paul Riches, Executive Officer  
Christy Berger, MHSA Coordinator

**Committee Members Absent:**

Joan Walmsley, LCSW Member

**Guest List:**

On File

Renee Lonner, Chair, called the meeting to order at 9:40 a.m.

#### **I. Introductions**

The Committee introduced themselves in place of roll. A quorum was established. Staff and audience members also introduced themselves.

#### **II. Purpose of the Committee**

Ms. Lonner explained that Board Chair Ian Russ created the LCSW Education Committee (Committee) to look at the landscape in terms of how Licensed Clinical Social Workers (LCSWs) are prepared to face today's workplace including public service, private practice, hospitals, schools, community mental health centers funded under the Mental Health Services Act (MHSA), jails, or child guidance clinics. LCSWs must be ready to practice independently in settings as varied as the recovery model, social justice model, a hospice or private practice setting. In terms of education, the Committee is concerned with those MSWs who want to pursue a clinical license to practice independently. As a board, this is the group it has jurisdiction over. The Committee will look at: 1) the educational foundation that LCSWs need in order to land on their feet in a complex environment and in workplaces where the level of demand is typically very high; 2) the core competencies required for licensed independent practice.

The Committee's role is information gathering and data collecting, and the Committee hopes for a great deal of feedback from stakeholders. This is an open-ended inquiry, and the Committee does not know where it will lead. This process will take many months, and

the Committee will travel around the state to talk with people. The bottom line is that people are being trained to perform certain jobs. Are they prepared for those types of settings.

Christy Berger thanked Dr. John Oliver, Chair at CSU Long Beach, for generously allowing the BBS staff and the Committee to utilize the meeting room.

### **III. Presentation about Mental Health Recovery from Chad Costello, MSW, of Mental Health America**

Chad Costello gave a presentation on Recovery-Based and Client-Centered Services. He gave a brief overview of the history of recovery and recovery services, stating that it has been around as long as people have been around, because people have always had to try to recover in mental health and life trauma. It is the roll of the mental health professionals to help expedite the recovery and make it more permanent, and use those skills to be able to recover from other experiences in the future. They end up trapped in a situation where they become dependent on a system. There are a number of things that systems do that inhibit people's ability to recover.

Mr. Costello stated that studies were conducted showing that people in third world nations in general have better mental health outcomes than those in developed nations. He feels that is because those in third world nations must continue to participate in life. In developed nations, people tend to be labeled and taken out of their normal environments such as jobs and housing. Third world nations do not have the resources to do that, and people have to continue working to survive.

People with mental illnesses were labeled and segregated from "normal" people. As places became crowded, other interventions were created to control people, such as institutions. During the rise of moral treatment, the philosophy was to treat people as people and with respect. It's been the most successful intervention to date. Years of moral treatment at large institutions were expensive. The population and costs continued to grow. Lack of funding and overcrowding resulted in the need to get people out faster. This is about the time that medicine became involved. Doctors believed that this was a disease of the mind and it could be treated. New treatments proved to be largely ineffective, and patients continued to stay in hospitals for years.

California no longer has large-scale institutions anymore. The bad thing about that is the community mental health was not done on the scale that it should have after the institutions closed down. Community mental health works fine for some people because they have a supportive environment and a good place to live, have something meaningful to do during the day, and take their medications.

The federal government became involved. Medicaid was never designed for mental health. Through advocacy work, it was expanded to include mental health, and still is the number one funding for community mental health services in the country. The problem is that it still has "medi" in the name. There is a huge disconnect because in recovery services, the service is provided in one world and it is documented in a completely different world. There is some resistance in providing recovery service because people are worried about audits. Will this stand up in an audit? The answer is yes and no, because the audit is not generally driven from a quality standpoint; it is driven from a budget and political standpoint.

Recovery is a process, not a service and not a “model.” It is a process that can be either facilitated or impeded depending on what professionals do. The four primary stages of recovery are: hope, empowerment, self-responsibility, and meaningful role in life.

A participant in the audience stated that when looking at the primary stages of recovery and the movement towards a recovery model, they are hampered. It’s getting worse in the public domain terms of how social workers carry out the recovery model and get paid for what they do. Social workers believe in the stages of recovery, but they are locked in a system that does not support the values of recovery. How does that impact the educational model to be social workers, and where does that fit in? Is a component of the education going to include skills on manipulating systems in order to fit the recovery model? It’s difficult to remain hopeful when a social worker tries to do something outside of the box but cannot get paid for it or cannot document it on the forms.

Mr. Costello responded that the bottom line is advocacy - changing the roles to accommodate people better rather than changing people to accommodate the world. Social workers know how to get resources that people don’t want to give them. These are skill sets of case management and care coordination, and those are the same skill sets needed to survive in a system that is always saying, “you can’t.” Mr. Costello suggested looking at policies and procedures. Most of the time, it does not say, “you can’t do that.” But social workers have a mandate to be vocal at all times. It’s not easy overcoming stereotypes about what social workers do and what social workers should do in addition to the people they are serving and the futures they hold.

A participant in the audience from the Department of Children and Family Services (DCFS) stated a problem with the recovery model is the timeframe. DCFS tells families that they have one year to work on their issues in order to get their children back, but the recovery model states that it takes at least two years to work on the issues.

Mr. Costello stated that some people can recover quickly sometimes. The problem is that social workers get in situations of limited resources when they are put in the roll to predict outcome for clients, and interventions are based upon that predicament. Clients are separated into two groups: those who can be helped and those who cannot be helped. If a person is completely ignored and they don’t get the help they need, that person will not do as well as if the social worker focuses their attention on them. It’s a typical challenge when there is a time limit to work with a client; and a social worker may place arbitrary limits on it that’s not based on any evidence. Another problem is fiscal; it’s difficult to get public systems to think about investment when they’re living day-to-day. That is also true of the people that they serve; it’s difficult setting long-term goals when they’re struggling everyday. There is no quick and easy fix for this. There are bigger issues; do not blame recovery for those issues. The bottom line is that social workers are generally working with people who are poor, and they are going through systems that do not necessarily care about the client, but about the systems survival.

Mr. Riches stated that bureaucratic change is difficult and slow, and it requires persistence to make changes.

A participant in the audience asked how can a curriculum be created to address these issues and not frustrate the social worker to the point where they give up? She stated that students need to be aware of these realities. How can the social worker succeed despite barriers? How can we get a larger number of students to survive and still remain with integrity intact, and actually help somebody?

A participant in the audience stated that social workers need more advocacy, planning, administering skills; but to get those skills, students need to be trained in policy and public administration.

Mr. Costello stated that the skill set in macro-advocacy is the same as the micro level. Information through relationships and creating change through relationships is something that can be discussed more in graduate school. At the graduate school, there should be a class just on listening. Listening is a skill but social workers are not that good at it – they are good at waiting their turn to talk.

Janlee Wong from the National Association of Social Workers (NASW) expressed his perspective about why LCSW Education Committee meetings are taking place. During the MFT Education Committee meetings, it was determined that marriage and family therapy was behind the times and it needed to catch up. The committee said that the jobs are now in recovery and in MHSA. In order to get those jobs we have to be able to say that we are educated in recovery. The BBS has legislation to change the MFT curriculum requirements. The next step is to change the MSW education. There is an evolution for this license that was originally designed for private practice suddenly being adopted by every other source including the MHSA. Now there is pressure to determine if the LCSW is clinical enough. Mr. Wong feels that these meetings are to explore that and determine if there is a need to have more clinical content in social work education, if it should consist of course titles, and if those titles should be legislated.

A participant in the audience stated that if we were to look at macro level, at least 80% of MSWs or LCSWs in mental health are called upon to work with DSM. They are hopefully getting some training on the job. What she is seeing in San Diego is that those agencies that previously would only take LCSWs are now taking MFTs. What they are saying is that they now are looking at the curriculum and the practice that MFTs come in with, and according to the funding source and according to the tests that mental health clinics need to do they have to be looking at funding. If you're in private practice that's called upon all the time because that's how you get funded.

Mr. Riches explained that the BBS has in law, as a basis of issuing a license, fulfilling its mandate. The basic mandate is public protection; ensuring minimally competent practitioners under the scope of practice for the license that the BBS issues – are they matching up. That is why these meetings are held. A big part of that environment has changed; now there is the MHSA. In reading the MHSA and talking to people involved with the MHSA, their goal is how to change the system. As a public agency we have an obligation to figure out how to incorporate the goal into what the BBS does.

Mr. Costello asked what is the skill set for a person in prevention? Is the education going to be there for folks? Is social work going to be ready as a profession to do prevention and intervention? There are a lot of things that LCSWs do right now that qualifies as early intervention.

Mr. Costello returned to his presentation and discussed the four primary stages of recovery. The first stage of recovery is hope. Recovery begins with a positive vision of the future. Hope must be real; it is more motivating when it takes form as a real image of what life can look like. Individuals need to see possibilities before they can make changes and move forward. Empowerment is the second stage. To move ahead, people need a sense of their capabilities. Hope needs to be focused on what people can do for themselves. They need to be informed and need opportunities to make their own choices. Those choices need to be real. Self-responsibility is the third stage. Self-responsibility

involves growth and taking risks such as, living independently, applying for a job. The fourth stage is a meaningful role in life. To recover, a person must have a purpose in their life separate from their illness.

Mr. Costello discussed philosophy and principles: client choice, quality of life, community focus, and whatever it takes. Client choice has to be real. The choices may be bad choices, but you have to be ok with that and be prepared to provide support to help the person learn from that. Client choice is also about de-emphasizing the traditional professional to patient relationships. Quality of life is about focusing on key life areas such as housing, work, education, finance, and social goals. It is also about establishing their roles as a member of the community of their choice. Medication and appointment compliance may be a means to these ends, but should not be considered ends in themselves. Community focus is about living, learning, and working through integration rather than segregation. It also means that staff needs to spend most of their time out of the office, supporting individuals as they pursue their quality of life. Staff also has a responsibility to cultivate relationships with others and share these relationships with clients. Whatever it takes is about a no fail approach. Transferring individuals because of the challenge they post is prohibited. It is also about being committed.

In recovery services, teaming between mental health professionals, paraprofessionals, clients, and family members is a powerful tool in service delivery. The use of specialized skill sets is essential. In recovery services, everybody including staff, case management, staff, and recovery workers must be on board. Recovery services must be welcoming and engaging. The environment must be created and maintained to provide positive relationship. Service planning must move away from compliance and/or diagnosis based goals. The plans must be tailored to each individual, and the individual must be involved in the development of the plan and in its implementation.

Psychiatric care in recovery services should emphasize client choice through use of education around symptoms and medication. This makes clients in control of their illnesses, and partners in their treatment.

Substance abuse recovery is a social workers job. It is the social workers job to treat the whole person; therefore, the social worker needs to know about substance abuse recovery. Services must be coordinated. Abstinence may be the goal, but recovery is the process. Mr. Costello suggested using harm reduction. Build a relationship and offer choices. Don't ever sacrifice a relationship in pursuit of the goal.

Housing and employment are treatment, and they are the social workers job. In order for the client to become stable, housing and employment are needed. A wide range of options is needed. When searching for housing, aim for permanent housing, not temporary housing. In regards to financial services, people need help learning how to manage their resources. In regards to community involvement, it helps reduce stigma and increase social inclusion.

The Committee adjourned for lunch at 12:09 a.m. and reconvened at 12:47 p.m.

#### **IV. Presentation about the Adoption of Mental Health Competencies and the Mental Health Stipend Program from Dr. Beverly Buckles of the California Social Work Education Center (CalSWEC)**

Dr. Beverly Buckles gave a presentation on the adoption of mental health competencies and the Mental Health Stipend Program. The history on CalSWEC with mental health began in 1990 when CalSWEC began. The group came together to formulate curriculum

competencies for mental health. In 1994, CalSWEC took another look at the curriculum and involved state, county, and school representatives trying to improve field practicum and how to continue to develop this area because there was a shortfall of social workers going into public services. CalSWEC created as an experiment a case management certificate to get individuals at the Bachelor's level bumped up. There were not enough public relations to make this successful. The Department of Social Services then picked up the program.

Under the next generation on CalSWEC, foundation funding was acquired through a grant, which allowed CalSWEC to focus on what it needed to do.

In 2003, CalSWEC began to engage in the original competencies. They also looked at issues that are now part of Proposition 63. There were over 200 entities that were involved in reviewing the competencies, including schools, counties, non-profit groups, consumers and families. There are areas that CalSWEC feels needs more work.

There are 17 schools and the numbers are growing. Forty-one percent have a form of mental health specialization. The foundation year is the basic premises of social work. The second year is a concentration year, but the concentration area has to do with the focus or methods of practice.

CalSWEC has a history in terms of implementing competencies and weaving them into the existing curriculum and have ways of tracking that. Building on that model, all programs have a method in which they can add electives, focus within particular agencies, county public health, and mental health services and are able to deliver the competencies required. The Mental Health Stipend Program provides compensation that can assist with additional education required of the students. All of the programs were initiated in the stipend program and began the curriculum competencies implementation in 2005.

CalSWEC continues to work with the schools and their curriculum committees. Schools chose how they wanted to implement this. Some schools chose to have a specialty field seminar where they separate out the group of students that are going through the stipend program and give them different content. Others had specialty coursework already in place for students to take and not have a seminar; some schools have both. There is a variety of ways in which this is done. There is intentionality in the MSW programs to weave the thread of where the competency exists in curriculum. There has been a series of specialty trainings for field instructors and faculty. In addition, every school is required to have consumers involved whether they are representatives of the families or individuals in recovery.

There have been and continue to be meetings with students, mental health directors, agency-based instructors, and other stakeholders with regards to the best ways to initially implement the content and to continue to implement the content.

There has been inclusion of evidence-based practice or promising practice models. That comes with some critique on what that means. Some things have not been researched that have been used historically but have been observed to be effective.

CalSWEC is working on identifying training needs of faculty and agency instructors. Schools have individually initiated research projects that engaged faculty and students. There has been substantial regional collaboration with the county mental health agencies and collaboration among discipline. There has been the development of specialized units and collaboration with agencies in terms of curriculum delivery. There are currently 66

mental health syllabi posted on the Web site. There is technical assistance in regards to the regional meetings.

Of the first group that started the stipend program, 92% are employed in county mental health or one of their contracted agencies, which is the requirement of the funding. There are 25 counties providing employment sites. We have consumers completing the stipend program. In the second year, 187 students finished the program, and 54% of those represent ethnic populations.

There are challenges of students becoming employed based on practices of counties. There is a wealth of funding in one area and severe cut-backs in another. Counties are doing the ethical thing in trying to preserve as many jobs as possible of those who were already employed by shifting them. That shift takes place before students are hired, or it delays the hiring of students. This results in a delay in students obtaining their license.

Other challenges include: 1) determining who the contract pay-back site is. Counties are producing huge lists of their subcontracting agencies. 2) Competitive factors for the students. The private non-profits of the contracted agencies often do not pay or have the same benefit package. 3) Other agencies are paying large salaries that exceed what the counties pay.

CalSWEC is trying to develop processes to bring more people into the system that represent the population that is being served. The Workforce Education Development Plan goes to the high schools to draw people in. Distance education will have another upsurge because there are not very many ways to educate those in remote areas.

Additional funders have come forward to pay for what the state funding will not pay for. One group that is providing some funding is looking at ways they could supplement to ensure better sustainability of CalSWEC's outcome. It evolves around the regional collaboration, but in more specific ways it involves curriculum infusion seminars for faculty and agency-based instructors. CalSWEC had two seminars - one on recovery and the one on co-occurring disorders. The next two seminars will be on working with the aging population and working with youth transition age.

The second Mental Health Summit will take place. There will be a panel of state and local experts and other individuals who will be supporting the movement forward. Curriculum modules will be presented.

There is a contract that is to be implemented for the next 3 years with the opportunity to look at amendments. There are continuing long range plans to work with county directors. The funding administered out of the state is a limited amount of funds. The responsibility will transfer to the counties. All 57 counties have authority over the education funding. They are looking at a fiscal authority where they will pull a portion of funding that they want to give back to the schools. However, every school must negotiate with every county that they work with, which makes it an unstable system for the students.

Schools were asked through a survey to describe the strategies used to integrate and implement the mental health curriculum competencies. The survey results presented were based on the schools that responded. The latest information is being evaluated for the survey.

Some discussion took place regarding the board's purpose for looking into social work curriculum. Mr. Riches explained that the board initiated the LCSW Education Committee

to look into the full range of social work – not just the curriculum. This includes supervision and training, as well as a holistic review of the examination process for all of the board programs. All of these pieces will allow the board to have a much better understanding of the impact of public protection. This is a part of a larger discussion about the changing world, and has the board changed in a way that supports public protection.

An audience member asked if the board views the Mental Health Services Act (MHSA) and its implementation as a call for public protection. Mr. Riches responded yes, stating that the board built a relationship with Department of Mental Health (DMH), and in an effort to align itself with what DMH is doing, so that the licensees have that foundation and preparation to practice in the environment of their choice. Access is a public protection issue.

Mr. Wong asked Mr. Riches to describe the funding that the board received from the MHSA. Mr. Riches responded that the board received one component of funding. Christy Berger holds a position that was underwritten by the MHSA. Ms. Berger's responsibility is to ensure that the board's work as it relates to the MHSA is a consistent part of the board's work. There will be additional funding to engage outside public mental health experts and to contract with outside experts to evaluate and review the examination process.

#### **V. Future Meeting Dates**

Ms. Berger reviewed the future meeting dates and locations. The next meeting is scheduled on October 27, 2008 in the northern California bay area. The last meeting of the year is scheduled on December 8, 2008 in San Diego.

#### **VI. Suggestions for Future Agenda Items**

No suggestions were made for future agenda items. Mr. Riches invited audience members to email or call him with any suggestions and ideas.

#### **VII. Public Comment for Items Not on the Agenda**

No public comments were made for items not on the agenda.

The meeting was adjourned at 2:45 p.m.



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## Tracking the LCSW Licensing Process: A Current Snapshot of 2002-2004 Graduates -August 21, 2008-

### Introduction

In July 2008, staff at the Board of Behavioral Sciences (BBS) analyzed a substantial amount of data relating to the LCSW licensing process. Staff used a new reporting tool made available by the Department of Consumer Affairs to access and organize various data for all 2002, 2003, and 2004 graduates who registered with the BBS.

This is the BBS' first attempt at accessing and analyzing this data. The information presented in this report provides a variety of statistical information relating to individuals pursuing LCSW licensure.

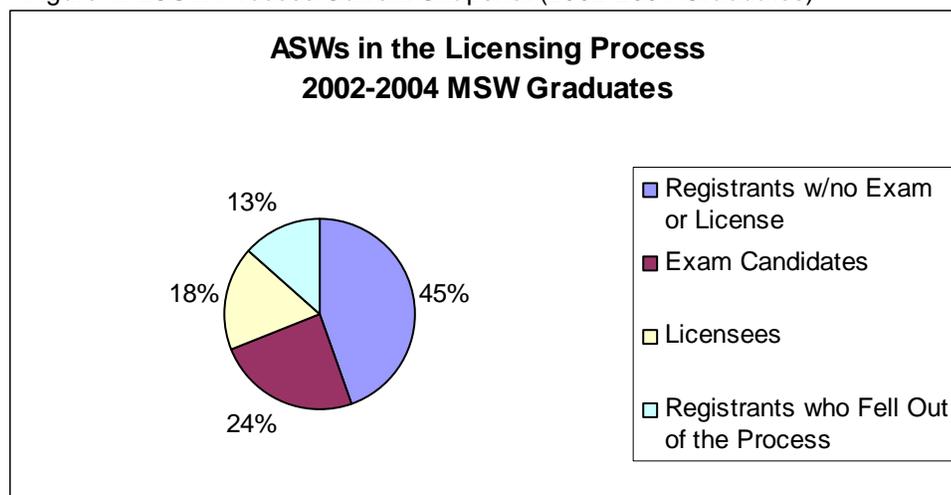
### Acknowledgements

A number of members of BBS staff contributed in a variety of ways to this report. From answering questions to looking at early drafts, their efforts are valued and worthy of commendation.

### Where Are They Now?

Of 2002-2004 graduates, 3,391 registered as Associate Clinical Social Workers (ASW). Within this population, a significant number have yet to earn their license or apply for examination eligibility. Figure 1 provides a current snapshot of where 2002-2004 graduates are in the licensing process. The appendix provides a year-by-year breakdown of each graduating class.

Figure 1. LCSW Process Current Snapshot (2002-2004 Graduates)



A quick appraisal of Figure 1 and the year-by-year breakdown provided in the appendix reveals a major trend. Many 2002-2004 graduates pursuing LCSW licensure have not yet made it to the examination process. The reason for this trend requires further study of these individuals.

### **A Closer Look at Those Who Register Early**

Most 2002-2004 graduates from MSW degree programs register within one year of degree conferral. 70% of ASWs applied for registration within a year of graduation.

A strong correlation exists between those who apply for registration early and those who have completed the process and earned their license. 93% of all 2002-2004 MSW graduates who have earned an LCSW license applied for ASW registration within a year of degree conferral. Please reference Tables 2, 3, 4, and 5 in the appendix for more statistics broken down by duration between degree conferral and registration application submission.

### **Year-by-Year Tracking of Licensing Process**

A year-by-year breakdown of where registrants are in the licensing process provides an opportunity to observe trend over time and also see where people “fall out” of the process. One consistent trend across all graphs is the increase in individuals getting their license in years “3-4” and “4-5.”

Tables 3, 4, and 5 offer a year-by-year breakdown of where registrants are in the process. Figures 5 through 7 display the data from the tables on area graphs.

### **Examination Statistics**

In order to receive an LCSW license, candidates must pass a Standard Written Examination and a Clinical Vignette Examination, meaning, at a minimum, a licensee will attempt two examinations. 2002 – 2004 graduates from this data set who earned their license generally took between 2-3 examinations prior to completing the examination process. These examination attempts can be any combination of the Standard Written Examination and the Clinical Vignette Examination. For example, if someone were to pass the Standard Written Examination on his or her first attempt, fail the Written Clinical Vignette Examination, then pass his or her first re-take of the Written Clinical Vignette Examination, that person would have attempted three total examinations prior to receiving his or her license.

While 2-3 examination attempts was the average for licensees in this population, the amount of time actually spent in the examination process ranged from about eight months to a little over a year. Please refer to Table 6 for more information.

### **Conclusions**

The analysis of this dataset provides both insight and raises additional questions. The information presented in this report is a starting point for future analysis of the Board's licensing processes and populations.

For more information or questions about this data, contact Sean O'Connor at (916) 574-7863 or at sean\_oconnor@dca.ca.gov.

**Appendix**

Table 1. Breakdown by Year Graduated

	2002 MSW Graduates		2003 MSW Graduates		2004 MSW Graduates		Totals
	#	%	#	%	#	%	
Obtained Registration	1080		1145		1166		3391
Received License	306	28%	190	17%	108	9%	604
Made it to Exam Process	579	54%	470	41%	372	32%	1421
Currently Taking Exams	273	25%	280	24%	264	23%	817
Registered But Yet to Apply for Exam	317	29%	508	44%	692	59%	1517
Registrants who Fell Out of the Process*	184	17%	167	15%	102	9%	453
Registrants with Out of State Degrees	257	24%	224	20%	249	21%	730

Figures 2-4. LCSW Process Current Snapshot Breakdown by Year

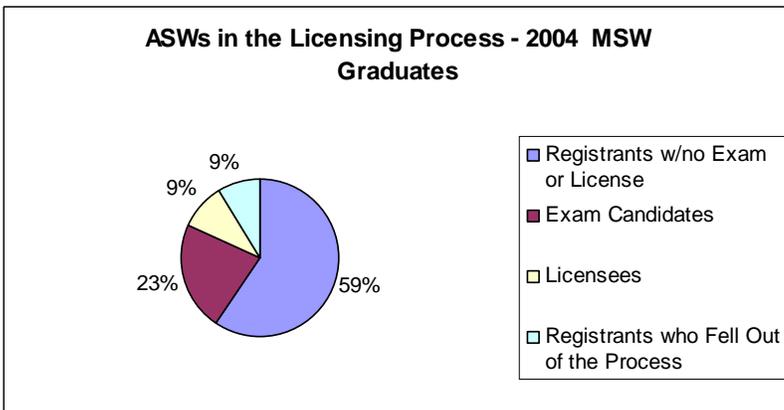
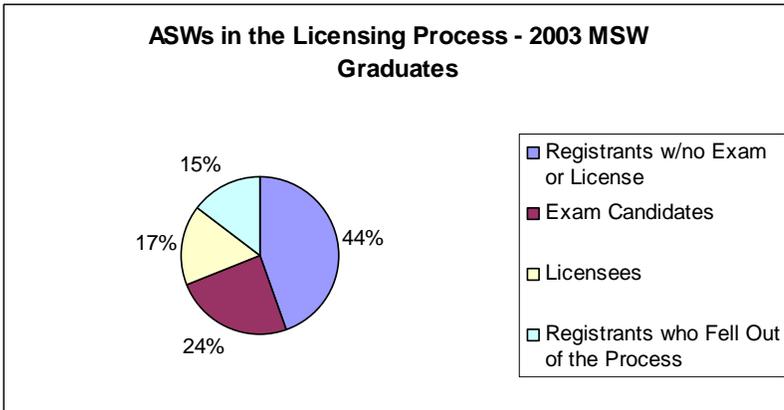
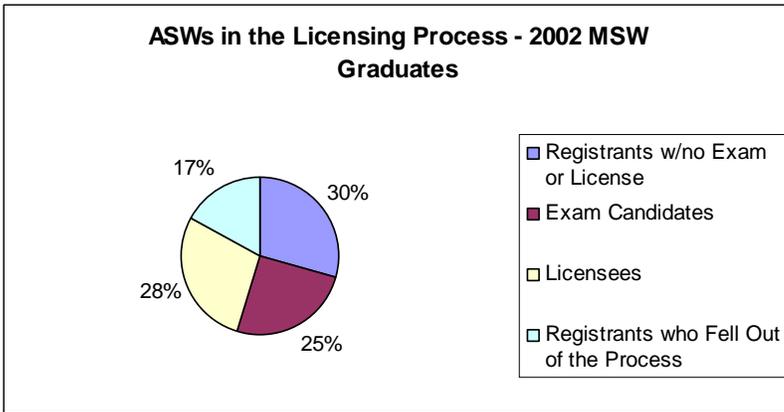


Table 2. Breakdown by Length of Time from Graduation to Registration Application

	Registered < 1 Year from Graduation		Registered > 1 Year from Graduation		Totals
	ASW		ASW		ASW
	#	%	#	%	
Obtained Registration (ASW)	2360	70%	1031	30%	3391
Received License (LCSW)	562	93%	42	7%	604
Made it to Exam Process	1261	89%	160	11%	1421
Currently Taking Exams	699	86%	118	14%	817
Registered But Yet to Apply for Exam	767	51%	750	49%	1517
Registrants who Fell Out of the Process	332	73%	121	27%	453
Registrants with Out of State Degrees	409	56%	321	44%	730

Table 3. Year-by-Year Tracking of Licensing Process - 2002 Graduates

Years from Graduation	0-1	1-2	2-3	3-4	4-5	5-6	6-7
Period	1	2	3	4	5	6	7
	LCS						
Registrants w/No Exam or License	766	862	712	504	391	317	317
Exam Candidates	0	0	172	290	305	289	273
Licensees	0	0	14	100	194	289	306
Registrants who Fell Out of the Process	0	32	75	123	159	184	184

Table 4. Year-by-Year Tracking of Licensing Process - 2003 Graduates

Years from Graduation	0-1	1-2	2-3	3-4	4-5	5-6
Period	1	2	3	4	5	6
	LCS	LCS	LCS	LCS	LCS	LCS
Registrants w/no Exam or License	777	919	805	627	507	508
Exam Candidates	0	0	139	247	291	280
Licensees	0	0	16	93	177	190
Registrants who Fell Out of the Process	0	33	82	130	167	167

Table 5. Year-by-Year Tracking of Licensing Process – 2004 Graduates

Years from Graduation	0-1	1-2	2-3	3-4	4-5
Period	1	2	3	4	5
	LCS	LCS	LCS	LCS	LCS
Registrants w/no Exam or License	815	957	854	693	692
Exam Candidates	0	0	139	274	264
Licensees	0	0	22	95	108
Registrants who Fell Out of the Process	0	27	65	102	102

Table 6. Licensees - Average Examination Attempts and Time to Licensure

	2002 Grads	2003 Grads	2004 Grads
	ASW	ASW	ASW
Avg Exam Attempts for Licensees	2.71	2.37	2.19
Avg Time from Examination Application to License Issue Date (in years)	1.34	1.03	0.66

Figure 5. Tracking the LCSW Licensing Process – 2002 Grads

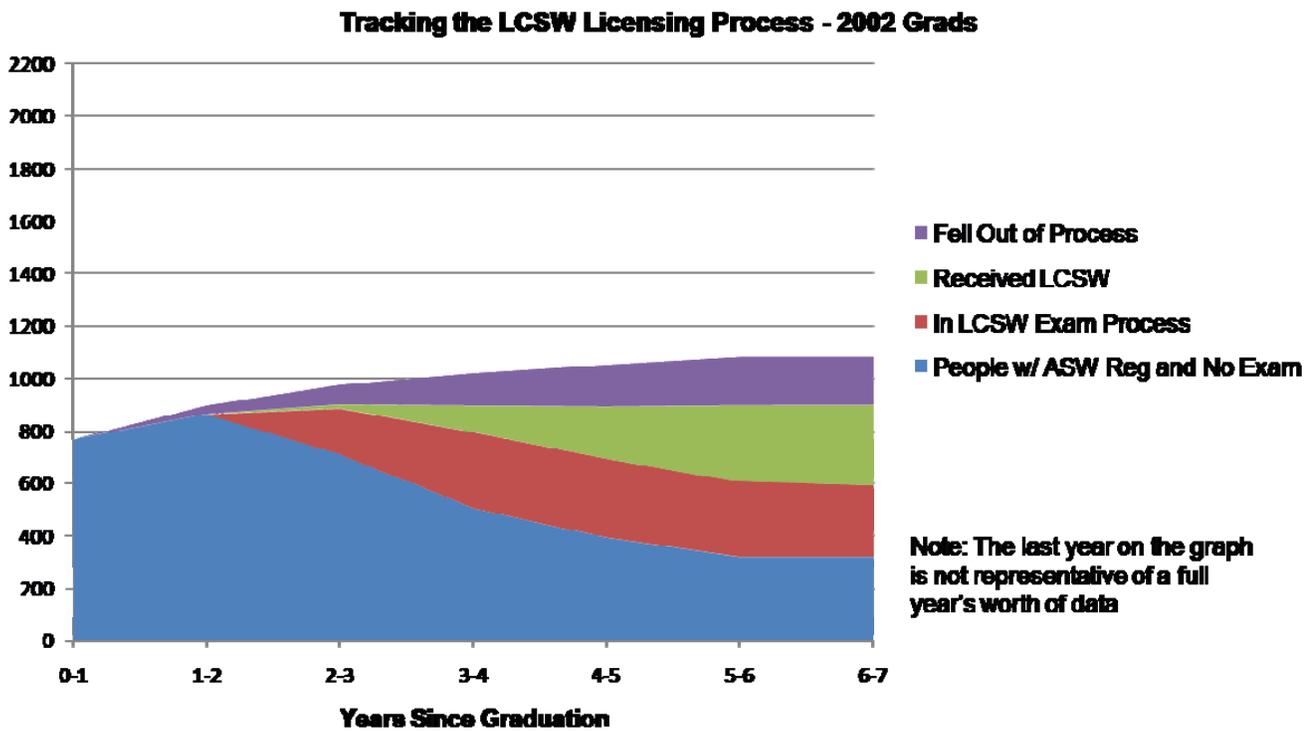


Figure 6. Tracking the LCSW Licensing Process – 2003 Grads

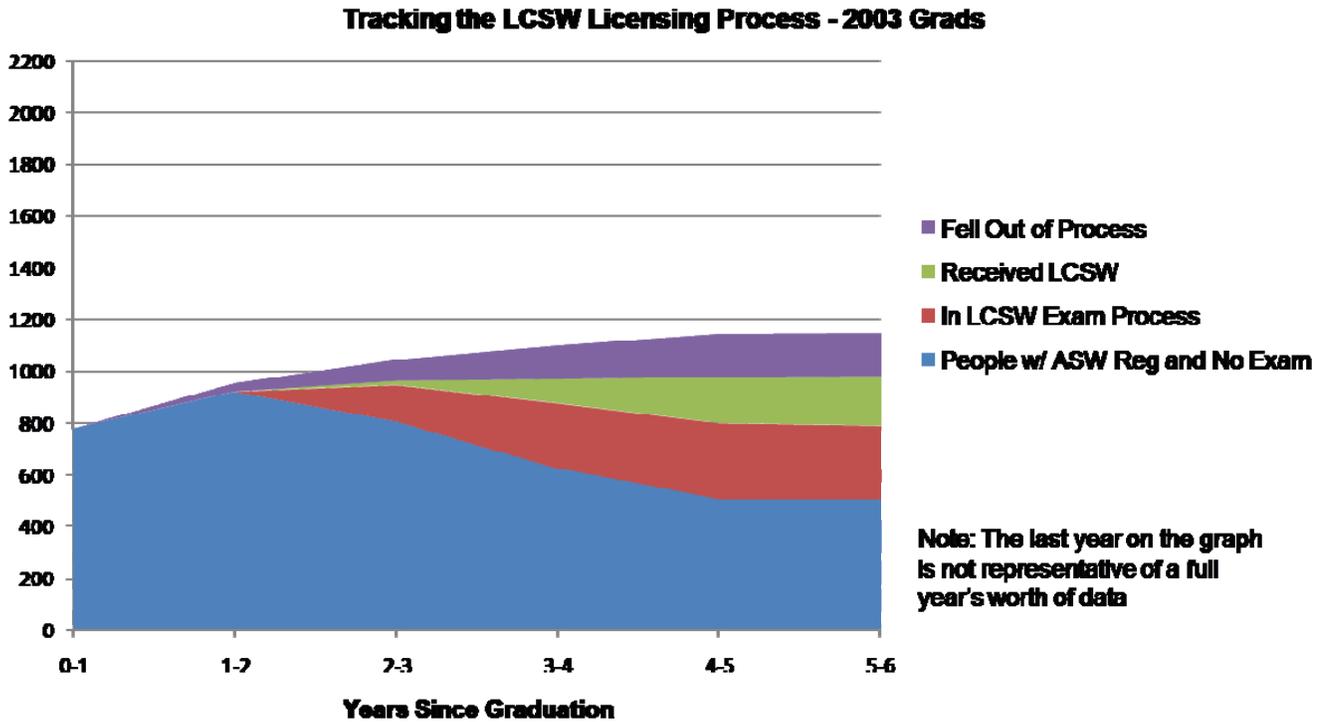
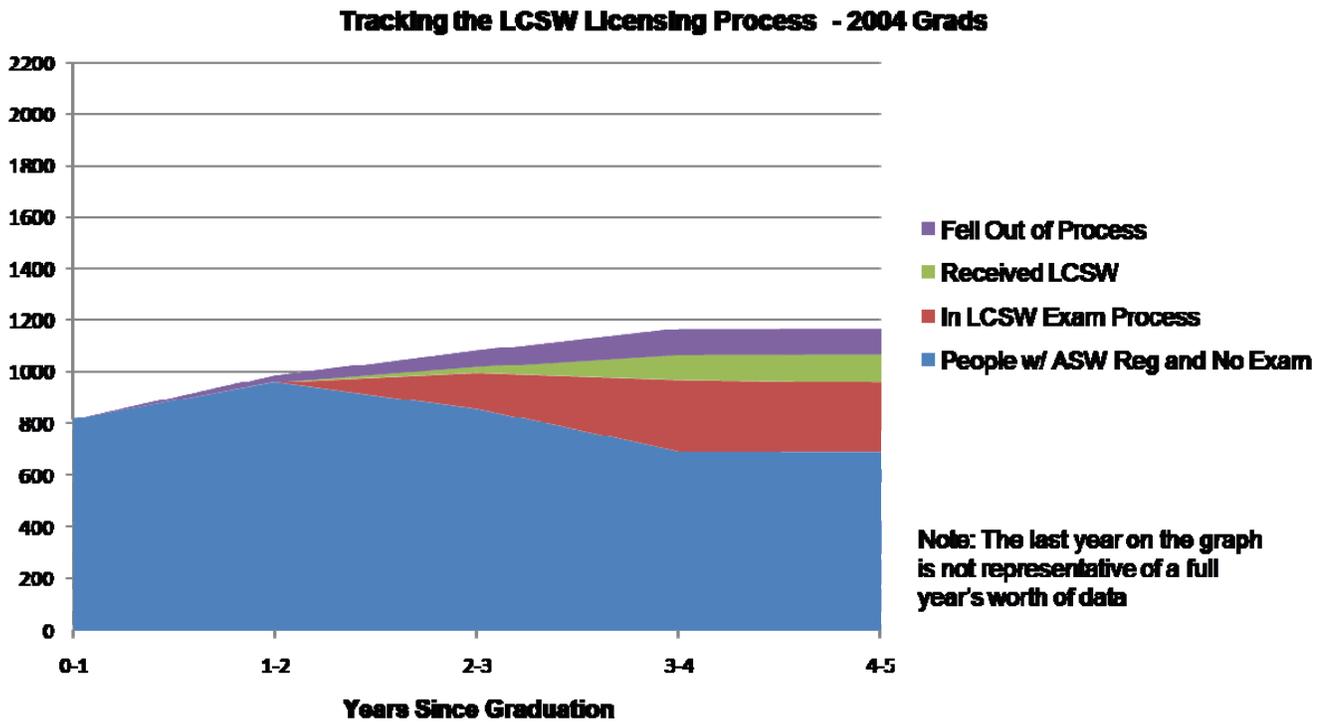


Figure 7. Tracking the LCSW Licensing Process – 2004 Grads



**Tracking the LCSW Licensing Process**  
**A Current Snapshot of 2004-2004 Graduates (as of July 2008)**  
**Side-by-Side of All Schools**

**2002 Graduating Class**

	Graduating MSWs*		Obtained Registration		Made it to Exam Process		Currently Taking Exams		Received License		Registered But Yet to Apply for Exam		Registrants who Fell Out of the Process		Avg Exam Attempts for Licensees
	#	% of Grads	#	% of ASWs	#	% of ASWs	#	% of ASWs	#	% of ASWs	#	% of ASWs	#	% of ASWs	#
CSU,Bakersfield	12	75%	9	44%	4	44%	4	44%	0	0%	5	56%	0	0%	N/A
CSU, Chico	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
CSU, Fresno	66	64%	42	45%	19	29%	12	29%	7	17%	14	33%	9	21%	2.71
CSU, Long Beach	172	53%	91	55%	50	29%	26	29%	24	26%	27	30%	14	15%	2.5
CSU, Los Angeles	43	77%	33	73%	24	42%	14	42%	10	30%	5	15%	4	12%	3
CSU, Sacramento	116	66%	77	52%	40	26%	20	26%	20	26%	30	39%	7	9%	2.7
CSU, San Bernardino	61	67%	41	56%	23	37%	15	37%	8	20%	15	37%	3	7%	3
CSU, Stanislaus	50	50%	25	80%	20	44%	11	44%	9	36%	4	16%	1	4%	3.55
Loma Linda University	39	51%	20	70%	14	40%	8	40%	6	30%	4	20%	2	10%	2.66
Out of State	N/A	N/A	255	45%	115	21%	53	21%	62	24%	80	31%	60	24%	2.74
San Diego State	132	68%	90	53%	48	19%	17	19%	31	34%	24	27%	18	20%	2.48
San Francisco State	59	76%	45	29%	13	11%	5	11%	8	18%	21	47%	11	24%	2.5
San Jose State	76	84%	64	50%	32	33%	21	33%	11	17%	22	34%	10	16%	3.1
UC, Berkeley	84	63%	53	57%	30	30%	16	30%	14	26%	10	19%	13	25%	2.57
UCLA	84	65%	55	69%	38	13%	7	13%	31	56%	10	18%	7	13%	2.26
USC	214	83%	178	61%	108	25%	44	25%	64	36%	47	26%	23	13%	2.86
<b>TOTALS</b>			<b>1078</b>		<b>578</b>		<b>273</b>		<b>305</b>		<b>318</b>		<b>182</b>		

\*Source: Graduating MSW data obtained from Reports available at the California Postsecondary Commission's Web site.

**Tracking the LCSW Licensing Process**  
**A Current Snapshot of 2004-2004 Graduates (as of July 2008)**  
**Side-by-Side of All Schools**

**2003 Graduating Class**

	Graduating MSWs*		Obtained Registration		Made it to Exam Process		Currently Taking Exams		Received License		Registered But Yet to Apply for Exam		Registrants who Fell Out of the Process		Avg Exam Attempts for Licensees
	#	% of Grads	#	% of ASWs	#	% of ASWs	#	% of ASWs	#	% of ASWs	#	% of ASWs	#	% of ASWs	#
CSU, Bakersfield	33	88%	29	24%	7	21%	6	3%	1	66%	19	10%	3	10%	2
CSU, Chico	29	76%	22	27%	6	23%	5	5%	1	64%	14	9%	2	9%	3
CSU, Fresno	70	64%	45	40%	18	22%	10	18%	8	33%	15	27%	12	27%	2.13
CSU, Long Beach	146	95%	138	49%	67	29%	40	20%	27	41%	56	11%	15	11%	2.41
CSU, Los Angeles	53	75%	40	43%	17	23%	9	20%	8	50%	20	8%	3	8%	2.5
CSU, Sacramento	175	59%	103	34%	35	17%	18	17%	17	45%	46	21%	22	21%	2.59
CSU, San Bernardino	62	45%	28	50%	14	43%	12	7%	2	46%	13	4%	1	4%	2.5
CSU, Stanislaus	33	67%	22	27%	6	23%	5	5%	1	59%	13	14%	3	14%	5
Loma Linda University	35	57%	20	25%	5	20%	4	5%	1	60%	12	15%	3	15%	3
Out of State	N/A	N/A	217	35%	75	18%	39	17%	36	43%	93	23%	49	23%	2.27
San Diego State	107	71%	76	55%	42	33%	25	22%	17	33%	25	12%	9	12%	2.35
San Francisco State	73	74%	54	30%	16	19%	10	11%	6	61%	33	9%	5	9%	2
San Jose State	106	73%	77	43%	33	31%	24	12%	9	44%	34	13%	10	13%	2.33
UC, Berkeley	90	57%	51	41%	21	20%	10	22%	11	53%	27	6%	3	6%	2.45
UCLA	92	65%	60	43%	26	17%	10	27%	16	40%	24	18%	11	18%	2.36
USC	186	84%	156	51%	80	33%	52	18%	28	38%	60	10%	16	10%	2.32
<b>TOTALS</b>			<b>1138</b>		<b>468</b>		<b>279</b>		<b>189</b>		<b>504</b>		<b>167</b>		

\*Source: Graduating MSW data obtained from Reports available at the California Postsecondary Commission's Web site.

**Tracking the LCSW Licensing Process**  
**A Current Snapshot of 2004-2004 Graduates (as of July 2008)**  
**Side-by-Side of All Schools**

**2004 Graduating Class**

	Graduating MSWs*		Obtained Registration		Made it to Exam Process		Currently Taking Exams		Received License		Registered But Yet to Apply for Exam		Registrants who Fell Out of the Process		Avg Exam Attempts for Licensees
	#	#	% of Grads	#	% of ASWs	#	% of ASWs	#	% of ASWs	#	% of ASWs	#	% of ASWs	#	
CSU, Bakersfield	33	22	67%	2	9%	2	9%	0	0%	20	91%	0	0%	N/A	
CSU, Chico	35	23	66%	5	22%	5	22%	0	0%	17	74%	1	4%	N/A	
CSU, Fresno	40	35	88%	11	31%	9	26%	2	6%	21	60%	3	9%	2	
CSU, Long Beach	176	154	88%	55	36%	40	26%	15	10%	87	56%	12	8%	2.3	
CSU, Los Angeles	50	51	102%	19	37%	19	37%	0	0%	29	57%	3	6%	N/A	
CSU, Sacramento	146	91	62%	28	31%	19	21%	9	10%	50	55%	13	14%	2	
CSU, San Bernardino	43	28	65%	6	21%	5	18%	1	4%	19	68%	3	11%	2	
CSU, Stanislaus	54	23	43%	5	22%	4	17%	1	4%	16	70%	2	9%	2	
Loma Linda University	33	20	61%	5	25%	3	15%	2	10%	14	70%	1	5%	2.5	
Out of State	N/A	246	N/A	77	31%	46	19%	31	13%	142	58%	27	11%	2.13	
San Diego State	128	83	65%	25	30%	18	22%	7	8%	48	58%	10	12%	2.14	
San Francisco State	90	54	60%	15	28%	13	24%	2	4%	35	65%	4	7%	2	
San Jose State	105	78	74%	25	32%	21	27%	4	5%	47	60%	6	8%	2.25	
UC, Berkeley	97	50	52%	13	26%	5	10%	8	16%	35	70%	2	4%	2.25	
UCLA	90	63	70%	22	35%	15	24%	7	11%	33	52%	8	13%	2.29	
USC	200	142	71%	59	42%	40	28%	19	13%	74	52%	9	6%	2.26	
<b>TOTALS</b>		<b>1163</b>		<b>372</b>		<b>264</b>		<b>108</b>		<b>687</b>		<b>104</b>			

\*Source: Graduating MSW data obtained from Reports available at the California Postsecondary Commission's Web site.

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**To:** LCSW Education Committee

**Date:** October 14, 2008

**From:** Christy Berger  
MHSA Coordinator

**Telephone:** (916) 574-7834

**Subject: Minnesota Report on Baseline Competencies for Mental Health Professionals**

---

The attached report, "Baseline of Competency: Common Licensing Standards for Mental Health Professionals" was ordered by the 2006 Minnesota legislature to evaluate the qualifications of licensed mental health professionals as related to requirements for reimbursement from Medical Assistance, the largest of Minnesota's three publicly funded health care programs. The study included the occupations of psychiatric nursing, clinical social work, psychology, psychiatry, and marriage and family therapy. The study was conducted by a task force comprising a variety of mental health stakeholders.

This report is a resource that may be helpful to the Committee in its review as it contains recommendations related to educational requirements for mental health licensure.

The goal of the study was to develop "a common set of minimum clinical licensure standards to qualify an individual as a mental health professional regardless of professional discipline." The report states that the resulting "recommendations reflect a high level of accord across the total mental health community." and "(The recommendations) are a catalyst for more and better services to clients who need them." The specific recommendations relating to educational requirements can be found starting on page 16 of the report.

**Attachment**

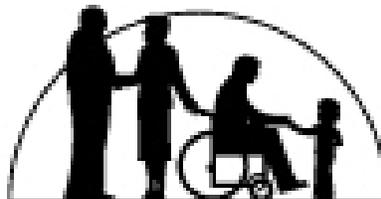
Baseline of Competency: Common Licensing Standards for Mental Health Professionals

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**Baseline of Competency:  
Common Licensing Standards for Mental Health Professionals**  
**A Report to the Minnesota Legislature**

Required by Laws of Minnesota 2006, Chapter 267, Article 1, Section 12

**January 15, 2007**



Minnesota Department of **Human Services**

This report is the product of the Mental Health Professional Licensing Standards Task Force and the Minnesota Department of Human Services, Divisions of Adult Mental Health and Children's Mental Health. Recommendations were developed by the Task Force. The report and the study leading to the report were mandated by:  
Laws of Minnesota 2006, Laws 2006, Chapter 267, Article 1, Section 12.

**Cost of this report**

The costs to produce this reports are approximately as follows:

Costs incurred by the Minnesota Department of Human Services: \$19,200.

Costs incurred by Task Force members to attend sessions: \$25,800

Minnesota Statutes, Section 3.197, requires that a report to the Legislature contain, at the beginning of the report, the cost of preparing the report, including costs incurred by another agency or another level of government.

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## Executive Summary

A study ordered by the 2006 Legislature recommends a common set of minimum clinical licensure standards to qualify an individual as a mental health professional regardless of professional discipline. Licensed mental health professionals in Minnesota include psychiatric nursing, clinical social work, psychology, psychiatry, and marriage and family therapy.

The Legislature ordered the study to evaluate the qualifications of licensed mental health professionals regarding requirements for Medical Assistance (MA) reimbursement. Since qualification for MA payment requires mental health licensure, evaluating qualifications for MA reimbursement leads to a study of licensing standards.

Conducting the study was a task force comprising mental health stakeholders already engaged in evaluating licensing standards when the Legislature ordered the study. These stakeholders had come close to agreement on several key issues, which allowed the task force to build on their foundation. Participants included representatives from the mental health licensing boards, professional associations, professional training schools, providers, advocates, and consumer/family groups. The Department of Human Services provided staff and served as host. Some members expressed concerns about the process used to establish the Task Force: shortage of time, licensing boards' participation in planning, and selection of members. Nevertheless, they expressed that the recommendations in the report reflect a serious collaboration among some of the best thinkers of the five mental health professions and the broad mental health community.

### RECOMMENDATIONS

Recommendations reflect a high level of accord across the total mental health community. They establish a baseline of much-needed clinical standards for coursework, supervised practice, and supervision. They are a catalyst for more and better services to clients who need them.

[Effective date recommended is 4 years after enactment, unless specified.]

#### **Recommendation 1. Requirements for Supervised Clinical Practice.**

Licensure in each mental health professional discipline—except Psychiatric Nursing<sup>1</sup>—requires post-graduate supervised clinical experience, as follows:

4,000 hours of supervised, post-Masters degree professional clinical practice in the diagnosis and treatment of child and adult psychosocial function and mental, emotional, and behavioral illnesses and disorders:

- (a) including a minimum of 1,800 hours of direct clinical client contact; and
- (b) including 200 post-Masters degree hours of direct clinical supervision, of which:
  - a minimum of 50% must be one-on-one supervision, of which at least half must be in-person supervision and up to half may be via eye-to-eye electronic media;
  - up to 50% may be via group eye-to-eye electronic media, group in-person, or telephone. (A supervision group shall include a maximum of six supervisees.)

E-mail or other electronic text communication is prohibited.

- (c) Supervision must be received under a written agreement and the supervisor must be a mental health professional with at least 2 years of post-licensure experience in the delivery of clinical services in the diagnosis and treatment of mental illnesses and disorders.

---

<sup>1</sup> Psychiatric Nursing provides equivalent monitoring and evaluation using other means, as provided in statute.

## **Recommendation 2. Education Requirements for Licensure.**

Licensure requires completion of education requirements, as follows:

Masters or doctoral degree, including field experience, in a clinical discipline recognized by statute as a mental health profession. The overall degree program must include:

360 clock hours or 24 semester credit hours education, minimum, in specified *clinical knowledge areas* to be distributed approximately as follows:

- 30% Diagnostic assessment for child and/or adult mental disorders; normative development; and psychopathology, including developmental psychopathology;
- 10% Clinical treatment planning, with measurable goals;
- 30% Clinical intervention methods informed by research evidence and community standards of practice;
- 10% Evaluation methodologies regarding the effectiveness of interventions;
- 20% Professional values / ethics applied to clinical practice, including cultural context and diversity.

The requirements, all in the specified clinical knowledge areas, may be satisfied by a combination of the following methods:

- accredited Masters-level coursework
- post-graduate coursework
- continuing education units (with a post test and a program description with goals and objectives available for public review) may be used for up to 90 hours or 25% of total education in clinical knowledge areas

## **Recommendation 3: Continuing Education Requirement.**

Licensure requires continuing education, as follows:

Post-licensure, at least 40 hours of Continuing Education are required during each licensure renewal period or continuing education reporting period, of which a minimum of 60% must be in the clinical knowledge areas (defined in Rec. #2).

## **Recommendation 4: Qualifications of a clinical supervisor.**

An individual qualified to provide mental health clinical supervision to persons working toward licensure and to workers who require supervision must:

- (1) be licensed in a mental health discipline as an independent mental health professional;  
and
- (2) be competent, qualified, or certified in the activities being supervised; and
- (3) demonstrate knowledge and skills in clinical supervision by:
  - (a) having completed at least one (1) year of post-licensure experience with at least 1,000 hours in clinical practice, as defined by statute and rule.
  - (b) providing written verification of 30 hours of training in supervision, which may be satisfied by completing accredited coursework or continuing education courses in clinical supervision or verification of approved supervisor status by a licensing board.
  - (c) completing 6 continuing education hours in clinical supervision each licensure renewal period or continuing education reporting period. CEUs may include consultation regarding the practice of supervision.

Each individual providing clinical supervision must be certified, or in some other manner recognized, as a qualified clinical supervisor by the individual's professional licensing board.

**Recommendation 5. Payment for Clinical Supervision.**

Minnesota Health Care Programs should cover payments for mental health clinical supervision as a distinct medically-necessary activity.

**Recommendation 6: *Allied Fields* as a class of mental health professional.**

Eliminate the statutory class of "allied fields" as a category of mental health professional—as defined in the Adult Mental Health Act and Children's Mental Health Act.

(Delete Paragraph (6) in both §245.462, Subd. 18, and §245.4871, Subd. 27.)

[Recommended effective date: Upon enactment]

**Recommendation 7: Follow-up Study on Age-Related Practice Standards.**

The Task Force recommends that the Legislature order a follow-up study to evaluate and make recommendations regarding mental health professionals' scope-of-practice in order to prescribe practice categories by age of the client, namely:

- (a) early childhood mental health,
- (b) children and adolescent mental health,
- (c) adult mental health, and
- (d) geriatric mental health.

[No effective date recommended]

**Recommendation 8: Delete Exception to Psychiatric Nursing Standard.**

Delete language in the in the Adult and Children's Mental Health Acts that permits individuals to function as independent psychiatric nurses without credentialing as Advance Practice Registered Nurses. (Adults—§245.462, Subd. 18; Children—§245.4871, Subd. 27)

Current law permits practice with a master's degree in nursing or one of the behavioral sciences or related fields with 4,000 hours of post-master's supervised experience.

[Recommended effective date: Upon enactment]

**Recommendation 9: Consistent standards across insurers or payors.**

Enact these recommendations consistently across payment sources. Professional qualifications for receiving Medical Assistance reimbursement should be no different than qualifications to receive payments for services provided under the MinnesotaCare, General Assistance Medical Care, or other health care insurance programs. Further, professional qualifications should be undifferentiated between the MA fee-for-service program and managed care programs such as Prepaid Medical Assistance Program (PMAP).

[No effective date recommended]

(NOTE: The focus of the Task Force was development of the recommendations. Participation on the Task Force does not represent endorsement of the descriptive sections of the report.)



# **Baseline of Competency: Common Licensing Standards for Mental Health Professionals A Report to the Minnesota Legislature**

*Baseline of Competency* recommends common standards of qualification for mental health professionals practicing in Minnesota regardless of their professional discipline.

Recommendations were ordered by the 2006 Legislature in a study to evaluate the necessary qualifications of mental health professionals for payment under publicly-financed health care programs. Results were to be reported to the 2007 Legislature.

A variety of disciplines are licensed to practice as mental health professionals under state law. A mental health *professional* is an individual qualified to engage in independent clinical practice; one who is qualified to perform diagnostic assessments and to provide clinical supervision to mental health *practitioners* and to *paraprofessionals*.

Under both the Adult<sup>2</sup> and Children's<sup>3</sup> Mental Health Acts, individuals are qualified to practice as mental health professionals when they meet the qualifications set out in the licensure statute for their clinical discipline. The mental health clinical disciplines are:

1. psychiatric nursing<sup>4</sup>
2. clinical social work<sup>5</sup>
3. psychology<sup>6</sup>
4. psychiatry<sup>7</sup>
5. marriage and family therapy<sup>8</sup> and
6. allied fields, expressly, the behavioral sciences or related fields.

Inconsistent standards across the professional disciplines characterize current licensure laws. In recent years, debate has been rigorous among the disciplines over what education, skills, and experience a clinician must possess in order to provide quality mental health care. While each discipline brings its own unique strengths to the clinical encounter with a mental health client, consensus has evolved within the mental health community that each mental health professional—regardless of discipline—should possess a common and basic set of qualifications: common standards to bolster the safety of mental health consumers and afford them effective high-quality care. Licensing requirements must establish a “knowledge core” across all disciplines of mental health professional. That is, each mental health professional must possess a baseline of clinical competency.

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<sup>2</sup> Minnesota Comprehensive Adult Mental Health Act, Minnesota Statutes 2006, Sections 245.461 to 245.488

<sup>3</sup> Minnesota Comprehensive Children's Mental Health Act, Minnesota Statutes 2006, Sections 245.487 to 245.4887

<sup>4</sup> Minnesota Board of Nursing, M.S., §148.181 - 148.191

<sup>5</sup> Minnesota Board of Social Work, M.S., §148D.025 – 148D.030

<sup>6</sup> Minnesota Board of Psychology, M.S., §148.90

<sup>7</sup> Must be a physician licensed under M.S., §147 and certified by the American Board of Psychiatry and Neurology

<sup>8</sup> Minnesota Board of Marriage and Family Therapy, M.S., §148B.30

## Purpose and Conduct of this Study

Following more than a year of productive but unconcluded debate within Minnesota's mental health community over the appropriate qualifications for mental health professionals, the 2006 Legislature ordered the community to evaluate qualifications necessary for payment under the State's publicly-financed health care programs and to resolve their differences. The resolution was to be reported to the 2007 Legislature in the form of recommendations.

The mandate was given to the Department of Human Services (DHS)—which functions as the State Medicaid Agency and State Mental Health Authority (both under federal law) and as supervisor of local mental health systems (under state law). The study was to be conducted in conjunction with the state's mental health licensing boards, each of which operates under separate statutory authority to oversee mental health professionals practicing within the recognized disciplines. The mandate was as follows:

*Laws 2006, Chapter 267, Article 1, Section 12:*

**Sec. 12. STUDY; REPORT.**

The medical director for medical assistance and the assistant commissioner for chemical and mental health services of the Department of Human Services, in conjunction with the mental health licensing boards, shall evaluate the requirements for licensed mental health practitioners to receive medical assistance reimbursement under Minnesota Statutes, section 256B.0625, subdivision 38. The purpose of this study is to evaluate qualifications of all licensed mental health practitioners and licensed mental health professionals and make recommendations regarding requirements for medical assistance reimbursement. This study is to be completed by January 15, 2007. Written results of the study are to be submitted to the chairs of the house of representatives and senate committees with jurisdiction over health related licensing boards.

Since qualification for MA payment requires mental health licensure, evaluating qualifications for MA reimbursement leads to a study of licensing standards.

The mental health community already had been engaged in evaluating licensing standards when the Legislature ordered the study. To build upon work already done, DHS formed a study group with a roster comprised largely of the diverse group of stakeholders who had been engaged in these discussions over the previous year-and-a-half. This allowed the study group to utilize the Stakeholders' momentum and their familiarity with complex licensure issues from inter-disciplinary points of view. Indeed, the Stakeholders' Group had come close to agreement on several key issues before the 2006 Session began. Participants had gained trust in each other and were eager to finish the job they had started.

Because of the crucial importance of licensing standards for mental health consumers and the public, DHS invited several additional members to ensure a balance of voices across the mental health disciplines and representation of mental health consumers.

Categorically, membership in what was called *The Task Force on Mental Health Professional Licensing Standards* included:

- mental health licensing boards for each discipline,
- mental health professional associations (or professional guilds) for each discipline,
- professional training schools/programs for each discipline,
- mental health advocacy organizations representing both children and adults,

- consumer and family organizations representing both children and adults,
- mental health provider associations,
- a clinical expert,
- the chairwoman of an ad hoc mental health professionals group, and
- DHS staff knowledgeable in mental health and Medical Assistance policy.

The complete roster of Task Force members is attached as Appendix A. Also included is a listing of other key attendees who contributed immensely to the success of this study.

Note: The focus of the Task Force was development of the recommendations. Participation on the Task Force does not necessarily represent endorsement of descriptive sections of the report.

### **Task Force Process**

DHS treated the Task Force as a continuation of Stakeholders' work and constructed agendas based upon the status of discussions at the final Stakeholders Group meeting in Spring 2006: agendas considered agreements already achieved and topics that Stakeholders had identified as needing resolution.

A group process was set up that began developing and reviewing recommendations continually. DHS staff sent proceedings from each meeting to members for redistribution to their respective constituencies: In this way, the mental health community was provided with opportunity to review and respond to each succeeding tentative agreement. Following input from stakeholders, several key agreements were reconsidered between meetings and revised at the next. Constituent boards and associations possessed all substantive recommendations within a week of the final meeting, allowing members nine weeks to review and revise the draft. The Task Force met again to edit a draft report in mid-December and members' comments were incorporated through the second week of January.

Decision-making was by consensus in the beginning. Midway, majority voting was adopted in order to gauge and demonstrate the level of agreement on each recommendation. As it turned out, alliance was strong: the weakest accord was decided by a 3:1 ratio of votes and about half of the polls taken produced no dissenting votes.

Strong final accord cannot be taken as harmony. Discussions produced anxious concerns and strong conflicts. Perhaps the two most serious contentions were, first, from members who are unconvinced that changes to the educational requirements, alone, would produce skillful clinicians and, second, from rural members who were greatly worried that their communities will not have resources necessary to meet enhanced professional standards. In addition, some members voiced distrust as to whether DHS had a "hidden agenda" that would distort this report.

Some members expressed concerns about the process used to establish the Task Force: shortage of time, licensing boards' inclusion in the planning process, and selection of members. Nevertheless, they expressed that the recommendations in the report reflect a serious collaboration among some of the best thinkers of the five mental health professions and the broad mental health community. They expressed appreciation to DHS for creating a forum that supported the development of positive recommendations for clinical educational standards and where participants could debate and collaborate freely.

## Goals of the Task Force

- Evaluate the qualifications of mental health professionals
- Develop common licensing standards, including comparable preparation and competence, for masters-level mental health professionals, while maintaining the uniqueness of the professional disciplines
- Develop professional licensures that comply with Medical Assistance provider requirements and medically-focused federal Medicaid standards
- Enhance qualifications of the mental health workforce and enhance quality of care
- Expand the workforce and access to services
- Provide support for an expected proposal from the Board of Behavioral Health and Therapy to establish a licensure for Professional Clinical Counselors in accordance with the recommendations of this Study
- Make recommendations as a united mental health community
- Comply with the legislative deadline and submit a report by January 15, 2007
- Focus on the most urgent issues within the permitted time frame

**Scope of the Study.** The scope of the Study had to be limited to accommodate the deadline. In planning, DHS saw that it would not be feasible to encompass both mental health professionals and mental health practitioners. Further, DHS believed it prudent to focus attention on those classes of professionals directly affected by the ongoing debate: masters-prepared mental health professionals. With these considerations in mind, DHS set the scope of the Study on masters-level mental health professionals, excluding consideration of:

- Psychiatrists and other medical doctors (MDs)
- Doctoral-prepared Licensed Psychologists (LPs)
- Mental Health Practitioners (who must practice under the clinical supervision of mental health professionals)
- Paraprofessionals, such as mental health behavioral aides (MHBAs) and personal care attendants (PCAs)

Psychiatric nursing presented planners with a quandary. Advanced Practice Registered Nurses (APRNs) with certification in psychiatric/mental health care complete a masters-level education, placing them within the chosen scope of the Study. Yet, comparison of education and clinical preparation models showed that the APRN model for preparation and for determination of clinical competency was different from the approaches used by other disciplines. Additionally, licensing and credentialing of APRNs is significantly different from other providers included in the study. Most important: no one was taking issue with the nurses' qualifications. In the end, Task Force members acknowledged that some of the recommendations would not apply to APRNs—and that nursing preparation unquestionably satisfied the minimum standards the Task Force was contemplating.

## History of the Legislative Study Mandate

Legislation that prompted the *Baseline of Competency* design emerged from a very different kind of idea. In 2005, the Minnesota Counseling Association sought a bill that would offer Medical Assistance coverage for a class of behavioral health workers called Licensed Professional Counselors, or LPCs. A companion proposal sought to change laws defining mental health

professionals such that this group of workers could practice with authority commensurate to the psychiatrists, psychologists, and other mental health clinicians who have qualifications allowing them to diagnose severe mental disorders, supervise complex treatments, and to practice independently of clinical supervision.

Consumers, advocates, providers, other mental health disciplines and their licensing boards, and the state mental health agency opposed the proposals: standards defining LPCs' qualifications do not meet the education and experience necessary under the Adult and Children's Mental Health Acts.

At the urging of the bill authors, these stakeholders gathered during that Session with a charge to produce an acceptable alternative. Early efforts by the stakeholders focused on removing the bills from consideration, revising law related to disciplinary actions against LPCs, and discussing appropriate licensing standards. A notion emerged to create a new tier of licensure, tentatively to be called Licensed Professional Clinical Counselors, or LPCCs. In contrast to LPCs, licensing standards for this new class would ensure education and experience that would emphasize the clinical aspects of professional preparation. Some key agreements were reached and areas of disagreement clarified.

During the 2005-2006 Session Interim, the Board of Behavioral Health and Therapy approached DHS with a legislative proposal to establish the clinical-level of licensure (LPCC). Board representatives came to the Stakeholder Group meetings with the goal of assembling a set of standards comparable to other masters-prepared professionals. Stakeholders considered initial educational requirements proposed by DHS excessively rigorous. BBHT was concerned that imposing standards on professional counselors that were higher than those required for other masters-level professionals would put their discipline at a competitive disadvantage vis-a-vis clinical social workers and marriage and family therapists.

As the 2006 legislative session approached, Stakeholders meetings ended with the Counselors' challenge to the group: *If you are going to raise standards for professional counselors, you need to raise standards for other disciplines.*

All sides agreed to take up the challenge of devising a common set of licensing standards for masters-prepared mental health professionals that would qualify them all as Medical Assistance-eligible providers and improve the overall qualifications of the mental health workforce. So Stakeholders agreed to meet during the next Interim and develop a proposal for the 2007 Session. The original authors of the LPC bills emphasized their expectation for a consensus proposal by ushering through the study mandate that would drive the next phase of development.

In summer 2006 communications with a group of mental health professionals who had participated as members of the stakeholders group, DHS proposed to establish a broad-based task force with membership drawn largely from the Stakeholder group and the Steering Committee. Membership was expanded somewhat in order to achieve balance across the disciplines with regard to licensing boards, professional associations, and professional training schools.

With DHS as host and staff, the Task Force held four intensive meetings in October and November 2006. Without tensions created by a pending bill, members achieved an atmosphere of collegiality and ultimately achieved its goal of bringing forward a roster of common licensing standards, crafted by representatives of the total mental health community including advocate and consumer groups, provider associations, licensing boards, professional associations, educators, and state regulators.



## RECOMMENDATIONS

Recommendations presented by the Task Force reflect a considerable level of accord across the diverse segments of Minnesota's mental health community. Each recommendation is followed by a supporting rationale.

### **Recommendation 1. Requirements for Supervised Clinical Practice.**

Requirements for licensure in each mental health professional discipline—except Psychiatric Nursing—should include a minimum standard for post-graduate supervised clinical experience, as follows:

4,000 hours of supervised, post-Masters degree professional clinical practice in the diagnosis and treatment of child and adult psychosocial function and mental, emotional, and behavioral illnesses and disorders:

- (a) including a minimum of 1,800 hours of direct clinical client contact; and
- (b) including 200 post-Masters degree hours of direct clinical supervision, of which:
  - a minimum of 50% must be one-on-one supervision, of which at least half must be in-person supervision and up to half may be via eye-to-eye electronic media;
  - up to 50% may be via group eye-to-eye electronic media, group in-person, or telephone. (A supervision group shall include a maximum of six supervisees.)Use of e-mail or other electronic text communication for clinical supervision is prohibited.

Supervision must:

- (c) be received under a written agreement that identifies clinical practice and the clinical supervisor (qualified as defined in Recommendation 4) must be a mental health professional with at least 2 years of post-licensure experience in the delivery of clinical services in the diagnosis and treatment of mental illnesses and disorders.
- (d) be distributed over the course of the supervised professional practice.

This requirement does not apply to Advanced Practice Registered Nurses (APRNs). Nursing does not use clinical supervision as defined in the other mental health professions and, instead, provides equivalent monitoring and evaluation of practice by other means defined in statute.

Rationale: This standard would require a newly-graduated clinician to practice for two years under the watchful eye of a clinical supervisor who has assumed full professional responsibility for the new clinician's actions and decisions, and for the services and treatments provided. Further, the supervisor is responsible for the supervisee's training and for evaluating the supervisee's practice. Accepting full professional responsibility means that the license of the clinical supervisor is at risk for errors of the supervisee, providing motivation for careful monitoring and guidance. Only upon completion of such an "apprenticeship" may the new clinician practice independently.

The Effective Date will be four (4) years after enactment of this provision.

## **Recommendation 2. Education Requirements for Licensure.**

Licensure in each mental health professional discipline should include completion of education requirements, as follows:

Masters or doctoral degree, including field experience (e.g., practicum or internship), from an accredited program in one of the clinical disciplines recognized by statute<sup>9</sup> as a mental health profession. The overall degree program must include:

360 clock hours or 24 semester credit hours education, minimum, in specified *clinical knowledge areas* to be distributed approximately as follows:

30% Diagnostic assessment for child and/or adult mental disorders; normative development; and psychopathology, including developmental psychopathology;

10% Clinical treatment planning, with measurable goals;

30% Clinical intervention methods informed by research evidence and community standards of practice;

10% Evaluation methodologies regarding the effectiveness of interventions;

20% Professional values / ethics applied to clinical practice, including cultural context and diversity.

The graduate education requirements may be completed as part of masters-level programs approved by the licensing boards for mental health professionals. The requirements, all in the specified clinical knowledge areas, may be satisfied by a combination of the following methods:

- accredited Masters-level coursework
- post-graduate coursework
- continuing education units (with a post test and a program description with goals and objectives available for public review) may be used for up to 90 hours or 25% of total education in clinical knowledge areas

### Rationale:

Completion of educational requirements and a clinical practicum do not guarantee competent clinical practice. However, they are essential and foundational for clinical preparation. Effective and ethical clinical practice requires mastery of core clinical knowledge, skills, and ethics in the content areas outlined above.

This requirement is expressed in equivalent values of clock hours and semester credits in order to accommodate differing curriculum structures among professional training schools and the varying practices among licensing boards. It is common in psychology programs, for example, to find an entire course devoted to diagnostic assessment: the value of the course toward satisfying the requirement is easily defined in semester credits. In another discipline, one course may comprise components of diagnostics, treatment planning, and professional values. Expressing the value of each component in clock hours allows the school to identify how the course satisfies the requirement. By expressing requirements for the five specified clinical

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<sup>9</sup> M.S., §245.462, Subd. 18, and §245.4871, Subd. 27

knowledge areas as a percentage of the total requirement, the schools and licensing boards may use either approach with identical results.

The Effective Date will be four (4) years after enactment of this provision.

**Recommendation 3: Continuing Education Requirement.**

Requirements for licensure in each mental health professional discipline should include a continuing education requirement, as follows:

Post-licensure, at least 40 hours of Continuing Education are required during each licensure renewal period or continuing education reporting period, of which a minimum of 60% must be in the clinical knowledge areas (as defined in the Recommendation 2, *Education Requirements for Licensure*).

Rationale: New illnesses emerge. Research produces new understandings of illnesses. New treatment methodologies are being developed and new medications are approved. Old skills need honing and new skills make a clinician more effective. New populations arrive, challenging clinicians to learn culturally appropriate methods to treat them. A mental health professional cannot stop learning.

The Effective Date will be four (4) years after enactment of this provision.

**Recommendation 4: Qualifications of a clinical supervisor.**

Qualifications for an individual providing mental health clinical supervision to individuals working toward licensure and to workers who require supervision should be enhanced and standardized in statute and rule, as follows:

An individual qualified to provide clinical supervision must:

- (1) be licensed in a mental health discipline as an independent mental health professional; and
- (2) be competent, qualified, or certified in the activities being supervised; and
- (3) demonstrate knowledge and skills in clinical supervision by:
  - having completed at least one (1) year of post-licensure experience with at least 1,000 hours in clinical practice, as defined by statute and rule.
  - providing written verification of 30 hours of training in supervision, which may be satisfied by completing accredited coursework or continuing education courses in clinical supervision or verification of approved supervisor status by a licensing board.
  - completing 6 continuing education hours in clinical supervision each licensure renewal period or continuing education reporting period. CEUs may include consultation regarding the practice of supervision.

Each individual providing clinical supervision must be certified, or in some other manner recognized, as a qualified clinical supervisor by the individual's professional licensing board.

This provision does not apply to psychiatric nursing, which does not utilize “clinical supervision” in the same manner as the other disciplines.

The Effective Date will be four (4) years after enactment of this provision.

Rationale: Clinical supervision promotes competent and ethical services to clients through development of the clinician’s knowledge, skills, and values. It is an essential professional relationship between a supervisor and a practitioner: the supervisor provides evaluation of and direction to services provided by the practitioner. In emerging treatment methodologies, which increasingly rely on practitioner-level clinicians and paraprofessionals for delivery, more clinical supervisors are needed to oversee workers who require clinical supervision by law. As a result, there are demands for more clinical supervisors with higher skills.

The role of clinical supervision in training clinicians is crucial: Historically, professional preparation has been a shared responsibility of the professional, academia, and the service delivery system. With the non-stop demand to learn emerging research, new treatment methods and technologies, and new skills—health and mental health care professionals spend years in intensive education and closely-monitored skill-building. Upon graduating from school, they move on to an apprenticeship, called supervised practice, where they further refine skills and deepen knowledge under the tutelage of a clinical supervisor. The system shares responsibility for ongoing professional training in the form of the supervisor’s compensation and time commitment.

Unfortunately, the inability to pay for clinical supervision in the midst of overall dwindling resources has forced provider agencies to abandon training and supervision. Training has become the sole individual responsibility of the professional. Many practicing professionals believe that clinical supervision has suffered both in quantity and quality and that the mental health system has lost the “culture of training” that once helped to prepare mental health professionals. Given the complexity of clinical work, client care is compromised.

The role of clinical supervision in delivering newly-emerging treatments will become increasingly important. Supervision has assumed new and larger roles in service delivery as providers seek to make efficient use of insufficient numbers of clinicians. Clinicians and researchers have developed interventions that are effective treatments for particular client populations and that can be delivered to the client by lesser-trained workers. This can stretch resources so long as these workers can rely on the guidance and oversight by mental health professionals specially trained as clinical supervisors. Well-prepared clinical supervision is, and will increasingly become, the medium in which mental health workers perform. Without the clinical expertise of a supervisor attending to both the technical and the relational aspects of treatment, these mid-level workers would not be able to intervene effectively with clients.

**Recommendation 5. Payment for Clinical Supervision.**

Minnesota Health Care Programs should cover payments for mental health clinical supervision as a distinct medically-necessary activity.

State-only funding would be necessary except in the unlikely event that federal reimbursement becomes available for an activity that the federal Medicaid agency historically has considered a cost of doing business.

Rationale: Minnesota’s mental health system is facing an unprecedented demand for clinical supervision: a greater number of clinical supervisors and more highly qualified clinical supervisors. Demands arise both from the deficiencies of the current system and from the promise of the emerging system.

The shortage of mental health professionals is forcing providers to utilize practitioners and paraprofessionals to the greatest extent possible: these are workers who require clinical supervision.

Professional preparation is breaking down from the shortage of clinical supervisors to guide and oversee the on-the-job training components of the state’s partial-apprenticeship training model.

In the future, the mental health system will increasingly utilize clinical supervision as a means to improve efficiency and expand workforce capacity, enhance treatment effectiveness, assure quality, and guide the training and early practice of new professionals.

The Effective Date will be four (4) years after enactment of this provision.

**Recommendation 6: *Allied Fields* as a class of mental health professional.**

Eliminate the statutory class of "allied fields" as a category of mental health professional—as defined in the Adult Mental Health Act and Children's Mental Health Act. Statute provides as follows:

*"Mental health professional" means a person providing clinical services in the treatment of mental illness who is qualified in at least one of the following ways...*

*(6) in allied fields: a person with a master's degree from an accredited college or university in one of the behavioral sciences or related fields, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness."*

The Task Force recommends deletion of Paragraph (6) in both of the following sections: §245.462, Subd. 18, and §245.4871, Subd. 27.

Rationale: The vagueness of this category is harmful to the public. It conveys authority to diagnose and treat children and adults with severe mental disorders to unknown, undefined, and unqualified individuals. The category is dangerous because it fails to clearly circumscribe a class of practitioners or the qualifications of the class. The term “*behavioral sciences*,” itself, is broad enough to include such non-clinical fields as sociology, or anthropology—both of which are unqualified by training and experience to function as mental health professionals. Aggravating the vagueness by adding the phrase “*or related fields*,” renders this provision devoid of any meaning as a professional qualification standard. Yet, by definition as mental health professionals, practitioners in any of these fields possess authority to provide mental health services alongside psychiatrists, doctoral-level psychologists, psychiatric nurses, and others with extensive clinical training.

Historically, the Mental Health Acts used this vague terminology in attempts to extend the mental health work force. Its utility is past, as the mental health system moves to expand its capacity by other, more effective, means.

The Effective Date will be upon enactment of this provision.

**Recommendation 7: Follow-up Study on Age-Related Practice Standards.**

The Task Force recommends that the Legislature order a follow-up study to evaluate and make recommendations regarding mental health professionals' scope-of-practice in order to prescribe practice categories by age of the client, namely:

- early childhood mental health,
- children and adolescent mental health,
- adult mental health, and
- geriatric mental health.

The purpose of the study would be to make recommendations regarding age-specific licensing or certification standards that would be applicable to all mental health professional disciplines without regard to payment source.

The Commissioner of Human Services, with a broad-based stakeholders task force, should be asked to conduct the study. The study would be due to the Legislature at the beginning of the 2009 Session.

Rationale: To be effective, mental health interventions must consider the client's age or, more accurately, the client's developmental level. The meaning of symptoms presented, the nuances of diagnosis, the selection of effective treatments, the nature of clinician-client communication, effectiveness of medications, and approaches to medication management all vary by age.

Developmental variation begins early in life and continues into old age. Children's mental health advocates have long argued that "children are not just small adults" and that children are fundamentally—that is, developmentally—different from adults. In recent years, developmental experts have begun to argue that even a distinction between child and adult mental health is insufficient. "Early childhood mental health" and "geriatric mental health" have emerged from research and best-practice models.

Licensure in most mental health professional disciplines does not recognize developmental differences when setting education and experience requirements for practice.<sup>10</sup> In a common scenario, a professional may complete professional training and supervised practice with a focus on the adult population but, once licensed, the professional may begin an independent practice with a children's population. Despite an expectation that a clinician "must have the knowledge base to support their areas of practice," according to a Task Force member, no proscription exists in most licensures to restrict a caseload.

**Recommendation 8: Delete Exception to Psychiatric Nursing Standard.**

Delete language in the in the Adult and Children's Mental Health Acts that permits individuals to function as independent psychiatric nurses without credentialing as Advance Practice Registered Nurses. Psychiatric/mental health clinical nurse specialists and psychiatric/mental health nurse practitioners meet nationally accepted competency standards and are credentialed to independently provide clinical services to psychiatric/mental health clients. Nurses who are not credentialed as clinical nurse specialists or nurse practitioners are not authorized to provide these services.

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<sup>10</sup> Advanced Practice Registered Nurses are the exception. As noted elsewhere psychiatric nursing certifies practice in age-specific populations.

The phrase proposed for deletion is shown in bold italics:

Both the Adult Mental Health Act (M.S., §245.462, Subd. 18) and the Children’s Mental Health Act (M.S., §245.4871, Subd. 27) define a mental health professional in psychiatric nursing as an individual who has been certified as a psychiatric/mental health clinical nurse specialist or a psychiatric/mental health nurse practitioner ***“or who has a master’s degree in nursing or one of the behavioral sciences or related fields from an accredited college or university or its equivalent, with at least 4,000 hours of post-master’s supervised experience in the delivery of clinical services in the treatment of mental illness;”***

Medical Assistance does not recognize persons defined under this legal exception as eligible providers for payment.

Effective Date: Upon enactment of this provision

**Recommendation 9: Consistent standards across insurers or payors.**

The Task Force supports consistent professional qualification standards regardless of payment source. Clients whose care is covered by Medical Assistance should receive care from professionals who are equally qualified as those professionals who treat non-MA covered clients. “The payor should not drive credentialing,” according to a Task Force member.

Professional qualifications for receiving Medical Assistance reimbursement should be no different than qualifications to receive payments for services provided under the MinnesotaCare, General Assistance Medical Care, or other health care insurance programs. Further, professional qualifications should be undifferentiated between the MA fee-for-service program and managed care programs such as Prepaid Medical Assistance Program (PMAP).

Rationale: The current system includes dysfunctions including cost-shifting between payers, perverse incentives, and gaps in services in which a medically necessary treatment is available under one health care program—but not another. These inefficiencies occur at the expense of the consumers.

Some individuals now enrolled in GAMC and MinnesotaCare have access to needed services only to the extent that funds are available through capped state grants or county funds. As a result, access to mental health services varies from region to region and county to county. Eliminating access and quality discrepancies between health coverage programs is a primary goal of the Minnesota Mental Health Action Group (MMHAG).



## Issues Affecting Mental Health Professional Qualifications

### Enhancing Quality in the Midst of Rural Resource Shortages

The Task Force rejected calls for lower qualification standards in rural communities. All mental health consumers deserve high-quality care from highly-qualified professionals, according to Task Force discussion. No mental health professional should be exempt from education and experience standards, despite resource and workforce shortages.

Members representing “Greater Minnesota” said that setting standards too high could threaten the viability of rural providers. In general, however, rural providers favored high quality standards—so long as implementation dates permit time to enhance their capabilities. “We’re in favor, if you give us time,” said a Mankato participant.

DHS asserted medical and legal principles supporting statewide standards of quality and said that both the Adult and Children’s Mental Health Divisions view any move to lower quality of care in rural communities as unacceptable.

Instead of lowering quality in rural areas, the Task Force supports policies to enhance the number of rural mental health professionals and the quality of the rural workforce, as well as policies to improve access to high-quality care in rural communities.

In particular, the Task Force supports an expected proposal from the Board of Behavioral Health and Therapy to establish a new clinical tier of licensure in the field of Professional Counseling that would satisfy the new standards proposed in this Report. The new class of mental health professionals—to be called *Licensed Professional Clinical Counselors (LPCC)*—could offer a boon of qualified mental health clinicians to Greater Minnesota.

According to DHS, both the Legislature and the Department of Human Services have undertaken recent initiatives to enhance rural access and quality; they include the following:

**Mental health telemedicine implemented.** October 1, 2006, saw the implementation of a new Medical Assistance (Medicaid) benefit covering mental health services provided via interactive video media. The new benefit permits any mental health service otherwise covered as a face-to-face service to be provided via interactive video media unless it is clinically inappropriate; few exceptions are envisioned. Rural and other under-served communities are expected to be the primary beneficiaries of this new benefit.

**Payment for psychiatric consultation implemented.** Another new benefit allows primary care physicians to bill Medical Assistance for consultations with psychiatrists. The benefit was effective October 1, 2006, following enactment by the 2005 Minnesota Legislature. The entire state is expected to gain; in particular, rural and other under-served communities will benefit.

**Integration of mental health and primary care.** Few approaches could expand mental health capacity and broaden access to care more rapidly than expanding the ability of primary care clinics to identify, refer, and provide treatment for mental disorders. For children, primary care is second only to schools in functioning as a nearly-universal point of contact, offering the ability to identify children who may suffer from mental or emotional problems. DHS has taken the following approaches to integrate children’s mental health and primary care:

- Sponsoring trainings for physicians focusing on mental development and on identification of emotional disorders (including the use of specific screening tools and an early childhood diagnostic classification scheme);
- Training primary care physicians in intervention methods;
- Developing a billing mechanism for screening;
- Establishing financial incentives in managed care contracts to perform screenings; and
- Promoting co-location—by placing mental health professionals in primary care staff positions and by building physically-adjointing mental health and primary care practices.

**State-sponsored core training expanding.** Following on the immense success of the Adult Mental Health Division’s *Core Competency Training Program*, the Children’s Mental Health Division of DHS secured funding, in 2006, to develop a training program aimed at providers of children’s mental health services and at parents of children with emotional disturbances. Curricula will be developed around evidence-based practices, Medical Assistance compliance, rehabilitation service-provider certification, cultural competence, and tribal mental health capacity enhancement. The Adult Division continues its training program, will disseminate detailed materials on core competencies for evidence-based practices, and expects to initiate dialogue on curriculum enhancement with mental health professional education programs.

### **Evidence-Based Practices May Impact Future Provider Preparation**

Core competencies for the adult evidence-based practices (EBPs) will not be an issue for licensure in the near future, according to DHS. However, preparation for the delivery of EBPs ultimately will be a necessary component of professional qualifications.

Though EBPs are now “in the infancy of development” in Minnesota, they are part of a commitment shared by the Adult and Children’s Mental Health divisions to a quality workforce of mental health professionals and practitioners. DHS is working with a stakeholders group to define the “core competencies” necessary for professionals and practitioners to competently deliver each specific EBP.

Since the Adult EBP models are designed largely for delivery by practitioner-level clinicians, demands on clinical supervisors are going to increase. Expansion of clinical supervision—both in scope and qualifications—will be crucial over the next three to five years.

### **Context of the Study on Mental Health Licensure**

Consumers’ needs and professional evolution already are driving changes in licensing requirements and professional schools’ curricula.

This Study takes place in the context of ongoing transformation of the mental health system—shaping it from both within and without. From the perspective of the Department of Human Services, the Study’s recommendations are part of a far-reaching strategy to improve the mental health service delivery system with its myriad branches, governing jurisdictions, and fragmented financing.

According to DHS, challenges facing the system include the following:

- Minnesotans with mental illness are suffering from an acute and longstanding shortage of people who have committed themselves to mental health as their field of endeavor. This “workforce shortage” is particularly severe in rural parts of the state and for people whose health coverage is financed publicly. The shortage is inclined against the most highly-trained clinicians. (Psychiatrists and psychologists, particularly those trained to work with children and adolescents, are in the shortest supply.) The system attempts to compensate by stretching clinicians with descending levels of preparation over its growing demands. Ultimately, using workers not qualified for independent practice steals highly-qualified professionals from direct client therapy in order to perform clinical supervision.
- Clients are presenting with more serious conditions. This is especially true of children. Parents, doctors, teachers, and mental health professionals are finding more first-time clients with more severe conditions, at earlier ages, and with fewer compensating environmental supports.
- Even as demands grow, the federal government—the largest funder of public mental health—is placing more stringent constraints on reimbursement and has begun to question the most innovative interventions.

Among the positive forces:

- Treatment methodologies have improved to such an extent that it is now possible for some adults with mental illnesses to look forward to recovery from a condition that heretofore would have confined them to lifelong dependence on social, familial, and economic supports. For children, research-proven treatments now increase their resilience to environmental traumas and ameliorate some conditions before the child reaches maturity.
- Minnesota is in the process of implementing evidence-based practices as research identifies practices that are effective on a wider variety of people and effective with a wider spectrum of conditions. While methodologies differ for adults and children, the goal and expectation is the same: reduction or cessation of mental disorder.
- With more mental disorders being recognized as biologically-based in the physiology or chemistry of the brain—and fewer seen as socially, environmentally, or parentally induced—inroads are being made against social stigma and toward parity between mental and medical health.
- Primary care doctors are learning to treat mental health problems, hiring mental health professionals into their clinics, consulting more often with mental health experts, and locating their clinics within conversational range of mental health clinics—all to address the mental health conditions among their patients that these physicians are increasingly learning to recognize. This serves to extend the capacity of the mental health system
- In fact, DHS is developing a transformation initiative that promises to integrate mental health with the state’s health care system and with local social services. It would utilize the strategies of Minnesota’s ongoing health care reform movement to overcome some of the threats of federal constrictions.

## **Appendix A: Roster of Task Force Members<sup>11</sup> and List of Other Contributors**

### **TASK FORCE ON MENTAL HEALTH PROFESSIONAL LICENSING STANDARDS MEMBERSHIP BY CATEGORY**

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<sup>11</sup> The focus of the Task Force was development of the recommendations. Participation on the Task Force does not necessarily represent endorsement of descriptive sections of the report.

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<b>BELONGS IN EDUCATION PROGRAM</b>		
<b>#</b>	<b>Competency</b>	<b>%</b>
	professional scope of practice and competence.	
<b>3</b>	Demonstrate knowledge of the experiences of immigrants, refugees and victims of torture and the impact of these experiences on individuals, families and succeeding generations.	<b>89%</b>
<b>4</b>	Understand recovery-oriented behavioral health services (e.g. self-help groups, 12-step programs, peer-to-peer services, supported employment).	<b>79%</b>
<b>6</b>	Develop with client input, measurable outcomes, treatment goals, treatment plans, and after-care plans.	<b>79%</b>
<b>12</b>	Recognize strengths, limitations, and contraindications of specific therapy models, including the risk of harm associated with models that incorporate assumptions of family dysfunction, pathogenesis, or cultural deficit.	<b>100%</b>
<b>15</b>	Respect multiple perspectives (e.g. clients, family, team, supervisor, practitioners from other disciplines involved in the case.)	<b>79%</b>
<b>18</b>	Integrate treatment for co-occurring disabilities including physical, developmental, and substance abuse disorders.	<b>84%</b>
<b>19</b>	Knowledge of the principles underlying strengths based service delivery including recovery, wellness, and resilience.	<b>84%</b>
<b>20</b>	Understand and monitor issues related to ethics, laws, regulations, and professional standards.	<b>84%</b>
<b>23</b>	Understanding of the developmental, intergenerational and life cycle approach to community mental health practice transculturally.	<b>74%</b>
<b>25</b>	Critique professional research and assess the quality of research studies and program evaluation in the literature as it relates to guiding practice	<b>79%</b>
<b>31</b>	Understand the concept of evidence-based treatment and development of evidence to evaluate promising or innovative practices.	<b>79%</b>
<b>32</b>	Knowledge of the principles underlying prevention of mental illness and early intervention.	<b>95%</b>
<b>33</b>	Provide services that are culturally competent and relevant.	<b>79%</b>

Similarly, there was solid consensus regarding the competencies best provided by on-the-job training, as follows. Note that there is some overlap in whether certain competencies “belongs in education program” or are “best provided by on-the-job training.” These overlapping items are indicated in *italics*.

<b>BEST PROVIDED BY ON-THE-JOB TRAINING</b>		
<b>#</b>	<b>Competency</b>	<b>%</b>
<b>1</b>	Integrate client feedback, assessment, contextual information, and diagnosis with treatment goals and plan.	<b>74%</b>
<b>2</b>	<i>Develop with client input, measurable outcomes, treatment goals, treatment plans, and after-care plans.</i>	<b>79%</b>
<b>3</b>	Work collaboratively with stakeholders, including family members, other significant persons and professionals who are significant to the client.	<b>84%</b>
<b>4</b>	Advocate in partnership with clients in obtaining quality care, appropriate resources, and services in the community.	<b>89%</b>
<b>5</b>	Develop a service plan for case management and supportive services.	<b>95%</b>
<b>6</b>	Assist clients and family members to understand and navigate the public mental health system.	<b>84%</b>

<b>BEST PROVIDED BY ON-THE-JOB TRAINING</b>		
<b>#</b>	<b>Competency</b>	<b>%</b>
7	Participate in quality assurance and improvement activities.	89%
13	Empower clients and their relational systems to establish effective relationships with each other and larger systems.	89%
14	Provide psychoeducation to clients and families whose members have serious mental illness or other disorders, including information about wellness and recovery.	89%
17	Assist client in obtaining and maintaining educational and vocational goals.	84%
18	<i>Integrate treatment for co-occurring disabilities including physical, developmental, and substance abuse disorders.</i>	79%
21	Demonstrate knowledge of adult and child systems of care and coordinated service.	79%
26	Coordinate treatment and discharge planning in higher level treatment facilities.	74%
27	Effectively handle consumer/family complaints and grievances.	95%
28	Participate in program development and design.	79%
29	Understand Medi-Cal, Medicare, and Social Security eligibility and assist in enrollment for entitlements and benefits counseling.	79%
30	Ability to write chart notes that support billing and accurately reflect the goal, intervention, and result; reflect the role of the client in the treatment process and choices of goals and treatment activities.	95%
33	<i>Provide services that are culturally competent and relevant.</i>	84%

### Open-Ended Responses

The open-ended responses varied in relation to the skills, knowledge and attitudes that public mental health system employers look for. Please refer to Attachment C for more information.

### **Attachments**

- A. Survey Cover Letter
- B. CCCMHA MSW Employer Survey Results/Competencies
- C. CCCMHA MSW Employer Survey Results/Other Questions & Comments

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To Whom It May Concern:

The Board of Behavioral Sciences is reviewing the educational preparation of individuals who become registered as Associate Clinical Social Workers (ASW). Your response to the attached survey will provide invaluable information regarding how new ASWs meet or don't meet the expectations of their supervisors and employers in community mental health agencies. The Board would like to thank you in advance for taking the time to complete the survey.

Responses to this survey will be aggregated by CCCMHA and provided to the Board to use in its deliberations. The Board has formed the LCSW Education Committee to undertake the review. The Committee will be meeting over the next 12-19 months around the state while conducting its assessment. We welcome your participation beyond responding to the survey. Meetings dates and locations are posted well in advance on the Board's website ([www.bbs.ca.gov/bd\\_activity/bd\\_mtgs.shtml](http://www.bbs.ca.gov/bd_activity/bd_mtgs.shtml)). In addition, you can subscribe to the BBS website and receive email notifications of meetings and other information updates by going to the BBS homepage ([www.bbs.ca.gov](http://www.bbs.ca.gov)) and clicking on "Subscriber List."

Again, thank you for responding to this survey. If you have any questions or comments on this or any other issue feel free to contact me at 916-574-7840 or [Paul\\_Riches@dca.ca.gov](mailto:Paul_Riches@dca.ca.gov).

Sincerely,

Paul Riches  
Executive Officer

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## CCCMHA MSW EMPLOYER SURVEY RESULTS October 2008

**Number Agencies Responding: 19/60**

**Approx total number MSW positions reflected: 850**

**Highlighted items reflect 74% or greater # respondents agree with item.**

A. Please review the list of Competencies below and check the appropriate box. You may check more than one box for each item.

COMPETENCY	BELONGS IN EDUCATION PROGRAM	BEST PROVIDED BY ON-THE- JOB TRAINING	CONTINUING EDUCATION NEEDED IN THIS FOR CURRENT STAFF	NON APPLICABLE
1. Solicit and use client feedback throughout the therapeutic process.	15 (79%)	12	7	
2. Evaluate individuals' needs to determine appropriateness for treatment within professional scope of practice and competence	14 (74%)	12	7	1
3. Demonstrate knowledge of the experiences of immigrants, refugees and victims of torture and the impact of these experiences on individuals, families and succeeding generations.	17 (89%)	11	15 (79%)	
4. Understand recovery-oriented behavioral health services (e.g. self-help groups, 12-step programs, peer-to-peer services, supported employment)	15 (79%)	12	15 (79%)	
5. Integrate client feedback, assessment, contextual information, and diagnosis with treatment goals and plan	13	14 (74%)	8	
6. Develop with client input, measurable outcomes, treatment goals, treatment plans, and after-care plans.	15 (79%)	15 (79%)	10	
7. Work collaboratively with stakeholders, including family members, other significant persons and professionals who are significant to the client.	11	16 (84%)	7	
8. Advocate in partnership with clients in obtaining quality care, appropriate resources, and services in the community	10	17 (89%)	9	Has to be reinforced
9. Develop a service plan for case management and supportive services.	13	18 (95%)	5	
10. Assist clients and family members to understand and navigate the public mental health system	9	16 (84%)	3	
11. Participate in quality assurance and improvement activities	4	17 (89%)	6	1
12. Recognize strengths, limitations, and contraindications of specific therapy models, including the risk of harm associated with models that incorporate assumptions of family dysfunction, pathogenesis, or cultural deficit.	19 (100%)	11	13	
13. Empower clients and their relational systems to establish effective relationships with each other and larger systems.	11	17 (89%)	6	

COMPETENCY	BELONGS IN EDUCATION PROGRAM	BEST PROVIDED BY ON-THE-JOB TRAINING	CONTINUING EDUCATION NEEDED IN THIS FOR CURRENT STAFF	NON APPLICABLE
14. Provide psychoeducation to clients and families whose members have serious mental illness or other disorders, including information about wellness and recovery	11	17 (89%)	9	
15. Respect multiple perspectives (e.g. clients, family, team, supervisor, practitioners from other disciplines involved in the case.)	15 (79%)	12	7	1
16. Set appropriate boundaries, manage issues of triangulation, and develop collaborative working relationships	13	13	6	
17. Assist client in obtaining and maintaining educational and vocational goals	10	16 (84%)	6	
18. Integrate treatment for co-occurring disabilities including physical, developmental, and substance abuse disorders	16 (84%)	15 (79%)	11	
19. Knowledge of the principles underlying strengths based service delivery including recovery, wellness, and resilience.	16 (84%)	13	13	
20. Understand and monitor issues related to ethics, laws, regulations, and professional standards.	16 (84%)	13	16 (84%)	
21. Demonstrate knowledge of adult and child systems of care and coordinated service	11	15 (79%)	5	
22. Provide education in parenting skills and/or foster parenting skills.	8	12	9	2
23. Understanding of the developmental, intergenerational and life cycle approach to community mental health practice transculturally	14 (74%)	11	12	
24. Understanding of the impact of mental illness and substance abuse on the consumer and family members at all stages of the life cycle.	11	11	13	1
25. Critique professional research and assess the quality of research studies and program evaluation in the literature as it relates to guiding practice.	15 (79%)	1	1	2
26. Coordinate treatment and discharge planning in higher level treatment facilities	4	14 (74%)	4	3
27. Effectively handle consumer/family complaints and grievances	7	18 (95%)	4	
28. Participate in program development and design	4	15 (79%)	3	1
29. Understand Medi-Cal, Medicare, and Social Security eligibility and assist in enrollment for entitlements and benefits counseling	12	15 (79%)	11	
30. Ability to write chart notes that support billing and accurately reflect the goal, intervention, and result; reflect the role of the client in the treatment process and choices of goals and treatment activities.	12	18 (95%)	4	

COMPETENCY	BELONGS IN EDUCATION PROGRAM	BEST PROVIDED BY ON-THE-JOB TRAINING	CONTINUING EDUCATION NEEDED IN THIS FOR CURRENT STAFF	NON APPLICABLE
31. Understand the concept of evidence-based treatment and development of evidence to evaluate promising or innovative practices.	15 (79%)	10	12	
32. Knowledge of the principles underlying prevention of mental illness and early intervention	18 (95%)	7	4	
33. Provide services that are culturally competent and relevant	15 (79%)	16 (84%)	14 (74%)	

Additional competencies needed, but not listed:

\_\_\_\_\_

\_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

B. Is the educational system producing MSW graduates who are adequately prepared to provide services in public mental health?  Yes  No

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

C. Would it influence your hiring decision if a candidate held a specialty certificate in Public Mental Health offered by a professional association or private business? (You may check more than one).

- Our hiring decisions are based on a diversity of factors beyond prior coursework or external indicators of competency
- With adequate changes in the educational curriculum a certification process would be unnecessary.
- Along with adequate changes in the educational system, we would also prefer to provide on-the-job training specific to our site and operations.
- Along with adequate changes in the educational curriculum, we would also prefer to have available CEU opportunities to continue developing and improving skills needed in the public sector.
- We would be most likely to hire a candidate who produced a specialty certificate.

F. Would the requirement or options to have a special certificate for serving the public sector contribute or add barriers to the availability of an adequately trained workforce for public sector agencies?  Contribute  Add Barriers  Undecided

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Survey Completed By: \_\_\_\_\_ Date: \_\_\_\_\_

Title: \_\_\_\_\_

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# CCCMHA MSW EMPLOYER SURVEY RESULTS

## October 2008

### Narrative Responses and Comments

#### **Additional competencies needed, but not listed:**

1. Work in a team environment
2. The importance of documentation and how it impacts the clinical processes. Understanding how to facilitate groups (tx.. case management) and family work appears to be lacking in the education setting.
3. Crisis intervention techniques and assessment tools/skills for SI/HI
4. Listening, Motivational Interviewing, conflict resolution, CBT.
5. Intergovernmental coordination, grants-management, federal and state funding streams for MH services, and training in recognizing deficiencies and shortfalls in the MH system and conducting advocacy to address those needs.
6. Understanding of infrastructure of CMH (County-State-Federal) in terms of service delivery and funding
7. Supervision skills for CMH setting

#### **Comments:**

- The way this survey is written, I could not check both educational programs and on the job training. Essentially, most of the competencies belong in both places. Thus I primarily checked “educational programs” and “continuing education” when I believed that both the educational program and the workplace should provide skill development.
- I believe it is a disservice to the MSW interns that a licensed MFT cannot provide supervision or oversight per College policy. Instead MSWs are often supervised by ASWs with far less experience. Most agencies have many MFT staff who would be eligible to provide supervision, which would also open the door to more field/community placements. This may also increase the opportunities for MSWs to have internships with a more focused clinical/theoretical emphasis.
- A number of the competencies listed have a clinical bias. One of the problems we have in the system both in terms of a shortage of staff and the

resulting poor client to staff ratios centers around the over reliance on licensed staff to perform tasks that don't require a license. We're assuming that the goal is to change the curriculum for all MSW students, whether or not they intend on pursuing their clinical license.

- Concerning competency #2, is this an eligibility question or a prognosis question? If it is the latter, we believe that students, workers and more importantly consumers, would all be much better off if the professionals got out of the business of predicting failure.
- With respect to competency #15, it is our concern that if someone does not already possess this quality prior to admission to graduate school we doubt that any course of instruction or on the job training would be able to inculcate this quality (of course this runs counter to our comment regarding #2).
- We didn't understand competency #23, other than it seems to be covered by competency #33.
- With respect to competency #24, we feel that the phrasing of the competency produces an unnecessary negative bias when it comes to substance use and/or mental health issues. Our system only sees half of the people that could be diagnosed with an Axis 1 disorder. Some of those we don't see do just fine without us.

**Is the educational system producing MSW graduates who are adequately prepared to provide services in public mental health?**

**Yes: 10 No: 6 No Response: 3**

**Comments:**

- It depends on which school they come out of.
- The strongest graduates are those who seek additional education, quality of internship, etc.
- I would like to see more training in providing in depth clinical treatment
- not enough on current public practice
- There is a deficit in their ability to diagnose and operationalize/implement treatment planning. There seems to be an emphasis on theoretical without enough balance addressing the actual implementation of providing services. Documentation is a serious deficit documentation as will be actual utilized in public health facilities. Often times too much time is needed in coaching/training MSWs in documentation, to the deficit in clinical training

once they are in the work place. Also the documentation expectations (perceived as something we have to do but is not part of care/tx) are often what most overwhelm MSW/ASW.

- As entry level staff
- It creates graduates who are eager to help, but don't know how to listen, how to develop relationships or how to sit with someone in their pain. The mantra should change to "don't just do something, stand there". Too little time is spent in helping students identify their own emotional baggage and how it might impact their ability to truly connect with those they serve and how it might influence their judgment. Somehow schools continue to graduate students who are afraid of the people they're supposed to help, and who have little understanding of what it means to be poor.
- More emphasis needs to be given to working with underserved populations, training in billing for various services provided in CMHC is needed.
- In may not be education's fault, but most seem oriented towards private practice with wealthier clientele.
- I believe so...the foundation is made in MSW school, but much of the intensive learning is done on the job. Graduate training needs to include an emphasis in gerontology and co-occurring psychiatric and substance use disorders (See the IOM book).

**Would it influence your hiring decision if a candidate held a specialty certificate in Public Mental Health offered by a professional association or private business? (You may check more than one).**

12\_\_Our hiring decisions are based on a diversity of factors beyond prior coursework or external indicators of competency

6\_\_With adequate changes in the educational curriculum a certification process would be unnecessary.

12\_\_Along with adequate changes in the educational system, we would also prefer to provide on-the-job training specific to our site and operations.

9\_\_Along with adequate changes in the educational curriculum, we would also prefer to have available CEU opportunities to continue developing and improving skills needed in the public sector.

4\_\_We would be most likely to hire a candidate who produced a specialty certificate.

**Would the requirement or options to have a special certificate for serving the public sector contribute or add barriers to the availability of an adequately trained workforce for public sector agencies?**

**\_\_6\_\_ Contribute    \_\_6\_\_ Add Barriers    \_\_5\_\_ Undecided**

**Comments:**

- To require a certificate would severely limit our pool of candidates. In our rural county, it is already difficult enough to find well trained, competent, motivated, dedicated individuals to work with our target population.
- I believe this should be part of the educational expectations as most will earn their hours and/ or complete their internship in Public Health/ Mental Health agencies.
- Commitment to Public service is more of a value or desire to serve the neediest people in our society. We can train these people if the desire/value is there. Often it seems that new therapists are more often trained or guided towards private practice with higher functioning clients.
- Receiving specialized training would absolutely contribute to the student and to the organization where the graduate eventually works.



5. Understand and interpret the history of the social work profession and its contemporary structures and issues.
6. Apply the knowledge and skills of a generalist social work perspective to practice with systems of all sizes.
7. Use theoretical frameworks supported by empirical evidence to understand individual development and behavior across the life span and the interactions among individuals and between individuals and families, groups, organizations, and communities.
8. Analyze, formulate, and influence social policies.
9. Evaluate research studies, apply research findings to practice, and evaluate their own practice interventions.
10. Use communication skills differentially across client populations, colleagues, and communities.
11. Use supervision and consultation appropriate to social work practice.
12. Function within the structure of organizations and service delivery systems and seek necessary organizational change.

### 3.1 Concentration Objectives/3.2 Additional Program Objectives (p. 8)

MSW graduates are advanced practitioners who apply the knowledge and skills of advanced social work practice in an area of concentration. They analyze, intervene, and evaluate in ways that are highly differentiated, discriminating, and self-critical. Graduates synthesize and apply a broad range of knowledge and skills with a high degree of autonomy and proficiency. They refine and advance the quality of their practice and that of the larger social work profession. A program may develop additional objectives to cover the required content in relation to its particular mission, goals, and educational level.

### 4. Foundation Curriculum Content (p. 8)

Foundational coursework is designed to provide the knowledge, values and skills that are fundamental to practice in any setting and which prepare the student for more advanced, specialized learning. Content is relevant to the mission, goals, and objectives of the program and to the purposes, values, and ethics of the social work profession. All social work programs provide foundation content in the areas specified below. Content areas may be combined. Each school's specific foundation year content is provided in Attachment B.

- *4.0 Values and Ethics*  
Social work education programs integrate content about values and principles of ethical decision making as presented in the National Association of Social Workers Code of Ethics. The educational experience provides students with the opportunity to be aware of personal values; develop, demonstrate, and promote the values of the profession; and analyze ethical dilemmas and the ways in which these affect practice, services, and clients.
- *4.1 Diversity*  
Social work programs integrate content that promotes understanding, affirmation, and respect for people from diverse backgrounds. The content emphasizes the interlocking and complex nature of culture and personal identity. It ensures that social services meet the needs of groups served and are culturally relevant. Programs educate students to recognize diversity within and between groups that may influence assessment, planning, intervention, and research. Students learn how to define, design, and implement strategies for effective practice with persons from diverse backgrounds.

- 4.2 Populations-at-Risk and Social and Economic Justice*

Social work education programs integrate content on populations-at-risk, examining the factors that contribute to and constitute being at risk. Programs educate students to identify how group membership influences access to resources, and present content on the dynamics of such risk factors and responsive and productive strategies to redress them. Programs integrate social and economic justice content grounded in an understanding of distributive justice, human and civil rights, and the global interconnections of oppression. Programs provide content related to implementing strategies to combat discrimination, oppression, and economic deprivation and to promote social and economic justice. Programs prepare students to advocate for nondiscriminatory social and economic systems.
- 4.3 Human Behavior and the Social Environment*

Social work education programs provide content on the reciprocal relationships between human behavior and social environments. Content includes empirically based theories and knowledge that focus on the interactions between and among individuals, groups, societies, and economic systems. It includes theories and knowledge of biological, sociological, cultural, psychological, and spiritual development across the life span; the range of social systems in which people live (individual, family, group, organizational, and community); and the ways social systems promote or deter people in maintaining or achieving health and well-being.
- 4.4 Social Welfare Policy and Services*

Programs provide content about the history of social work, the history and current structures of social welfare services, and the role of policy in service delivery, social work practice, and attainment of individual and social well-being. Course content provides students with knowledge and skills to understand major policies that form the foundation of social welfare; analyze organizational, local, state, national, and international issues in social welfare policy and social service delivery; analyze and apply the results of policy research relevant to social service delivery; understand and demonstrate policy practice skills in regard to economic, political, and organizational systems, and use them to influence, formulate, and advocate for policy consistent with social work values; and identify financial, organizational, administrative, and planning processes required to deliver social services.
- 4.5 Social Work Practice*

Social work practice content is anchored in the purposes of the social work profession and focuses on strengths, capacities, and resources of client systems in relation to their broader environments. Students learn practice content that encompasses knowledge and skills to work with individuals, families, groups, organizations, and communities. This content includes engaging clients in an appropriate working relationship, identifying issues, problems, needs, resources, and assets; collecting and assessing information; and planning for service delivery. It includes using communication skills, supervision, and consultation.

Practice content also includes identifying, analyzing, and implementing empirically based interventions designed to achieve client goals; applying empirical knowledge and technological advances; evaluating program outcomes and practice effectiveness; developing, analyzing, advocating, and providing leadership for policies and services; and promoting social and economic justice.
- 4.6 Research*

Qualitative and quantitative research content provides understanding of a scientific, analytic, and ethical approach to building knowledge for practice. The content prepares

students to develop, use, and effectively communicate empirically based knowledge, including evidence-based interventions. Research knowledge is used by students to provide high-quality services; to initiate change; to improve practice, policy, and social service delivery; and to evaluate their own practice.

- **4.7 Field Education**

Field education is an integral component of social work education anchored in the mission, goals, and educational level of the program. It occurs in settings that reinforce students' identification with the purposes, values, and ethics of the profession; fosters the integration of empirical and practice-based knowledge; and promotes the development of professional competence. Field education is systematically designed, supervised, coordinated, and evaluated on the basis of criteria by which students demonstrate the achievement of program objectives.

**5. Advanced Curriculum Content** (p. 11)

Using a conceptual framework to identify advanced knowledge and skills, programs build an advanced curriculum from the foundation content. In the advanced curriculum, the foundation content areas (Section 4, 4.0–4.7) are addressed in greater depth, breadth, and specificity and support the program's conception of advanced practice.

*Accreditation Standards*

**2. Curriculum** (p. 12)

2.0 The curriculum is developed and organized as a coherent and integrated whole consistent with program goals and objectives. Social work education is grounded in the liberal arts and contains a coherent, integrated professional foundation in social work practice from which an advanced practice curriculum is built at the graduate level.

2.0.1 The program:

- Describes its coverage of the required foundation and advanced curriculum content.
- Defines its conception of advanced practice
- Explains how the advanced curriculum is built from the professional foundation
- Has a concentration curriculum that includes:
  - (a) concentration objectives
  - (b) a conceptual framework built on relevant theories
  - (c) curriculum design and content
  - (d) field education that supports the advanced curriculum
- Demonstrates how the depth, breadth, and specificity of the advanced curriculum are addressed in relation to the professional foundation.

**Concentrations**

MSW programs prepare graduates for advanced professional practice in an area of concentration, consisting of advanced training in a specific practice method. Frameworks and perspectives for concentration include fields of practice, problem areas, intervention methods, and practice contexts and perspectives. MSW programs are required to identify one or more concentrations for their program, and where there is more than one concentration offered, students must select just one. For schools which only offer one concentration, it is typically for “advanced generalist practice,” defined a little differently for each school, but always includes training in both micro (individuals, families and groups) and macro (organizations and communities) practice. For those schools this overall focus is integrated throughout the program.

A list of the concentrations offered by each school is provided in Attachment C.

**Specializations**

A specialization is an emphasis or focus area within the curriculum and generally requires one or more courses and for some, a field placement. Specializations are optional, and students often specialize within their concentrations. A list of the specializations offered by each school is provided in Attachment C.

**Attachments**

- A. CSWE Accreditation Standards - 2001
- B. Foundation Year Coursework
- C. Concentrations and Specializations
- D. CSWE Accreditation Standards - 2008

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COUNCIL ON SOCIAL WORK EDUCATION

# **Educational Policy and Accreditation Standards**

## **Educational Policy and Accreditation Standards**

### **Preamble**

Social work practice promotes human well-being by strengthening opportunities, resources, and capacities of people in their environments and by creating policies and services to correct conditions that limit human rights and the quality of life. The social work profession works to eliminate poverty, discrimination, and oppression. Guided by a person-in-environment perspective and respect for human diversity, the profession works to effect social and economic justice worldwide. Social work education combines scientific inquiry with the teaching of professional skills to provide effective and ethical social work services. Social work educators reflect their identification with the profession through their teaching, scholarship, and service. Social work education, from baccalaureate to doctoral levels, employs educational, practice, scholarly, interprofessional, and service delivery models to orient and shape the profession's future in the context of expanding knowledge, changing technologies, and complex human and social concerns. The Council on Social Work Education (CSWE) Educational Policy and Accreditation Standards (EPAS) promotes academic excellence in baccalaureate and master's social work education. The EPAS specifies the curricular content and educational context to prepare students for professional social work practice. The EPAS sets forth basic requirements for these purposes. Beyond these basic requirements of EPAS, individual programs focus on areas relevant to their institutional and program mission, goals, and objectives.

The EPAS permits programs to use time-tested and new models of program design, implementation, and evaluation. It does so by balancing requirements that promote comparability across programs with a level of flexibility that encourages programs to respond to changing human, professional, and institutional needs. The EPAS focuses on assessing the results of a program's development and its continuous improvement. While accreditation is ultimately evaluative, in social work education it is based on a consultative and collaborative process that determines whether a program meets the requirements of the EPAS.

## **Functions of Educational Policy and Accreditation**

### **1. Educational Policy**

The Educational Policy promotes excellence, creativity, and innovation in social work education and practice. It sets forth required content areas that relate to each other and to the purposes, knowledge, and values of the profession. Programs of social work education are offered at the baccalaureate, master's, and doctoral levels. Baccalaureate and master's programs are accredited by CSWE. This document supersedes all prior statements of curriculum policy for baccalaureate and master's program levels.

### **2. Accreditation**

Accreditation ensures that the quality of professional programs merits public confidence. The Accreditation Standards establish basic requirements for baccalaureate and master's levels. Accreditation Standards pertain to the following program elements:

- Mission, goals, and objectives
- Curriculum
- Governance, structure, and resources
- Faculty
- Student professional development
- Nondiscrimination and human diversity
- Program renewal
- Program assessment and continuous improvement

### **3. Relationship of Educational Policy to Accreditation**

CSWE uses the EPAS for the accreditation of social work programs. The Educational Policy and the Accreditation Standards are conceptually integrated. Programs use Educational Policy, Section 1 as one important basis for developing program mission, goals, and objectives. Programs use Educational Policy, Section 3 to develop program objectives and Educational Policy, Sections 4 and 5 to develop content for demonstrating attainment of the objectives. The accreditation process reviews the program's self-study document, site team report, and program response to determine compliance with the Educational Policy and Accreditation Standards. Accredited programs meet all standards.

## **Educational Policy**

### **1. Purposes**

#### **1.0 Purposes of the Social Work Profession**

The social work profession receives its sanction from public and private auspices and is the primary profession in the development, provision, and evaluation of social services. Professional social workers are leaders in a variety of organizational settings and service delivery systems within a global context.

The profession of social work is based on the values of service, social and economic justice, dignity and worth of the person, importance of human relationships, and integrity and competence in practice. With these values as defining principles, the purposes of social work are:

- To enhance human well-being and alleviate poverty, oppression, and other forms of social injustice.
- To enhance the social functioning and interactions of individuals, families, groups, organizations, and communities by involving them in accomplishing goals, developing resources, and preventing and alleviating distress.
- To formulate and implement social policies, services, and programs that meet basic human needs and support the development of human capacities.
- To pursue policies, services, and resources through advocacy and social or political actions that promote social and economic justice.
- To develop and use research, knowledge, and skills that advance social work practice.
- To develop and apply practice in the context of diverse cultures.

#### **1.1 Purposes of Social Work Education**

The purposes of social work education are to prepare competent and effective professionals, to develop social work knowledge, and to provide leadership in the development of service delivery systems. Social work education is grounded in the profession's history, purposes, and philosophy and is based on a body of knowledge, values, and skills. Social work education enables students to integrate the knowledge, values, and skills of the social work profession for competent practice.

## **1.2 Achievement of Purposes**

Among its programs, which vary in design, structure, and objectives, social work education achieves these purposes through such means as:

- Providing curricula and teaching practices at the forefront of the new and changing knowledge base of social work and related disciplines.
- Providing curricula that build on a liberal arts perspective to promote breadth of knowledge, critical thinking, and communication skills.
- Developing knowledge.
- Developing and applying instructional and practice-relevant technology.
- Maintaining reciprocal relationships with social work practitioners, groups, organizations, and communities.
- Promoting continual professional development of students, faculty, and practitioners.
- Promoting interprofessional and interdisciplinary collaboration.
- Preparing social workers to engage in prevention activities that promote well-being.
- Preparing social workers to practice with individuals, families, groups, organizations, and communities.
- Preparing social workers to evaluate the processes and effectiveness of practice.
- Preparing social workers to practice without discrimination, with respect, and with knowledge and skills related to clients' age, class, color, culture, disability, ethnicity, family structure, gender, marital status, national origin, race, religion, sex, and sexual orientation.
- Preparing social workers to alleviate poverty, oppression, and other forms of social injustice.
- Preparing social workers to recognize the global context of social work practice.
- Preparing social workers to formulate and influence social policies and social work services in diverse political contexts.

## **2. Structure of Social Work Education**

### **2.0 Structure**

Baccalaureate and graduate social work education programs operate under the auspices of accredited colleges and universities. These educational institutions vary by auspices, emphasis, and size. With diverse strengths, missions, and resources, social work education programs share a common commitment to educate competent, ethical social workers.

The baccalaureate and master's levels of social work education are anchored in the purposes of the social work profession and promote the knowledge, values, and skills of the profession. Baccalaureate social work education programs prepare graduates for generalist professional practice. Master's social work education programs prepare graduates for advanced professional practice in an area of concentration. The baccalaureate and master's levels of educational preparation are differentiated according to (a) conceptualization and design, (b) content, (c) program objectives, and (d) depth, breadth, and specificity of knowledge and skills. Frameworks and perspectives for concentration include fields of practice, problem areas, intervention methods, and practice contexts and perspectives.

Programs develop their mission and goals within the purposes of the profession, the purposes of social work education, and their institutional context. Programs also recognize academic content and professional experiences that students bring to the educational program. A conceptual framework, built upon relevant theories and knowledge, shapes the breadth and depth of knowledge and practice skills to be acquired.

### **2.1 Program Renewal**

Social work education remains vital, relevant, and progressive by pursuing exchanges with the practice community and program stakeholders and by developing and assessing new knowledge and technology.

### **3. Program Objectives**

Social work education is grounded in the liberal arts and contains a coherent, integrated professional foundation in social work. The graduate advanced curriculum is built from the professional foundation. Graduates of baccalaureate and master's social work programs demonstrate the capacity to meet the foundation objectives and objectives unique to the program. Graduates of master's social work programs also demonstrate the capacity to meet advanced program objectives.

#### **3.0 Foundation Program Objectives**

The professional foundation, which is essential to the practice of any social worker, includes, but is not limited to, the following program objectives.

Graduates demonstrate the ability to:

1. Apply critical thinking skills within the context of professional social work practice.
2. Understand the value base of the profession and its ethical standards and principles, and practice accordingly.
3. Practice without discrimination and with respect, knowledge, and skills related to clients' age, class, color, culture, disability, ethnicity, family structure, gender, marital status, national origin, race, religion, sex, and sexual orientation.
4. Understand the forms and mechanisms of oppression and discrimination and apply strategies of advocacy and social change that advance social and economic justice.
5. Understand and interpret the history of the social work profession and its contemporary structures and issues.
- B6. Apply the knowledge and skills of generalist social work practice with systems of all sizes.<sup>1</sup>
- M6. Apply the knowledge and skills of a generalist social work perspective to practice with systems of all sizes.
7. Use theoretical frameworks supported by empirical evidence to understand individual development and behavior across the life span and the interactions among individuals and between individuals and families, groups, organizations, and communities.
8. Analyze, formulate, and influence social policies.

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<sup>1</sup> Items preceded by a B or M apply only to baccalaureate or master's programs, respectively.

9. Evaluate research studies, apply research findings to practice, and evaluate their own practice interventions.
10. Use communication skills differentially across client populations, colleagues, and communities.
11. Use supervision and consultation appropriate to social work practice.
12. Function within the structure of organizations and service delivery systems and seek necessary organizational change.

### **3.1 Concentration Objectives**

Graduates of a master's social work program are advanced practitioners who apply the knowledge and skills of advanced social work practice in an area of concentration. They analyze, intervene, and evaluate in ways that are highly differentiated, discriminating, and self-critical. Graduates synthesize and apply a broad range of knowledge and skills with a high degree of autonomy and proficiency. They refine and advance the quality of their practice and that of the larger social work profession.

### **3.2 Additional Program Objectives**

A program may develop additional objectives to cover the required content in relation to its particular mission, goals, and educational level.

## **4. Foundation Curriculum Content**

All social work programs provide foundation content in the areas specified below. Content areas may be combined and delivered with a variety of instructional technologies. Content is relevant to the mission, goals, and objectives of the program and to the purposes, values, and ethics of the social work profession.

### **4.0 Values and Ethics**

Social work education programs integrate content about values and principles of ethical decision making as presented in the National Association of Social Workers Code of Ethics. The educational experience provides students with the opportunity to be aware of personal values; develop, demonstrate, and promote the values of the profession; and analyze ethical dilemmas and the ways in which these affect practice, services, and clients.

#### **4.1 Diversity**

Social work programs integrate content that promotes understanding, affirmation, and respect for people from diverse backgrounds. The content emphasizes the interlocking and complex nature of culture and personal identity. It ensures that social services meet the needs of groups served and are culturally relevant. Programs educate students to recognize diversity within and between groups that may influence assessment, planning, intervention, and research. Students learn how to define, design, and implement strategies for effective practice with persons from diverse backgrounds.

#### **4.2 Populations-at-Risk and Social and Economic Justice**

Social work education programs integrate content on populations-at-risk, examining the factors that contribute to and constitute being at risk. Programs educate students to identify how group membership influences access to resources, and present content on the dynamics of such risk factors and responsive and productive strategies to redress them.

Programs integrate social and economic justice content grounded in an understanding of distributive justice, human and civil rights, and the global interconnections of oppression. Programs provide content related to implementing strategies to combat discrimination, oppression, and economic deprivation and to promote social and economic justice. Programs prepare students to advocate for nondiscriminatory social and economic systems.

#### **4.3 Human Behavior and the Social Environment**

Social work education programs provide content on the reciprocal relationships between human behavior and social environments. Content includes empirically based theories and knowledge that focus on the interactions between and among individuals, groups, societies, and economic systems. It includes theories and knowledge of biological, sociological, cultural, psychological, and spiritual development across the life span; the range of social systems in which people live (individual, family, group, organizational, and community); and the ways social systems promote or deter people in maintaining or achieving health and well-being.

#### **4.4 Social Welfare Policy and Services**

Programs provide content about the history of social work, the history and current structures of social welfare services, and the role of policy in service delivery, social work practice, and attainment of individual and social well-being. Course

content provides students with knowledge and skills to understand major policies that form the foundation of social welfare; analyze organizational, local, state, national, and international issues in social welfare policy and social service delivery; analyze and apply the results of policy research relevant to social service delivery; understand and demonstrate policy practice skills in regard to economic, political, and organizational systems, and use them to influence, formulate, and advocate for policy consistent with social work values; and identify financial, organizational, administrative, and planning processes required to deliver social services.

#### **4.5 Social Work Practice**

Social work practice content is anchored in the purposes of the social work profession and focuses on strengths, capacities, and resources of client systems in relation to their broader environments. Students learn practice content that encompasses knowledge and skills to work with individuals, families, groups, organizations, and communities. This content includes engaging clients in an appropriate working relationship, identifying issues, problems, needs, resources, and assets; collecting and assessing information; and planning for service delivery. It includes using communication skills, supervision, and consultation. Practice content also includes identifying, analyzing, and implementing empirically based interventions designed to achieve client goals; applying empirical knowledge and technological advances; evaluating program outcomes and practice effectiveness; developing, analyzing, advocating, and providing leadership for policies and services; and promoting social and economic justice.

#### **4.6 Research**

Qualitative and quantitative research content provides understanding of a scientific, analytic, and ethical approach to building knowledge for practice. The content prepares students to develop, use, and effectively communicate empirically based knowledge, including evidence-based interventions. Research knowledge is used by students to provide high-quality services; to initiate change; to improve practice, policy, and social service delivery; and to evaluate their own practice.

#### **4.7 Field Education**

Field education is an integral component of social work education anchored in the mission, goals, and educational level of the program. It occurs in settings that reinforce students' identification with the purposes, values, and ethics of the profession; fosters the integration of empirical and practice-based knowledge;

and promotes the development of professional competence. Field education is systematically designed, supervised, coordinated, and evaluated on the basis of criteria by which students demonstrate the achievement of program objectives.

## **5. Advanced Curriculum Content**

The master's curriculum prepares graduates for advanced social work practice in an area of concentration. Using a conceptual framework to identify advanced knowledge and skills, programs build an advanced curriculum from the foundation content. In the advanced curriculum, the foundation content areas (Section 4, 4.0–4.7) are addressed in greater depth, breadth, and specificity and support the program's conception of advanced practice.

## Accreditation Standards

### **1. Program Mission, Goals, and Objectives**

- 1.0 The social work program has a mission appropriate to professional social work education as defined in Educational Policy, Section 1.1. The program's mission is appropriate to the level or levels for which it is preparing students for practice and is consistent with the institution's mission.
- 1.1 The program has goals derived from its mission. These goals reflect the purposes of the Educational Policy, Section 1.1. Program goals are not limited to these purposes.
- 1.2 The program has objectives that are derived from the program goals. These objectives are consistent with Educational Policy, Section 3. Program objectives are reflected in program implementation and continuous assessment (see Accreditation Standard 8).
- 1.3 The program makes its constituencies aware of its mission, goals, and objectives and outcomes.

### **2. Curriculum**

- 2.0 The curriculum is developed and organized as a coherent and integrated whole consistent with program goals and objectives. Social work education is grounded in the liberal arts and contains a coherent, integrated professional foundation in social work practice from which an advanced practice curriculum is built at the graduate level.
  - B2.0.1 The program defines its conception of generalist social work practice, describes its coverage of the professional foundation curriculum identified in Educational Policy, Section 4, and demonstrates how its conception of generalist practice is implemented in all components of the professional curriculum.
  - M2.0.1 The program describes its coverage of the foundation and advanced curriculum content, identified in Educational Policy, Sections 4 and 5. The program defines its conception of advanced practice and explains how the advanced curriculum is built from the professional foundation. The master's program has a concentration curriculum that includes (a) concentration objectives, (b) a conceptual framework built on relevant theories, (c) curriculum design and content, and (d) field education that supports the advanced curriculum. The program demonstrates how the depth,

breadth, and specificity of the advanced curriculum are addressed in relation to the professional foundation.

- 2.1 The social work program administers field education (Educational Policy, Section 4.7 and Section 5) consistent with program goals and objectives that:
- 2.1.1 Provides for a minimum of 400 hours of field education for baccalaureate programs and 900 hours for master's programs.
  - 2.1.2 Admits only those students who have met the program's specified criteria for field education.
  - 2.1.3 Specifies policies, criteria, and procedures for selecting agencies and field instructors; placing and monitoring students; maintaining field liaison contacts with agencies; and evaluating student learning and agency effectiveness in providing field instruction.
  - 2.1.4 Specifies that field instructors for baccalaureate students hold a CSWE-accredited baccalaureate or master's social work degree.<sup>2</sup> Field instructors for master's students hold a CSWE-accredited master's social work degree. In programs where a field instructor does not hold a CSWE-accredited baccalaureate or master's social work degree, the program assumes responsibility for reinforcing a social work perspective.
  - 2.1.5 Provides orientation, field instruction training, and continuing dialog with agencies and field instructors.
  - 2.1.6 Develops policies regarding field placements in an agency in which the student is also employed. Student assignments and field education supervision differ from those associated with the student's employment.

### **3. Program Governance, Administrative Structure, and Resources**

- 3.0 The social work program has the necessary autonomy and administrative structure to achieve its goals and objectives.
- 3.0.1 The social work faculty defines program curriculum consistent with the Educational Policy and Accreditation Standards and the institution's policies.
  - 3.0.2 The administration and faculty of the social work program participate in formulating and implementing policies related to the

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<sup>2</sup> This and all future references to "CSWE-accredited baccalaureate or master's social work degree" include degrees from CSWE-accredited programs or programs approved by its Foreign Equivalency Determination Service.

- recruitment, hiring, retention, promotion, and tenure of program personnel.
- 3.0.3 The chief administrator has demonstrated leadership ability through teaching, scholarship, curriculum development, administrative experience, and other academic and professional activities in the field of social work.
    - B3.0.3 At the baccalaureate level, the social work program director who is the chief administrator, or his or her designee, has a master's of social work degree from a CSWE-accredited program with a doctoral degree preferred or a baccalaureate degree in social work from a CSWE-accredited program and a doctoral degree.
    - M3.0.3 At the master's level, the social work program director who is the chief administrator, or his or her designee, has a master's of social work degree from a CSWE-accredited program. In addition, it is preferred that the MSW program director have a doctoral degree.
  - 3.0.4 Social work program directors have a full-time appointment to the social work program and sufficient assigned time (at least 50% at the master's level and at least 25% at the baccalaureate level) to provide educational and administrative leadership. Combined programs designate a full-time social work faculty member to administer the baccalaureate social work program.
  - 3.0.5 The field education director has a master's degree in social work from a CSWE-accredited program and at least two years post-baccalaureate or post-master's social work degree practice experience.
  - 3.0.6 The field education director has a full-time appointment to the program and sufficient assigned time (at least 25% for baccalaureate programs and 50% for master's programs) to provide educational and administrative leadership for field education.
  - 3.1 The social work program has sufficient resources to achieve program goals and objectives.
    - 3.1.1 The program has sufficient support staff, other personnel, and technological resources to support program functioning.
    - 3.1.2 The program has sufficient and stable financial supports that permit program planning and achievement of program goals and objectives. These include a budgetary allocation and procedures for budget development and administration.
    - 3.1.3 The program has comprehensive library holdings and electronic access, as well as other informational and educational resources necessary for achieving the program's goals and objectives.

- 3.1.4 The program has sufficient office and classroom space, computer-mediated access, or both to achieve the program's goals and objectives.
- 3.1.5 The program has access to assistive technology, including materials in alternative formats (such as Braille, large print, books on tape, assistive learning systems).

#### **4. Faculty**

- 4.0 The program has full-time faculty, which may be augmented by part-time faculty, with the qualifications, competence, and range of expertise in social work education and practice to achieve its goals and objectives. The program has a sufficient full-time equivalent faculty-to-student ratio (usually 1:25 for baccalaureate programs and 1:12 for master's programs) to carry out ongoing functions of the program.
- 4.1 The program demonstrates how the use of part-time faculty assists in the achievement of the program's goals and objectives.
- 4.2 Faculty size is commensurate with the number and type of curricular offerings in class and field; class size; number of students; and the faculty's teaching, scholarly, and service responsibilities.
  - B4.2.1 The baccalaureate social work program has a minimum of two full-time faculty with master's social work degrees from a CSWE-accredited program, with full-time appointment in social work, and whose principal assignment is to the baccalaureate program. It is preferred that faculty have a doctoral degree.
  - M4.2.1 The master's social work program has a minimum of six full-time faculty with master's social work degrees from a CSWE-accredited program and whose principal assignment is to the master's program. The majority of the full-time master's social work program faculty have a master's degree in social work and a doctoral degree.
- 4.3 Faculty who teach required practice courses have a master's social work degree from a CSWE-accredited program and at least two years post-baccalaureate or post-master's social work degree practice experience.
- 4.4 The program has a faculty workload policy that supports the achievement of institutional priorities and the program's goals and objectives.

## **5. Student Professional Development**

- 5.0 The program has admissions criteria and procedures that reflect the program's goals and objectives.
  - M5.1 Only candidates who have earned a bachelor's degree are admitted to the master's social work degree program.
- 5.2 The program has a written policy indicating that it does not grant social work course credit for life experience or previous work experience.
- 5.3 In those foundation curriculum areas where students demonstrate required knowledge and skills, the program describes how it ensures that students do not repeat that content.
  - 5.3.1 The program has written policies and procedures concerning the transfer of credits.
    - M5.3.2 Advanced standing status is only awarded to graduates of baccalaureate social work programs accredited by CSWE.
- 5.4 The program has academic and professional advising policies and procedures that are consistent with the program's goals and objectives. Professional advising is provided by social work program faculty, staff, or both.
- 5.5 The program has policies and procedures specifying students' rights and responsibilities to participate in formulating and modifying policies affecting academic and student affairs. It provides opportunities and encourages students to organize in their interests.
- 5.6 The program informs students of its criteria for evaluating their academic and professional performance.
- 5.7 The program has policies and procedures for terminating a student's enrollment in the social work program for reasons of academic and professional performance.

## **6. Nondiscrimination and Human Diversity**

- 6.0 The program makes specific and continuous efforts to provide a learning context in which respect for all persons and understanding of diversity (including age, class, color, disability, ethnicity, family structure, gender, marital status, national origin, race, religion, sex, and sexual orientation) are practiced. Social work education builds upon professional purposes and values; therefore, the program provides a learning context that is nondiscriminatory and reflects the profession's fundamental tenets. The program describes how its learning context and educational program (including faculty, staff, and student composition; selection of agencies and their clientele as field education settings; composition of program advisory or

field committees; resource allocation; program leadership; speakers series, seminars, and special programs; research and other initiatives) and its curriculum model understanding of and respect for diversity.

## **7. Program Renewal**

- 7.0 The program has ongoing exchanges with external constituencies that may include social work practitioners, social service recipients, advocacy groups, social service agencies, professional associations, regulatory agencies, the academic community, and the community at large.
- 7.1 The program's faculty engage in the development and dissemination of research, scholarship, or other creative activities relevant to the profession.
- 7.2 The program seeks opportunities for innovation and provides leadership within the profession and the academic community.

## **8. Program Assessment and Continuous Improvement**

- 8.0 The program has an assessment plan and procedures for evaluating the outcome of each program objective. The plan specifies the measurement procedures and methods used to evaluate the outcome of each program objective.
- 8.1 The program implements its plan to evaluate the outcome of each program objective and shows evidence that the analysis is used continuously to affirm and improve the educational program.

## **Program Changes**

The EPAS supports change necessary to improve the educational quality of a program in relation to its goals and objectives. The EPAS recognizes that such change is ongoing. When a program is granted initial accreditation or its accreditation is reaffirmed, the program is, by that action, accredited only at the level or levels and for the components that existed and were reviewed at the time of that action. Prior to the next scheduled accreditation review, changes may take place within the program. Although it is not necessary to report minor changes, programs notify the Commission on Accreditation (COA) of changes such as new leadership, governance, structure, and off-campus programs. Depending on the nature of the change, the COA may request additional information. Prior to the implementation of a substantive change the program submits a proposal and receives approval. Substantive changes are defined as those that require a waiver of one or more aspects of EPAS.

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## Foundation Year Coursework in California MSW Programs

	<b>Azusa Pacific</b>	<b>CSU Bakersfield</b>	<b>CSU Chico</b>	<b>CSU Dominguez Hills</b>
<b>Foundation Year Courses</b>	<ul style="list-style-type: none"> <li>▪ SOCW 511 Introduction to the Social Work Profession (2)</li> <li>▪ SOCW 512 Social Welfare Policy and Policy Practice (3)</li> <li>▪ SOCW 513 Micro-Theory and Human Development (3)</li> <li>▪ SOCW 514 Practice I: Interviewing and Assessment (3)</li> <li>▪ SOCW 515 Field Seminar I (1)</li> <li>▪ SOCW 516 Field I (3)</li> <li>▪ SOCW 521 Introductory Research Methods (2)</li> <li>▪ SOCW 522 Diversity and Social Justice (3)</li> <li>▪ SOCW 523 Macro-Theory and Practice with Communities/Organizations (3)</li> <li>▪ SOCW 524 Practice II: Intervention and Evaluation (3)</li> <li>▪ SOCW 525 Field Seminar II (1)</li> <li>▪ SOCW 526 Field II (3)</li> </ul>	<ul style="list-style-type: none"> <li>▪ SW 510: Social policy and services (5)</li> <li>▪ SW 520: Foundations of Human Behavior (5)</li> <li>▪ SW 530: Research methods for Social Work (5)</li> <li>▪ SW 540: Generalist Social Work Practice I (5)</li> <li>▪ SW 541: Generalist Social Work Practice II (5)</li> <li>▪ SW 593: Assessment and Diagnosis in Social Work (5)</li> <li>▪ SW 550: Field Practicum I (3) (Taken 3 times - or equivalent)</li> <li>▪ Elective</li> </ul>	<ul style="list-style-type: none"> <li>▪ SWRK 601 Human Behavior &amp; Social Environment I (3)</li> <li>▪ SWRK 605 Social Welfare Policy &amp; Services (3)</li> <li>▪ SWRK 608 Gen SWRK Theory &amp; Practice I (3)</li> <li>▪ SWRK 609 Gen SWRK Theory &amp; Practice II (3)</li> <li>▪ SWRK 610 Gen SWRK Theory &amp; Practice III (3)</li> <li>▪ SWRK 612 SWRK Practice in Multicultural Contexts (3)</li> <li>▪ SWRK 617 Res Methods - Knowledge &amp; Practice (4)</li> <li>▪ SWRK 631 Foundation Practicum I (3)</li> <li>▪ SWRK 632 Foundation Practicum II (3)</li> <li>▪ SWRK 644 Human Behavior &amp; Social Environment II (3)</li> </ul>	<ul style="list-style-type: none"> <li>▪ MSW 500 Human Behavior and the Social Environment I (3)</li> <li>▪ MSW 501 Human Behavior and the Social Environment II (3)</li> <li>▪ MSW 510 Social Welfare Policy I (3)</li> <li>▪ MSW 511 Social Welfare Policy II (3)</li> <li>▪ MSW 520 Generalist Social Work Practice I (3)</li> <li>▪ MSW 521 Generalist Social Work Practice II (3)</li> <li>▪ MSW 523 Social Justice in Social Work Practice (3)</li> <li>▪ MSW 530 Social Welfare Research (3)</li> <li>▪ MSW 540 Fieldwork Practicum I (3)</li> <li>▪ MSW 541 Fieldwork Practicum II (3)</li> </ul>
<b>Unit System</b>	Semester Units	Quarter Units	Semester Units	Semester Units

	<b>CSU East Bay</b>	<b>CSU Fresno</b>	<b>CSU Long Beach</b>	<b>CSU Los Angeles</b>	<b>CSU Northridge</b>
<b>Foundation Year Courses</b>	<ul style="list-style-type: none"> <li>▪ SW 6000 Human Behavior and Social Environment I (4)</li> <li>▪ SW 6001 Human Behavior and Social Environment II (4)</li> <li>▪ SW 6010 Race, Gender, and Inequality in Social Work Practice (4)</li> <li>▪ SW 6011 Generalist Practice I (4)</li> <li>▪ SW 6012 Generalist Practice II (4)</li> <li>▪ SW 6013 Generalist Practice III (4)</li> <li>▪ SW 6020 Field Instruction I (4)</li> <li>▪ SW 6021 Field Instruction II (4)</li> <li>▪ SW 6022 Field Instruction III (4)</li> <li>▪ SW 6030 Social Welfare Policy: History and Philosophy (4)</li> <li>▪ SW 6032 Social Welfare Policy: Research (4)</li> </ul>	<ul style="list-style-type: none"> <li>▪ S Wrk 200 Social Welfare Policy I (3)</li> <li>▪ S Wrk 203 Social Welfare Policy II (3)</li> <li>▪ S Wrk 212 Human Behavior and Social Environment (3)</li> <li>▪ S Wrk 213 Human Behavior and Social Environment: Cultural Diversity and Oppression (3)</li> <li>▪ S Wrk 220 Social Work Practice I (4)</li> <li>▪ S Wrk 221 Social Work Practice II (4)</li> <li>▪ S Wrk 260 Quantitative Research (3)</li> <li>▪ S Wrk 261 Qualitative Research (3)</li> <li>▪ S Wrk 280 Foundation Field Instructed Practice I (2)</li> <li>▪ S Wrk 281 Foundation Field Instructed Practice II (2)</li> </ul>	<ul style="list-style-type: none"> <li>▪ SW 500 Foundations for Generalist and Multicultural Social Work Practice (3)</li> <li>▪ SW 503A Human Behavior and Environment in Multicultural Perspectives: Focus on Prenatal through Adolescence (3)</li> <li>▪ SW 503B Human Behavior and Environment in Multicultural Perspectives: Focus on Young Adulthood Through Old Age (3)</li> <li>▪ SW 505 Oppressed Groups: Social Policy Analysis (3)</li> <li>▪ SW 561 Direct Intervention with Individuals and Families: Focus on Older Adults (3)</li> <li>▪ SW 592 Community Projects I (3)</li> <li>▪ SW 594A Research Methods in Social Work I (3)</li> <li>▪ SW 594B Research Methods in Social Work II (3)</li> <li>▪ SW 596A Field Instruction I (3)</li> <li>▪ SW 596B Field Instruction II (3)</li> </ul>	<ul style="list-style-type: none"> <li>▪ SW 510 A Human Behavior and the Social Environment I (4)</li> <li>▪ SW 510 B Human Behavior and the Social Environment II (4)</li> <li>▪ SW 510 C Human Behavior and the Social Environment III (4)</li> <li>▪ SW 520 A Parameters of Practice 4</li> <li>▪ SW 520 B Micro Practice (4)</li> <li>▪ SW 530 A Social Welfare History and Introduction to Macro Practice (4)</li> <li>▪ SW 530 B Social Welfare Policy Analysis (4)</li> <li>▪ SW 530 C Community Organizing (4)</li> <li>▪ SW 540 Social Welfare Research and Statistics (4)</li> <li>▪ SW 549 A Field Practicum (3)</li> <li>▪ SW 549 B Field Practicum (3)</li> <li>▪ SW 549 C Field Practicum (3)</li> </ul>	<ul style="list-style-type: none"> <li>▪ SWRK 501 Human Behavior and Social Environment I (3)</li> <li>▪ SWRK 502 Human Behavior and Social Environment II (3)</li> <li>▪ SWRK 510 Generalist Social Work Theory and Practice I (3)</li> <li>▪ SWRK 520 Social Work Practice in Multicultural Contexts (3)</li> <li>▪ SWRK 521 Generalist Social Work Theory and Practice II (3)</li> <li>▪ SWRK 522 Foundations of Field Education I (3)</li> <li>▪ SWRK 523 Foundations of Field Education II (3)</li> <li>▪ SWRK 525 Social Welfare Policy and Services (3)</li> <li>▪ SWRK 535 Research Methods for Social Knowledge and Practice (3)</li> <li>▪ SWRK 603 DSM-IV-TR (3)</li> </ul>
<b>Unit System</b>	Quarter Units	Semester Units	Semester Units	Quarter Units	Semester Units

## Foundation Year Coursework in California MSW Programs

	<b>CSU Sacramento</b>	<b>CSU San Bernardino</b>	<b>CSU Stanislaus</b>	<b>Humboldt State</b>
<b>Foundation Year Courses</b>	<ul style="list-style-type: none"> <li>▪ SWRK 202 Social Work with Diverse Populations (3)</li> <li>▪ SWRK 204A Social Work Practice I (3)</li> <li>▪ SWRK 204B Social Work Practice II (3)</li> <li>▪ SWRK 210 Methods of Social Research (Undergraduate Social Statistics) (3)</li> <li>▪ SWRK 235A Theoretical Bases of Social Behavior (3)</li> <li>▪ SWRK 235B Theoretical Bases of Social Behavior (3)</li> <li>▪ SWRK 250 Social Welfare Policy &amp; Services (3)</li> <li>▪ SWRK 295A First Year Field Instruction (3)</li> <li>▪ SWRK 295B First Year Field Instruction (4)</li> </ul>	<ul style="list-style-type: none"> <li>▪ SW 602A: Foundation Micro Practice I (4)</li> <li>▪ SW 602B: Foundation Micro Practice II (4)</li> <li>▪ SW 602C: Foundation Micro Practice III (2)</li> <li>▪ SW 604A: Human Behavior in the Social Environment: Birth through Adolescence (4)</li> <li>▪ SW 604B: Human Behavior in the Social Environment: Adulthood and Aging (4)</li> <li>▪ SW 606A: Foundation Macro Practice I (4)</li> <li>▪ SW 606B: Foundation Macro Practice II (4)</li> <li>▪ SW 606C: Foundation Macro Practice III (2)</li> <li>▪ SW 608A: Foundation Field Work I (4)</li> <li>▪ SW 608B: Foundation Field Work II (4)</li> <li>▪ SW 608C: Foundation Field Work III (4)</li> <li>▪ SW 612: Social Work Research I (4)</li> <li>▪ SW 613: Social Work Research II (4)</li> <li>▪ Elective (4)</li> </ul>	<ul style="list-style-type: none"> <li>▪ SW 5005 Human Behavior and the Social Environment I (3)</li> <li>▪ SW 5010 Human Behavior and the Social Environment II (3)</li> <li>▪ SW 5020 Social Work Research Methods (3)</li> <li>▪ SW 5030 Foundation I: Generalist SW Practice Using a Strengths Perspective (3)</li> <li>▪ SW 5031 Foundation II: Generalist SW Practice Using a Strengths Perspective (3)</li> <li>▪ SW 5040 Field Instruction (Practicum) I (3)</li> <li>▪ SW 5040 Field Instruction (Practicum) I (3)</li> <li>▪ SW 5050 Social Work Research, Data Analysis (3)</li> <li>▪ Elective (3)</li> </ul>	<ul style="list-style-type: none"> <li>▪ SW 500 Values and Ethics: An Orientation to the Philosophy of Social Work (3)</li> <li>▪ SW 530 Social Welfare Policy and Services (3)</li> <li>▪ SW 540 Generalist Social Work Practice (3)</li> <li>▪ SW 541 Social Work Practice in Native American Communities (3)</li> <li>▪ SW 550 Human Dev., Diversity &amp; Relationships: Change through the Life Course (3)</li> <li>▪ SW 555 Foundation Internship &amp; Seminar (3) (Taken twice)</li> <li>▪ SW 570 Dynamics of Groups, Agencies, Organizations and Communities (3)</li> <li>▪ SW 582 Methods of Social Work Research (3)</li> </ul>
<b>Unit System</b>	Semester Units	Quarter Units	Semester Units	Semester Units

	<b>Loma Linda</b>	<b>SDSU</b>	<b>SFSU</b>	<b>San Jose State</b>
<b>Foundation Year Courses</b>	<ul style="list-style-type: none"> <li>▪ RELE 522 Bioethics for Social Work (4)</li> <li>▪ SOWK 511 Human Behavior in a Cross-cultural Environment I (3)</li> <li>▪ SOWK 512 Human Behavior in a Cross-cultural Environment II (3)</li> <li>▪ SOWK 515 Social Policy I (3)</li> <li>▪ SOWK 615 Social Policy II (3)</li> <li>▪ SOWK 547 Research Methods I (3)</li> <li>▪ SOWK 549 Research Methods II (3)</li> <li>▪ SOWK 517 Foundation Practice I: Individuals (3)</li> <li>▪ SOWK 518 Foundation Practice II: Groups (3)</li> <li>▪ SOWK 519 Foundation Practice III: Organizations and Communities (3)</li> <li>▪ SOWK 520 Foundation Practice IV: Families (3)</li> <li>▪ SOWK 671 Foundation Practice V: Social Work Administration (3)</li> <li>▪ SOWK 578 Field Orientation (1)</li> <li>▪ STCJ 515 Graduate Research Writing (2)</li> </ul>	<ul style="list-style-type: none"> <li>▪ SW 601 Seminar in Social Welfare Policy &amp; Services (3)</li> <li>▪ SW 610 Computer Application in Soc Work Practice (3)</li> <li>▪ SW 619 Human Behavior in the Social Environment (3)</li> <li>▪ SW 620A Seminar in Human Behavior and Social Environment (3)</li> <li>▪ SW 630 Social Work Practice: A Generalist Perspective (3)</li> <li>▪ SW 631 Social Work Practice: Individuals, Families, and Groups (3)</li> <li>▪ SW 632 Social Work Practice: Organizations and Communities (3)</li> <li>▪ SW 650 Field Practicum (3/4) (Taken twice)</li> <li>▪ SW 690 Seminar in Social Work Research Methods (3)</li> </ul>	<ul style="list-style-type: none"> <li>▪ SW 700 History and Philosophy of Social Welfare (3)</li> <li>▪ SW 710 Human Behavior and the Social Environment (3)</li> <li>▪ SW 720 Research Methods in Social Work (3)</li> <li>▪ SW 730 Social Work Practice Methods (3)</li> <li>▪ SW 740 Field Education (2-5) (Taken twice)</li> <li>▪ SW 741 Graduate Field Education Seminar (2) (Taken twice)</li> <li>▪ SW 770 Ethnic &amp; Cultural Concepts and Principles I (3)</li> <li>▪ SW 771 Ethnic &amp; Cultural Concepts and Principles II (3)</li> </ul> <p><i>Social Work Practice with Individuals, Families, and Groups Students:</i></p> <ul style="list-style-type: none"> <li>▪ SW 810 Health, Illness, and Disordered Behavior (3)</li> <li>▪ SW 830 Social Casework (3)</li> </ul> <p><i>Administration and Planning Students:</i></p> <ul style="list-style-type: none"> <li>▪ SW 811 Organizations, Institutions and Communities (3)</li> <li>▪ Elective</li> </ul> <p><i>Social Development Students:</i></p> <ul style="list-style-type: none"> <li>▪ SW 801 Change Strategies and Professional Values (3)</li> <li>▪ SW 811 Organizations, Institutions and Communities (3)</li> </ul>	<ul style="list-style-type: none"> <li>▪ ScWk 202 - Social Policy and Services: History and Values (3)</li> <li>▪ ScWk 204 - Social Policy Analysis (3)</li> <li>▪ ScWk 212 - Human Behavior in the Social Environment I (3)</li> <li>▪ ScWk 214 - Human Behavior in the Social Environment II (3)</li> <li>▪ ScWk 220 - Transcultural Generalist Practice I (3)</li> <li>▪ ScWk 221 - Transcultural Generalist Practice II (3)</li> <li>▪ ScWk 230 - Social Work Practicum I (4)</li> <li>▪ ScWk 231 - Social Work Practicum II (4)</li> <li>▪ ScWk 240 - Research Methods and Design (3)</li> <li>▪ ScWk 242 - Research Methods, Data Analysis, and Evaluation (3)</li> </ul>
<b>Unit System</b>	Quarter Units	Semester Units	Quarter Units	Semester Units

### Foundation Year Coursework in California MSW Programs

UC Berkeley		UCLA	USC	
<b>Foundation Year Courses</b>	<ul style="list-style-type: none"> <li>▪ SW 200, Human Behavior and the Social Environment (2)</li> <li>▪ SW 205, Psychosocial Problems and Psychopathology (2) (except MAP students)</li> <li>▪ SW 220, Introduction to Social Welfare Policy (2)</li> <li>▪ SW 240, Introduction to the Field of Social Welfare and the Profession of Social Work (2)</li> <li>▪ SW 241, Foundations of Social Work Practice (3)</li> <li>▪ SW 280 Introduction to Social Welfare Research (2)</li> <li>▪ SW 400, First Year MSW Field Seminar (1)</li> <li>▪ SW 401, Field Instruction (1-10)</li> </ul> <p><i>Community Mental Health Students:</i></p> <ul style="list-style-type: none"> <li>▪ SW 222 Mental Health and Social Policy (2)</li> <li>▪ SW 244 Direct Practice in Mental Health Settings (2)</li> </ul> <p><i>Health Services Students:</i></p> <ul style="list-style-type: none"> <li>▪ SW 245 Direct Practice in Health Settings (2)</li> <li>▪ SW 238C Health Policy--A Social Welfare Perspective (2)</li> </ul>	<p><i>Child and Family Services Students:</i></p> <ul style="list-style-type: none"> <li>▪ SW 243 Direct Practice in Child and Family Settings (2)</li> <li>▪ SW 230 Social Policy: Children and Families (2)</li> </ul> <p><i>Gerontology Services Students:</i></p> <ul style="list-style-type: none"> <li>▪ SW 246 Direct Practice in Aging Settings (2)</li> <li>▪ SW 226 Social Policy and Gerontology (2)</li> </ul> <p><i>Management and Planning (MAP) Students:</i></p> <ul style="list-style-type: none"> <li>▪ SW 210I Group, Organizational, and Community Dynamics (2)</li> <li>▪ SW 251 Community Practice (2)</li> </ul> <p>AND <b>one</b> of the following:</p> <ul style="list-style-type: none"> <li>▪ SW 222 Mental Health and Social Policy (2)</li> <li>▪ SW 226 Social Policy and Gerontology (2)</li> <li>▪ SW 230 Social Policy: Children and Families (2)</li> <li>▪ SW 238C Health Policy--A Social Welfare Perspective (2)</li> </ul>	<ul style="list-style-type: none"> <li>▪ SW 201A Human Development (3)</li> <li>▪ SW 201B Community Theory (3)</li> <li>▪ SW 202A Dynamics of Human Behavior (2) (<i>optional</i> for concentration in Social Work in Organizations, Communities, and Policy Settings)</li> <li>▪ SW 205 Cross-Cultural Awareness (4)</li> <li>▪ SW 221A Social Welfare Policy (4)</li> <li>▪ SW 230A Theory of Social Welfare with Individuals, Groups and Families (2)</li> <li>▪ SW 230B Theory of Social Welfare Practice with Individuals, Families, and Groups II (2)</li> <li>▪ SW 230C Theory of Social Welfare Practice with Individuals, Families, and Groups III (2)</li> <li>▪ SW 240A Theory of Social Welfare Practice in Organizations, Communities, &amp; Policy Settings I (3)</li> <li>▪ SW 240B Theory of Social Welfare Practice in Organizations, Communities, and Policy Settings II (3)</li> <li>▪ SW 280 Social Welfare Research (3)</li> <li>▪ SW 401A Practicum – Social Work (3)</li> <li>▪ SW 401B Practicum: Social Work (3)</li> <li>▪ SW 401C Practicum: Social Work (3)</li> </ul>	<ul style="list-style-type: none"> <li>▪ SW 503 Human Behavior and the Social Environment I (3)</li> <li>▪ SW 505 Human Behavior and the Social Environment II (3)</li> <li>▪ SW 534 Policy and Practice in Social Service Organizations (3)</li> <li>▪ SW 535 Social Policy (3)</li> <li>▪ SW 543 Social Work Practice with Individuals and Families (3)</li> <li>▪ SW 545 Social Work Practice with Groups and Complex Cases (3)</li> <li>▪ SW 562 Social Work Research (3)</li> <li>▪ SW 586a Field Practicum (3)</li> <li>▪ SW 586b Field Practicum (3)</li> <li>▪ SW 587a Integrative Learning for Social Work Practice (2)</li> <li>▪ SW 587b Integrative Learning for Social Work Practice (2)</li> </ul>
<b>Unit System</b>	Semester Units	Quarter Units	Semester Units	

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## Concentrations and Specializations Available in California MSW Programs 2008

School	Concentration(s)	# of Students Graduating in 2008	Specialization(s) or Sub-Concentration(s)	# of Students Graduating in 2008	Verified by:
<b>Azusa Pacific University*</b>	Clinical Practice with Individuals and Families	Program started in Fall 2008	None		Katy Tangenberg
	Community Practice and Partnerships	Program started in Fall 2008			
<b>CSU Bakersfield</b>	Advanced Generalist		Child Welfare		
<b>CSU Chico</b>	Advanced Generalist		Families, Children and Youth Services	16	Donna Jensen
			Mental Health Services	24	
<b>CSU Dominguez Hills*</b>	Community Practice		Children Youth and Families	11	Larry Ortiz
			Community Mental Health	2	
			Community Capacity Building	0	
<b>CSU East Bay</b>	Children Youth and Families	158	None		Dianne Woods
	Community Mental Health	82			
<b>CSU Fresno</b>	Multi Systems Practice		Child Welfare	21	Andrea Carlin
			School Social Work	21	
			Public Mental Health	7	
<b>CSU Long Beach</b>	Children Youth and Families		Public Child Welfare	30	Rebecca Lopez
	Older Adults and Families		School Social Work	34	
			Community Mental Health	20	
			Geriatric Social Work	4	
<b>CSU Los Angeles</b>	Advanced Urban Generalist		Aging and Families	36	Karin Elliott Brown
			Children, Youth, Women, and Families	70	
			Forensic Social Work	12	

\*School is in candidacy status for CSWE accreditation

\*\*# of students are an estimate

## Concentrations and Specializations Available in California MSW Programs 2008

School	Concentration(s)	# of Students Graduating in 2008	Specialization(s) or Sub-Concentration(s)	# of Students Graduating in 2008	Verified by:
<b>CSU Northridge</b>	Urban Family Strengths-Based Practice	33	None		James Decker
<b>CSU Sacramento</b>	Advanced Integrated Practice		None		Robin Carter
<b>CSU San Bernardino</b>	Advanced Generalist Practice		None		Teresa Morris
<b>CSU Stanislaus</b>	Advanced Integrative Practice		Mental Health		
			Child Welfare		
			Aging		
<b>Humboldt State University</b>	Advanced Generalist Practice (emphasis on rural and native Americans)		Child Welfare	8	Pamela Brown
			Mental Health	3	
			Tribal/Native Social Services	1	
<b>Loma Linda University</b>	Clinical Practice		Child Welfare		Terry Forrester
	Policy, Planning and Administration				
<b>San Diego State University</b>	Direct Practice	92	Mental Health	30	Loring Jones
			Children, Youth, and Families	50	
	Administration	16	Health & Aging	12	
			International Social Work	0	
<b>San Jose State University</b>	Transcultural Multisystems Practice		Aging	10	Peter Allen Lee
			Children, Youth, and Families	50	
			School Social Work	25	
			Health and Mental Health	45	

\*School is in candidacy status for CSWE accreditation

\*\*# of students are an estimate

## Concentrations and Specializations Available in California MSW Programs 2008

School	Concentration(s)	# of Students Graduating in 2008	Specialization(s) or Sub-Concentration(s)	# of Students Graduating in 2008	Verified by:
<b>San Francisco State University**</b>	Administration and Planning	15	None		Rita Takahashi
	Individuals, Families, and Groups	35			
	Social Action and Change	15			
<b>UC Berkeley</b>	Management and Planning	13	School Social Work	11	Amanda Reiman
	Child and Family Services	27	Child Welfare	18	
	Community Mental Health Services	28	Mental Health	10	
	Health Services	17			
	Gerontology Services	9			
<b>UCLA</b>	Social Work Practice with Individuals, Families and Groups	67	Children and Youth Services (includes Public Child Welfare and School Social Work)	35	Alfreda Iglehart & Steven Clark
			Social Work Practice in Organizations, Communities, and Policy Settings	21	
	Health Services	6			
	Mental Health	26			
	Non-Profit Sector	14			
<b>University of Southern California</b>	Community Organization, Planning and Administration	65	Older Adults	12	Micki Gress
			Public Child Welfare	40	
			School Social Work/PPSC	110	
	Families and Children	100	Mental Health Options	20	
	Health	27	Systems of Care	14	
	Mental Health	75	Systems of Recovery	New	
	Work and Life	22	Military Social Work	New	

\*School is in candidacy status for CSWE accreditation

\*\*# of students are an estimate

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COUNCIL ON SOCIAL WORK EDUCATION

## **Educational Policy and Accreditation Standards**

### **Purpose: Social Work Practice, Education, and Educational Policy and Accreditation Standards**

The purpose of the social work profession is to promote human and community well-being. Guided by a person and environment construct, a global perspective, respect for human diversity, and knowledge based on scientific inquiry, social work's purpose is actualized through its quest for social and economic justice, the prevention of conditions that limit human rights, the elimination of poverty, and the enhancement of the quality of life for all persons.

Social work educators serve the profession through their teaching, scholarship, and service. Social work education—at the baccalaureate, master's, and doctoral levels—shapes the profession's future through the education of competent professionals, the generation of knowledge, and the exercise of leadership within the professional community.

The Council on Social Work Education (CSWE) uses the Educational Policy and Accreditation Standards (EPAS) to accredit baccalaureate- and master's-level social work programs. EPAS supports academic excellence by establishing thresholds for professional competence. It permits programs to use traditional and emerging models of curriculum design by balancing requirements that promote comparability across programs with a level of flexibility that encourages programs to differentiate.

EPAS describe four features of an integrated curriculum design: (1) program mission and goals; (2) explicit curriculum; (3) implicit curriculum; and (4) assessment. The Educational Policy and Accreditation Standards are conceptually linked. Educational Policy describes each curriculum feature. Accreditation Standards (*in italics*) are derived from the Educational Policy and specify the requirements used to develop and maintain an accredited social work program at the baccalaureate (B) or master's (M) level.

# 1. Program Mission and Goals

## **Educational Policy 1.0—Program Mission and Goals**

The mission and goals of each social work program address the profession's purpose, are grounded in core professional values (EP 1.1), and are informed by context (EP 1.2).

## **Educational Policy 1.1—Values**

Service, social justice, the dignity and worth of the person, the importance of human relationships, integrity, competence,<sup>1</sup> human rights, and scientific inquiry are among the core values of social work. These values underpin the explicit and implicit curriculum and frame the profession's commitment to respect for all people and the quest for social and economic justice.

## **Educational Policy 1.2—Program Context**

Context encompasses the mission of the institution in which the program is located and the needs and opportunities associated with the setting. Programs are further influenced by their historical, political, economic, social, cultural, demographic, and global contexts and by the ways they elect to engage these factors. Additional factors include new knowledge, technology, and ideas that may have a bearing on contemporary and future social work education and practice.

### ***Accreditation Standard 1.0—Mission and Goals***

*The social work program's mission and goals reflect the profession's purpose and values and the program's context.*

**1.0.1** *The program submits its mission statement and describes how it is consistent with the profession's purpose and values and the program's context.*

**1.0.2** *The program identifies its goals and demonstrates how they are derived from the program's mission.*

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<sup>1</sup> These six value elements reflect the National Association of Social Workers *Code of Ethics*.

National Association of Social Workers (approved 1996, revised 1999). *Code of Ethics for Social Workers*. Washington, D.C.: NASW.

## **2. Explicit Curriculum**

### **Educational Policy 2.0—The Social Work Curriculum and Professional Practice**

The explicit curriculum constitutes the program's formal educational structure and includes the courses and the curriculum. Social work education is grounded in the liberal arts, which provide the intellectual basis for the professional curriculum and inform its design. The explicit curriculum achieves the program's competencies through an intentional design that includes the foundation offered at the baccalaureate and master's levels and the advanced curriculum offered at the master's level. The BSW curriculum prepares its graduates for generalist practice through mastery of the core competencies. The MSW curriculum prepares its graduates for advanced practice through mastery of the core competencies augmented by knowledge and practice behaviors specific to a concentration.

### **Educational Policy 2.1—Core Competencies**

Competency-based education is an outcome performance approach to curriculum design. Competencies are measurable practice behaviors that are comprised of knowledge, values, and skills. The goal of the outcome approach is to demonstrate the integration and application of the competencies in practice with individuals, families, groups, organizations, and communities. The ten core competencies are listed below [EP 2.1.1–EP 2.1.10(d)], followed by a description of characteristic knowledge, values, skills, and the resulting practice behaviors that may be used to operationalize the curriculum and assessment methods. Programs may add competencies consistent with their missions and goals.

#### **Educational Policy 2.1.1—Identify as a professional social worker and conduct oneself accordingly.**

Social workers serve as representatives of the profession, its mission, and its core values. They know the profession's history. Social workers commit themselves to the profession's enhancement and to their own professional conduct and growth. Social workers

- advocate for client access to the services of social work;
- practice personal reflection and self-correction to assure continual professional development;
- attend to professional roles and boundaries;
- demonstrate professional demeanor in behavior, appearance, and communication;
- engage in career-long learning; and
- use supervision and consultation.

**Educational Policy 2.1.2—Apply social work ethical principles to guide professional practice.**

Social workers have an obligation to conduct themselves ethically and to engage in ethical decision-making. Social workers are knowledgeable about the value base of the profession, its ethical standards, and relevant law. Social workers

- recognize and manage personal values in a way that allows professional values to guide practice;
- make ethical decisions by applying standards of the National Association of Social Workers Code of Ethics<sup>2</sup> and, as applicable, of the International Federation of Social Workers/International Association of Schools of Social Work Ethics in Social Work, Statement of Principles;<sup>3</sup>
- tolerate ambiguity in resolving ethical conflicts; and
- apply strategies of ethical reasoning to arrive at principled decisions.

**Educational Policy 2.1.3—Apply critical thinking to inform and communicate professional judgments.**

Social workers are knowledgeable about the principles of logic, scientific inquiry, and reasoned discernment. They use critical thinking augmented by creativity and curiosity. Critical thinking also requires the synthesis and communication of relevant information. Social workers

- distinguish, appraise, and integrate multiple sources of knowledge, including research-based knowledge, and practice wisdom;
- analyze models of assessment, prevention, intervention, and evaluation; and
- demonstrate effective oral and written communication in working with individuals, families, groups, organizations, communities, and colleagues.

**Educational Policy 2.1.4—Engage diversity and difference in practice.**

Social workers understand how diversity characterizes and shapes the human experience and is critical to the formation of identity. The dimensions of diversity are understood as the intersectionality of multiple

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<sup>2</sup> National Association of Social Workers (approved 1996, revised 1999). *Code of Ethics for Social Workers*. Washington, DC: NASW.

<sup>3</sup> International Federation of Social Workers and International Association of Schools of Social Work. (2004). *Ethics in Social Work, Statement of Principles*. Retrieved January 2, 2008 from <http://www.ifsw.org>

factors including age, class, color, culture, disability, ethnicity, gender, gender identity and expression, immigration status, political ideology, race, religion, sex, and sexual orientation. Social workers appreciate that, as a consequence of difference, a person's life experiences may include oppression, poverty, marginalization, and alienation as well as privilege, power, and acclaim. Social workers

- recognize the extent to which a culture's structures and values may oppress, marginalize, alienate, or create or enhance privilege and power;
- gain sufficient self-awareness to eliminate the influence of personal biases and values in working with diverse groups;
- recognize and communicate their understanding of the importance of difference in shaping life experiences; and
- view themselves as learners and engage those with whom they work as informants.

**Educational Policy 2.1.5—Advance human rights and social and economic justice.**

Each person, regardless of position in society, has basic human rights, such as freedom, safety, privacy, an adequate standard of living, health care, and education. Social workers recognize the global interconnections of oppression and are knowledgeable about theories of justice and strategies to promote human and civil rights. Social work incorporates social justice practices in organizations, institutions, and society to ensure that these basic human rights are distributed equitably and without prejudice. Social workers

- understand the forms and mechanisms of oppression and discrimination;
- advocate for human rights and social and economic justice; and
- engage in practices that advance social and economic justice.

**Educational Policy 2.1.6—Engage in research-informed practice and practice-informed research.**

Social workers use practice experience to inform research, employ evidence-based interventions, evaluate their own practice, and use research findings to improve practice, policy, and social service delivery. Social workers comprehend quantitative and qualitative research and understand scientific and ethical approaches to building knowledge. Social workers

- use practice experience to inform scientific inquiry and
- use research evidence to inform practice.

**Educational Policy 2.1.7—Apply knowledge of human behavior and the social environment.**

Social workers are knowledgeable about human behavior across the life course; the range of social systems in which people live; and the ways social systems promote or deter people in maintaining or achieving health and well-being. Social workers apply theories and knowledge from the liberal arts to understand biological, social, cultural, psychological, and spiritual development. Social workers

- utilize conceptual frameworks to guide the processes of assessment, intervention, and evaluation; and
- critique and apply knowledge to understand person and environment.

**Educational Policy 2.1.8—Engage in policy practice to advance social and economic well-being and to deliver effective social work services.**

Social work practitioners understand that policy affects service delivery, and they actively engage in policy practice. Social workers know the history and current structures of social policies and services; the role of policy in service delivery; and the role of practice in policy development. Social workers

- analyze, formulate, and advocate for policies that advance social well-being; and
- collaborate with colleagues and clients for effective policy action.

**Educational Policy 2.1.9—Respond to contexts that shape practice.**

Social workers are informed, resourceful, and proactive in responding to evolving organizational, community, and societal contexts at all levels of practice. Social workers recognize that the context of practice is dynamic, and use knowledge and skill to respond proactively. Social workers

- continuously discover, appraise, and attend to changing locales, populations, scientific and technological developments, and emerging societal trends to provide relevant services; and
- provide leadership in promoting sustainable changes in service delivery and practice to improve the quality of social services.

**Educational Policy 2.1.10(a)–(d)—Engage, assess, intervene, and evaluate with individuals, families, groups, organizations, and communities.**

Professional practice involves the dynamic and interactive processes of engagement, assessment, intervention, and evaluation at multiple levels. Social workers have the knowledge and skills to practice with individuals, families, groups, organizations, and communities. Practice knowledge includes

identifying, analyzing, and implementing evidence-based interventions designed to achieve client goals; using research and technological advances; evaluating program outcomes and practice effectiveness; developing, analyzing, advocating, and providing leadership for policies and services; and promoting social and economic justice.

#### **Educational Policy 2.1.10(a)—Engagement**

Social workers

- substantively and affectively prepare for action with individuals, families, groups, organizations, and communities;
- use empathy and other interpersonal skills; and
- develop a mutually agreed-on focus of work and desired outcomes.

#### **Educational Policy 2.1.10(b)—Assessment**

Social workers

- collect, organize, and interpret client data;
- assess client strengths and limitations;
- develop mutually agreed-on intervention goals and objectives; and
- select appropriate intervention strategies.

#### **Educational Policy 2.1.10(c)—Intervention**

Social workers

- initiate actions to achieve organizational goals;
- implement prevention interventions that enhance client capacities;
- help clients resolve problems;
- negotiate, mediate, and advocate for clients; and
- facilitate transitions and endings.

#### **Educational Policy 2.1.10(d)—Evaluation**

Social workers critically analyze, monitor, and evaluate interventions.

#### **Educational Policy B2.2—Generalist Practice**

Generalist practice is grounded in the liberal arts and the person and environment construct. To promote human and social well-being, generalist practitioners use a range of prevention and intervention methods

in their practice with individuals, families, groups, organizations, and communities. The generalist practitioner identifies with the social work profession and applies ethical principles and critical thinking in practice. Generalist practitioners incorporate diversity in their practice and advocate for human rights and social and economic justice. They recognize, support, and build on the strengths and resiliency of all human beings. They engage in research-informed practice and are proactive in responding to the impact of context on professional practice. BSW practice incorporates all of the core competencies.

### **Educational Policy M2.2—Advanced Practice**

Advanced practitioners refine and advance the quality of social work practice and that of the larger social work profession. They synthesize and apply a broad range of interdisciplinary and multidisciplinary knowledge and skills. In areas of specialization, advanced practitioners assess, intervene, and evaluate to promote human and social well-being. To do so they suit each action to the circumstances at hand, using the discrimination learned through experience and self-improvement. Advanced practice incorporates all of the core competencies augmented by knowledge and practice behaviors specific to a concentration.

### **Educational Policy 2.3—Signature Pedagogy: Field Education**

Signature pedagogy represents the central form of instruction and learning in which a profession socializes its students to perform the role of practitioner. Professionals have pedagogical norms with which they connect and integrate theory and practice.<sup>4</sup> In social work, the signature pedagogy is field education. The intent of field education is to connect the theoretical and conceptual contribution of the classroom with the practical world of the practice setting. It is a basic precept of social work education that the two interrelated components of curriculum—classroom and field—are of equal importance within the curriculum, and each contributes to the development of the requisite competencies of professional practice. Field education is systematically designed, supervised, coordinated, and evaluated based on criteria by which students demonstrate the achievement of program competencies.

#### **Accreditation Standard B2.0—Curriculum**

*The 10 core competencies are used to design the professional curriculum. The program*

**B2.0.1** *Discusses how its mission and goals are consistent with generalist practice as defined in EP B2.2.*

**B2.0.2** *Identifies its competencies consistent with EP 2.1 through 2.1.10(d).*

**B2.0.3** *Provides an operational definition for each of its competencies used in its curriculum design and its assessment [EP 2.1 through 2.1.10(d)].*

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<sup>4</sup> Shulman, L. S. (2005, Summer). Signature pedagogies in the professions. *Daedalus*, 52-59.

- B2.0.4** *Provides a rationale for its formal curriculum design demonstrating how it is used to develop a coherent and integrated curriculum for both classroom and field (EP 2.0).*
- B2.0.5** *Describes and explains how its curriculum content (knowledge, values, and skills) implements the operational definition of each of its competencies.*

**Accreditation Standard M2.0—Curriculum**

*The 10 core competencies are used to design the foundation and advanced curriculum. The advanced curriculum builds on and applies the core competencies in an area(s) of concentration. The program*

- M2.0.1** *Identifies its concentration(s) (EP M2.2).*
- M2.0.2** *Discusses how its mission and goals are consistent with advanced practice (EP M2.2).*
- M2.0.3** *Identifies its program competencies consistent with EP 2.1 through 2.1.10(d) and EP M2.2.*
- M2.0.4** *Provides an operational definition for each of the competencies used in its curriculum design and its assessment [EP 2.1 through 2.1.10(d); EP M2.2].*
- M2.0.5** *Provides a rationale for its formal curriculum design (foundation and advanced), demonstrating how it is used to develop a coherent and integrated curriculum for both classroom and field (EP 2.0).*
- M2.0.6** *Describes and explains how its curriculum content (relevant theories and conceptual frameworks, values, and skills) implements the operational definition of each of its competencies.*

**Accreditation Standard 2.1—Field Education**

*The program discusses how its field education program*

- 2.1.1** *Connects the theoretical and conceptual contribution of the classroom with the practice setting, fostering the implementation of evidence-informed practice.*
- B2.1.2** *Provides generalist practice opportunities for students to demonstrate the core competencies.*
- M2.1.2** *Provides advanced practice opportunities for students to demonstrate the program's competencies.*
- 2.1.3** *Provides a minimum of 400 hours of field education for baccalaureate programs and 900 hours for master's programs.*
- 2.1.4** *Admits only those students who have met the program's specified criteria for field education.*
- 2.1.5** *Specifies policies, criteria, and procedures for selecting field settings; placing and monitoring students; maintaining field liaison contacts with field education settings; and evaluating student learning and field setting effectiveness congruent with the program's competencies.*

- 2.1.6** *Specifies the credentials and practice experience of its field instructors necessary to design field learning opportunities for students to demonstrate program competencies. Field instructors for baccalaureate students hold a baccalaureate or master's degree in social work from a CSWE-accredited program. Field instructors for master's students hold a master's degree in social work from a CSWE-accredited program. For cases in which a field instructor does not hold a CSWE-accredited social work degree, the program assumes responsibility for reinforcing a social work perspective and describes how this is accomplished.*
- 2.1.7** *Provides orientation, field instruction training, and continuing dialog with field education settings and field instructors.*
- 2.1.8** *Develops policies regarding field placements in an organization in which the student is also employed. To ensure the role of student as learner, student assignments and field education supervision are not the same as those of the student's employment.*

### **3. Implicit Curriculum**

#### **Educational Policy 3.0—Implicit Curriculum: The Learning Environment**

The implicit curriculum refers to the educational environment in which the explicit curriculum is presented. It is composed of the following elements: the program's commitment to diversity; admissions policies and procedures; advisement, retention, and termination policies; student participation in governance; faculty; administrative structure; and resources. The implicit curriculum is manifested through policies that are fair and transparent in substance and implementation, the qualifications of the faculty, and the adequacy of resources. The culture of human interchange; the spirit of inquiry; the support for difference and diversity; and the values and priorities in the educational environment, including the field setting, inform the student's learning and development. The implicit curriculum is as important as the explicit curriculum in shaping the professional character and competence of the program's graduates. Heightened awareness of the importance of the implicit curriculum promotes an educational culture that is congruent with the values of the profession.<sup>5</sup>

#### **Educational Policy 3.1—Diversity**

The program's commitment to diversity—including age, class, color, culture, disability, ethnicity, gender,

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<sup>5</sup> Eisner, E. W. (2002). *The educational imagination: On the design and evaluation of school programs* (3<sup>rd</sup> ed.). New York: Macmillan.

gender identity and expression, immigration status, political ideology, race, religion, sex, and sexual orientation—is reflected in its learning environment (institutional setting; selection of field education settings and their clientele; composition of program advisory or field committees; educational and social resources; resource allocation; program leadership; speaker series, seminars, and special programs; support groups; research and other initiatives; and the demographic make-up of its faculty, staff, and student body).

**Accreditation Standard 3.1—Diversity**

- 3.1.1** *The program describes the specific and continuous efforts it makes to provide a learning environment in which respect for all persons and understanding of diversity and difference are practiced.*
- 3.1.2** *The program describes how its learning environment models affirmation and respect for diversity and difference.*
- 3.1.3** *The program discusses specific plans to improve the learning environment to affirm and support persons with diverse identities.*

**Educational Policy 3.2—Student Development**

Educational preparation and commitment to the profession are essential qualities in the admission and development of students for professional practice. To promote the social work education continuum, BSW graduates admitted to MSW programs are presented with an articulated pathway toward a concentration. Student participation in formulating and modifying policies affecting academic and student affairs are important for the student’s professional development.

**Accreditation Standard 3.2—Student Development: Admissions; Advisement, Retention, and Termination; and Student Participation**

**Admissions**

- B3.2.1** *The program identifies the criteria it uses for admission.*
- M3.2.1** *The program identifies the criteria it uses for admission. The criteria for admission to the master’s program must include an earned bachelor’s degree from a college or university accredited by a recognized regional accrediting association.*
- 3.2.2** *The program describes the process and procedures for evaluating applications and notifying applicants of the decision and any contingent conditions associated with admission.*
- M3.2.3** *BSW graduates entering MSW programs are not to repeat what has been mastered in their BSW programs. MSW programs describe the policies and procedures used for awarding*

*advanced standing. These policies and procedures should be explicit and unambiguous. Advanced standing is awarded only to graduates holding degrees from baccalaureate social work programs accredited by CSWE, those recognized through its International Social Work Degree Recognition and Evaluation Service, or covered under a memorandum of understanding with international social work accreditors.*

**3.2.4** *The program describes its policies and procedures concerning the transfer of credits.*

**3.2.5** *The program submits its written policy indicating that it does not grant social work course credit for life experience or previous work experience. The program documents how it informs applicants and other constituents of this policy.*

#### **Advisement, retention, and termination**

**3.2.6** *The program describes its academic and professional advising policies and procedures. Professional advising is provided by social work program faculty, staff, or both.*

**3.2.7** *The program spells out how it informs students of its criteria for evaluating their academic and professional performance, including policies and procedures for grievance.*

**3.2.8** *The program submits its policies and procedures for terminating a student's enrollment in the social work program for reasons of academic and professional performance.*

#### **Student participation**

**3.2.9** *The program describes its policies and procedures specifying students' rights and responsibilities to participate in formulating and modifying policies affecting academic and student affairs.*

**3.2.10** *The program demonstrates how it provides opportunities and encourages students to organize in their interests.*

### **Educational Policy 3.3—Faculty**

Faculty qualifications, including experience related to the program's competencies, and an appropriate student-faculty ratio are essential for developing an educational environment that promotes, emulates, and teaches students the knowledge, values, and skills expected of professional social workers. Through their teaching, scholarship, and service—as well as their interactions with one another, administration, students, and community—the program's faculty models the behavior and values expected of professional social workers.

#### **Accreditation Standard 3.3—Faculty**

**3.3.1** *The program identifies each full and part-time social work faculty member and discusses her/his qualifications, competence, expertise in social work education and practice, and years of service to the program. Faculty who teach social work practice courses have a*

*master's degree in social work from a CSWE-accredited program and at least two years of social work practice experience.*

- 3.3.2** *The program discusses how faculty size is commensurate with the number and type of curricular offerings in class and field; class size; number of students; and the faculty's teaching, scholarly, and service responsibilities. To carry out the ongoing functions of the program, the full-time equivalent faculty-to-student ratio is usually 1:25 for baccalaureate programs and 1:12 for master's programs.*
- B3.3.3** *The baccalaureate social work program identifies no fewer than two full-time faculty assigned to the program, with full-time appointment in social work, and whose principal assignment is to the baccalaureate program. The majority and no fewer than two of the full-time faculty has either a master's degree in social work from a CSWE-accredited program, with a doctoral degree preferred, or a baccalaureate degree in social work from a CSWE-accredited program and a doctoral degree preferably in social work.*
- M3.3.3** *The master's social work program identifies no fewer than six full-time faculty with master's degrees in social work from a CSWE-accredited program and whose principal assignment is to the master's program. The majority of the full-time master's social work program faculty has a master's degree in social work and a doctoral degree preferably in social work.*
- 3.3.4** *The program describes its faculty workload policy and discusses how the policy supports the achievement of institutional priorities and the program's mission and goals.*
- 3.3.5** *Faculty demonstrate ongoing professional development as teachers, scholars, and practitioners through dissemination of research and scholarship, exchanges with external constituencies such as practitioners and agencies, and through other professionally relevant creative activities that support the achievement of institutional priorities and the program's mission and goals.*
- 3.3.6** *The program describes how its faculty models the behavior and values of the profession in the program's educational environment.*

### **Educational Policy 3.4—Administrative Structure**

Social work faculty and administrators, based on their education, knowledge, and skills, are best suited to make decisions regarding the delivery of social work education. They exercise autonomy in designing an administrative and leadership structure, developing curriculum, and formulating and implementing policies that support the education of competent social workers.

#### **Accreditation Standard 3.4—Administrative Structure**

- 3.4.1** *The program describes its administrative structure and shows how it provides the necessary autonomy to achieve the program's mission and goals.*

- 3.4.2** *The program describes how the social work faculty has responsibility for defining program curriculum consistent with the Educational Policy and Accreditation Standards and the institution's policies.*
- 3.4.3** *The program describes how the administration and faculty of the social work program participate in formulating and implementing policies related to the recruitment, hiring, retention, promotion, and tenure of program personnel.*
- 3.4.4** *The program identifies the social work program director. Institutions with accredited BSW and MSW programs appoint a separate director for each.*
- B3.4.4(a)** *The program describes the BSW program director's leadership ability through teaching, scholarship, curriculum development, administrative experience, and other academic and professional activities in social work. The program documents that the director has a master's degree in social work from a CSWE-accredited program with a doctoral degree preferred or a baccalaureate degree in social work from a CSWE-accredited program and a doctoral degree, preferably in social work.*
- B3.4.4(b)** *The program provides documentation that the director has a full-time appointment to the social work program.*
- B3.4.4(c)** *The program describes the procedures for determining the program director's assigned time to provide educational and administrative leadership to the program. To carry out the administrative functions of the program, a minimum of 25% assigned time is required at the baccalaureate level. The program demonstrates this time is sufficient.*
- M3.4.4(a)** *The program describes the MSW program director's leadership ability through teaching, scholarship, curriculum development, administrative experience, and other academic and professional activities in social work. The program documents that the director has a master's degree in social work from a CSWE-accredited program. In addition, it is preferred that the MSW program director have a doctoral degree, preferably in social work.*
- M3.4.4(b)** *The program provides documentation that the director has a full-time appointment to the social work program.*
- M3.4.4(c)** *The program describes the procedures for determining the program director's assigned time to provide educational and administrative leadership to the program. To carry out the administrative functions of the program, a minimum of 50% assigned time is required at the master's level. The program demonstrates this time is sufficient.*

- 3.4.5** *The program identifies the field education director.*
- 3.4.5(a)** *The program describes the field director's ability to provide leadership in the field education program through practice experience, field instruction experience, and administrative and other relevant academic and professional activities in social work.*
  - 3.4.5(b)** *The program documents that the field education director has a master's degree in social work from a CSWE-accredited program and at least 2 years of postbaccalaureate or postmaster's social work degree practice experience.*
  - B3.4.5(c)** *The program describes the procedures for determining the field director's assigned time to provide educational and administrative leadership for field education. To carry out the administrative functions of the field at least 25% assigned time is required for baccalaureate programs. The program demonstrates this time is sufficient.*
  - M3.4.5(c)** *The program describes the procedures for determining the field director's assigned time to provide educational and administrative leadership for field education. To carry out the administrative functions of the field at least 50% assigned time is required for master's programs. The program demonstrates this time is sufficient.*
  - 3.4.5(d)** *The program provides documentation that the field director has a full-time appointment to the social work program.*

### **Educational Policy 3.5—Resources**

Adequate resources are fundamental to creating, maintaining, and improving an educational environment that supports the development of competent social work practitioners. Social work programs have the necessary resources to support learning and professionalization of students and program improvement.

#### **Accreditation Standard 3.5—Resources**

- 3.5.1** *The program describes the procedures for budget development and administration it uses to achieve its mission and goals. The program submits the budget form to demonstrate sufficient and stable financial supports that permit program planning and faculty development.*
- 3.5.2** *The program describes how it uses resources to continuously improve the program and address challenges in the program's context.*
- 3.5.3** *The program demonstrates sufficient support staff, other personnel, and technological resources to support itself.*

- 3.5.4** *The program submits the library form to demonstrate comprehensive library holdings and/or electronic access and other informational and educational resources necessary for achieving its mission and goals.*
- 3.5.5** *The program describes and demonstrates sufficient office and classroom space and/or computer-mediated access to achieve its mission and goals.*
- 3.5.6** *The program describes its access to assistive technology, including materials in alternative formats (e.g., Braille, large print, books on tape, assistive learning systems).*

## **4. Assessment**

### **Educational Policy 4.0—Assessment**

Assessment is an integral component of competency-based education. To evaluate the extent to which the competencies have been met, a system of assessment is central to this model of education. Data from assessment continuously inform and promote change in the explicit and implicit curriculum to enhance attainment of program competencies.

### **Accreditation Standard 4.0—Assessment**

- 4.0.1** *The program presents its plan to assess the attainment of its competencies. The plan specifies procedures, multiple measures, and benchmarks to assess the attainment of each of the program's competencies (AS B2.0.3; AS M2.0.4).*
- 4.0.2** *The program provides evidence of ongoing data collection and analysis and discusses how it uses assessment data to affirm and/or make changes in the explicit and implicit curriculum to enhance student performance.*
- 4.0.3** *The program identifies any changes in the explicit and implicit curriculum based on the analysis of the assessment data.*
- 4.0.4** *The program describes how it makes its constituencies aware of its assessment outcomes.*
- 4.0.5** *The program appends the summary data for each measure used to assess the attainment of each competency for at least one academic year prior to the submission of the self-study.*