

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 role 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 such large-scale institutions. 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 role 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 system’s 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 number of audience members expressed similar concerns about the purpose of the LCSW Education Committee.

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 the 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 clarified that the Committee is currently just gathering information and is not jumping to any conclusions about mandating any curriculum for social workers. He explained that the board's overriding legal mandate is public protection; ensuring minimally competent practitioners under the scope of practice for the licenses that the Board issues. That is why these meetings are held. A big part of that environment has changed; now there is the Mental Health Services Act (MHSA). The MHSA is a state mandate and is creating change in the system. As a public agency we have an obligation to figure out how to incorporate that goal into what the Board 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 the MHSA. 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 in the near future. 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 plans to look into the full range of social work requirements – 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.

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 MHSA is reflected in 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.