

LICENSED SOCIAL WORKERS IN BEHAVIORAL HEALTH, 2004

Chapter 1 of 7

Overview

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Washington, DC**

March 2006

Preface

This report summarizes and interprets the responses of social workers in the practice areas of Mental Health and Addictions obtained through a national sample survey of licensed social workers in the U.S. conducted in 2004. It is one of six reports prepared by the National Association of Social Workers (NASW) in partnership with the Center for Health Workforce Studies (CHWS), School of Public Health, University at Albany.

Existing sources of data on social workers provide important but fragmented information on the field, preventing the development of an accurate comprehensive picture of the social work workforce. The NASW/CHWS study and this report provide comprehensive, up-to-date information on active licensed social workers working in the health care arena. This information includes: demographic characteristics, education and training, employment roles and tasks, work environment, client characteristics, career paths, and workplace issues.

The resulting profile of the licensed social work workforce will be a valuable resource for planners and policy makers making decisions about the future of the social work profession and its related education programs.

This report was prepared by Bonnie Primus Cohen, Sandra McGinnis, and Paul Wing of the CHWS staff, with assistance and guidance from Tracy Whitaker and Toby Weismiller of NASW. Reviews by a project advisory committee are gratefully acknowledged.

Funding support of the Robert Wood Johnson Foundation is also gratefully acknowledged. The findings and conclusions presented in this report are those of the authors alone, and do not necessarily reflect the opinions of the foundation.

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Chapter 1. Overview

Behavioral health problems affect individuals across age groups, educational levels and economic status. Many individuals need clinical treatment and/or support services to help them address and recover from one or more mental health and substance abuse disorders. Consider the following national statistics:

- More than 54 million Americans are affected by mental illness each year¹.
- An estimated 21.4 million American adults (10% of all adults) have serious psychological distress².
- More than half of the population currently drinks alcohol, and 7% are heavy drinkers. Approximately one in five ages 12 years and older participate in binge drinking³.
- Approximately 8 percent of Americans use illicit drugs⁴.
- 4.6 million adults have diagnoses of substance abuse disorder and serious mental illness⁵.

Behavioral health conditions can impair individuals' abilities to cope with life's ordinary demands and routines. Many individuals with these diagnoses must further contend with life circumstances that complicate their problems, e.g. family dysfunction, poverty, trauma, community disasters, or the return from war. Their reduced or lost productivity are both staggering personal and social costs⁶.

Clinical treatment and support services have been demonstrated to help people address their problems, recover, and reestablish fulfilling lives. However, the availability of these services varies considerably across the country, as do the requirements for access to these services. Behavioral health insurance coverage differs among health plans, employers, and states. While this coverage has increased in the past decades, and efforts to achieve parity with reimbursement for other medical and surgical care are growing, mental health coverage is limited. Substance abuse is not consistently included by insurance plans.

Social workers play a significant role in providing care to clients in need of behavioral health services in this challenging environment. They are involved in preventing, diagnosing, and treating mental and behavioral disorders. They assist clients to cope with loss, manage anxiety, and move toward recovery. In addition to clinical services, they provide support services that enable clients to connect to community resources responsive to their unique situations. They assist families to understand and support their loved ones' recovery, and support caregiving efforts. It is important to note that many social workers advocate for and lead programs that utilize evidenced-based practices to assist clients addressing these problems.

¹ National Mental Health Association, www.nhma.org, 2006.

² SAMHSA, op.cit.

³ SAMHSA, op. cit.

⁴ SAMHSA, op.cit.

⁵ SAMSHA, op.cit.

⁶ Rice, D.P., & Miller, L.S. (1993). The economic burden of affective disorders. In R.M. Scheffler, L.F. Rossiter, & T.-W. Hu (Eds), *Advances in Health Economics and Health Services Research: Vol. 14* (pp. 37-53). Greenwich, CT: JAI Press.

Understanding the experience and perspectives of licensed social workers who provide behavioral services to clients is important. Only by clarifying their needs will it be possible to help sustain them in their work. Further, the perspectives of these social workers will help to identify barriers to the delivery of services to clients. This information will assist in assuring that quality behavioral health services are provided to those in need.

Goals of this Report

This report has been prepared to inform policy makers, educators, and practitioners about the licensed social work workforce in Behavioral Health. Identifying what is common and what differs among these professionals and licensed social workers in other practice areas will facilitate educational planning, policy development, and program design, and ultimately will contribute to improving the quality of care provided in the United States.

The workforce profile that follows is a comprehensive description of the licensed social work workforce in the practice area of Behavioral Health in 2004. It addresses the roles and practices of these social workers within key employment settings as well as the issues they confront in providing services to clients. This description will help focus attention and resources to engage, prepare, and sustain social workers in their work.

The Social Work Workforce in Behavioral Health

Background

The data presented in *Licensed Social Workers in Behavioral Health* is drawn from a survey conducted in 2004 by the National Association of Social Workers (NASW) in collaboration with the Center for Health Workforce Studies (CHWS), School of Public Health, University at Albany. The survey provides important new insights about the nation's licensed social workers.

Despite the significant contributions of social workers to the American health care system, gaps continue to exist in knowledge about the roles and tasks Behavioral Health social workers perform in different settings. Existing sources of data about the field (e.g., Bureau of Labor Statistics [BLS], Census Public-Use Microdata Sample [PUMS] and NASW studies) are valuable, but the picture they provide of the profession is fragmented. The NASW/CHWS study was undertaken to clarify practice patterns among licensed social workers.

Licensed social workers were selected for this study because they represent a major cohort of social workers that provide frontline services to clients, and that were readily identifiable through state licensing lists. Their commitment to the field, as evidenced by their pursuing licensure and the diversity of their practice focuses, makes them a very important group to study. Licensed social workers constitute 63 percent of the 460,000 reported by the Bureau of Labor Statistics (BLS), and the study findings provide an important baseline for monitoring changes within this profession. It is recognized, however, that practice patterns of licensed social workers ultimately need to be compared with other groups of social workers to gain a more complete understanding of this profession.

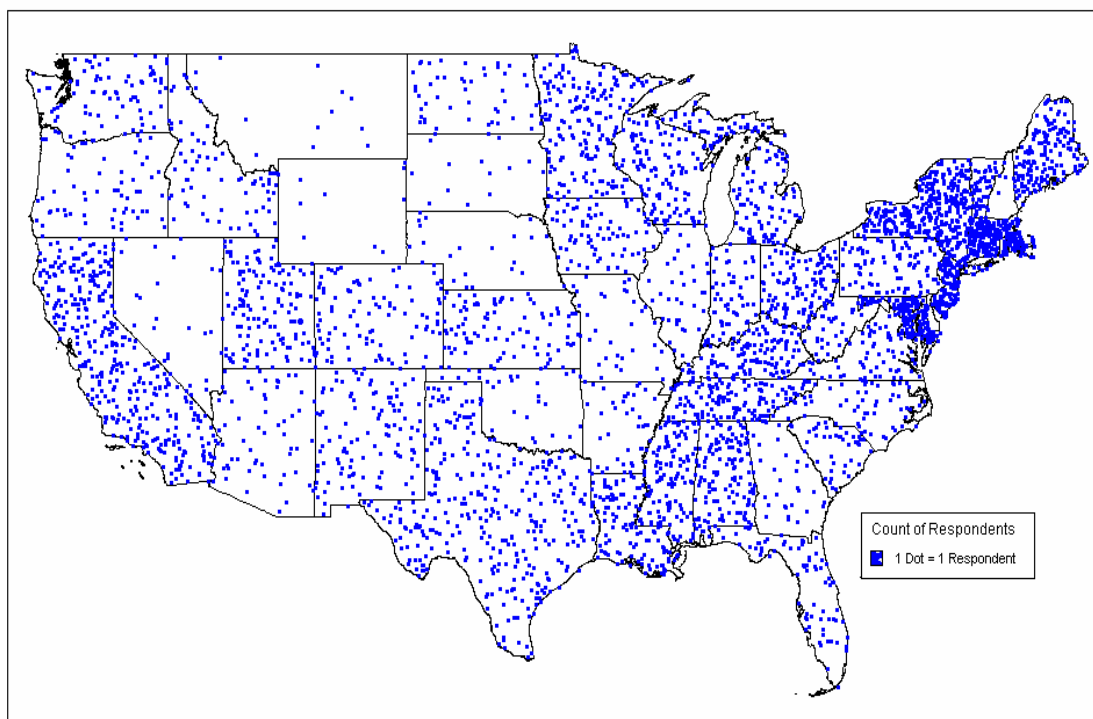
Legal regulation of professions, including social work, varies from state to state. Generally, jurisdictions may regulate as many as four broad areas of social work practice: baccalaureate social work degree upon graduation; master's degree in social work (MSW) upon graduation; MSW with two years of postgraduate supervised experience; and MSW with two years of post-

master's direct clinical social work experience. Some jurisdictions regulate only one of these practice levels, but most regulate two or more levels of social work practice. Currently, 35 jurisdictions recognize and regulate baccalaureate level practice, while all states recognize and regulate master's degree level practice. A few jurisdictions license at an associate level, and a small number offer more than four licensure categories. While the study sample of licensed social workers does not represent the full range of professionally educated social workers, it does offer a good representation of those providing frontline services.

The study findings are based on a national survey distributed to a stratified random sample of 10,648 licensed social workers in 48 states plus the District of Columbia. Based on this, it is estimated about 106,000 social workers practice in Behavioral Health nationwide (97,000 in Mental Health and 9,000 in Addictions). The study achieved a response rate of 49.4%. The distribution of licensed social workers that responded to the survey is seen below. Data collected includes information on licensed social workers' demographic and educational backgrounds, practice patterns, the clients they serve, and their perspectives on changes in their practice. The survey instrument can be found in Appendix B.

The findings of the larger report on social workers and this supplement pertain only to licensed social workers. Findings should not be generalized as conclusions about practice patterns of the non-licensed social work workforce.

Figure 1. Distribution of Responses to NASW/CHWS Survey

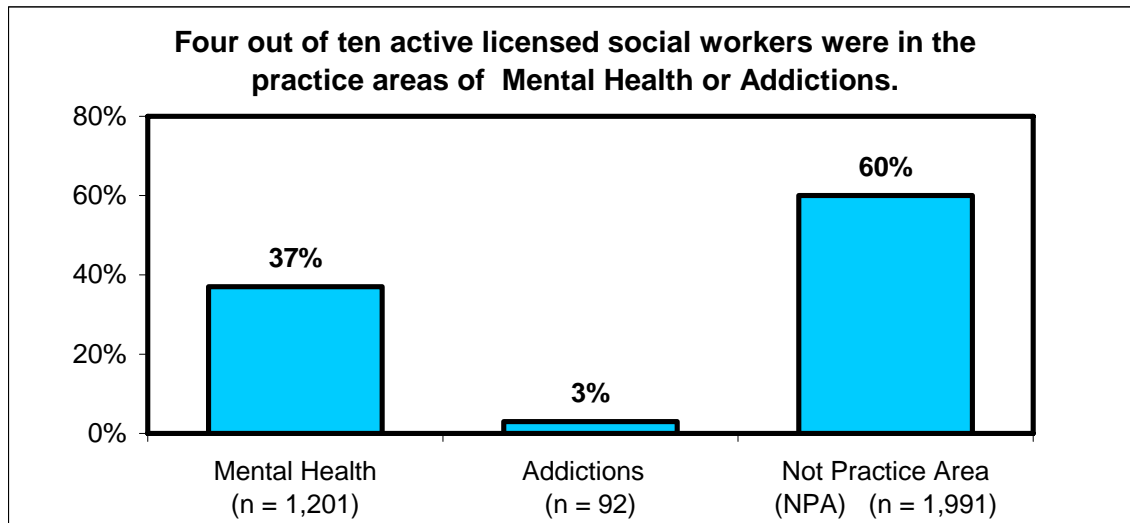


Note: The above map reflects only responses received to the NASW/CHWS survey, and is not intended for use in comparing actual numbers of social workers practicing in these states. Response rates varied dramatically from state to state. Furthermore, the original sampling frame was restricted to licensed social workers, and was subject to variations between states in licensing requirements.

Framework for Analysis

Social workers who identify Behavioral Health as the focus of their primary employment represent a large group of licensed social workers: More than one-third of licensed social workers (37%) are in the practice area of Mental Health, while another 3 percent are in the practice area of Addictions.

Figure 2. Primary Practice Area Of Active, Licensed Social Workers

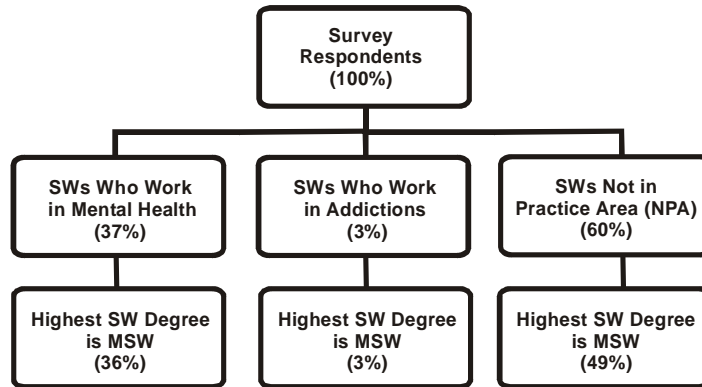


A significant majority of social workers in Behavioral Health practice areas hold master's degrees in social work (MSWs). Fewer than 4 percent in either Mental Health or Addictions are BSWs. Some Behavioral Health social workers do not have formal social work degrees (4 percent of those in Mental Health and 8 percent of those in Addictions), but this is less common in Behavioral Health than among social workers overall (8%).

This report describes and compares the experiences of MSWs in Mental Health and in Addictions, the two Behavioral Health practice areas. It also compares experiences of Behavioral Health MSWs with licensed MSWs in other practice areas. Comparisons with BSWs are not presented throughout the report as the small size of the BSW sample precludes inference of meaningful conclusions. It should be noted that Behavioral Health BSWs represent fewer than 10 percent of all baccalaureate trained licensed social workers responding to the NASW/CHWS survey. However, a discussion of Behavioral Health BSWs can be found in Appendix A.

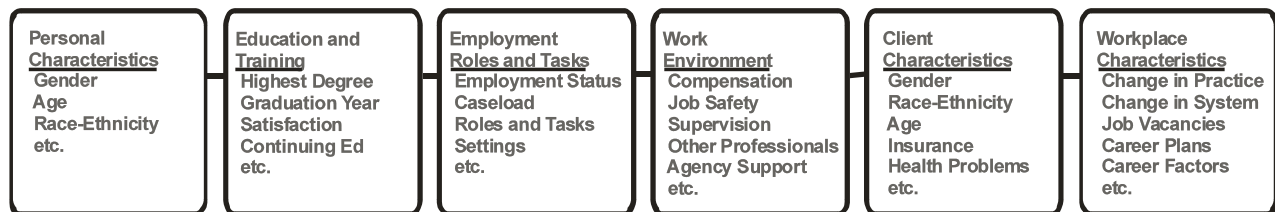
Comparisons with social workers overall (survey respondents regardless of degree history) are provided within the report where this information provides insights into Behavioral Health practice. Similarly, when relevant, social workers are compared by employment setting and by the client populations served. Figure 3 is a "map" that indicates the characteristics and factors covered in the report.

Figure 3. Schematic “Map” of the Factors and Characteristics of Licensed Social Workers



The report will reference the following characteristics of social workers employed in Behavioral Health.

Figure 4. Characteristics of Licensed Social Workers in the Practice Area of Behavioral Health



Interesting variations in the patterns will be displayed throughout the report in tables and charts. The pink cells in the tables highlight the smallest percentages in their respective rows, and the green cells highlight the largest percentages. Only rows for which the difference between the largest and smallest percentages was at least 10 percentage points have highlighted cells. Only differences among groups will be presented in the text.

Appendix A. A Profile of Behavioral Health BSWs

Fewer than 10% of licensed baccalaureate trained social workers who responded to the NASW/CHWS survey identified a Behavioral Health practice area as the focus of their social work practice. Thirty-seven respondents identified their practice area as Mental Health and three identified Addictions. The small size of the BSW sample precludes inference of meaningful conclusions, and comparisons were therefore not made in the presentation of results in *Licensed Social Workers in Behavioral Health*.

The following is a summary description of BSWs respondents in the practice area of Mental Health only. Because so few respondents identified Addictions, general statements cannot be made for this practice area. *The description that follows applies to the 37 BSW respondents in Mental Health only and **should not be generalized** to BSW social workers or BSWs in Behavioral Health overall.*

BSW respondents in Mental Health were younger than MSWs in this practice area (43 years versus 50.5 years), and more likely to be female (90% versus 81%). They were similar to MSWs, however, in racial and ethnic background. BSWs were significantly less likely than MSWs to work in metropolitan areas (54% versus 84%), and more likely to work in all other practice locations, e.g., micropolitan areas (23% versus 10%), small towns (14% versus 5%) and rural areas (9% versus 2%).

BSWs mirrored MSWs in their perspectives on the adequacy of their educational preparation, as well as their interests in future training. BSWs like MSWs, were generally satisfied with their degree programs and continuing education training, (68% versus 60%, 76% versus 74%). Clinical practice and trauma/disaster were the topics both groups were most interested in for future training. However, these BSWs were less likely to have certification in chemical dependency than MSWs (8% versus 18%).

BSW respondents in Mental Health had fewer years experience in social work than MSWs (a median of 10 versus 15 years). Almost half had been with their employers less than 5 years, similar to MSWs (48% versus 45%), but fewer had been with current employers more than 15 years (11% versus 21%).

These BSWs did not work in substantially different settings than MSWs. Within the most common behavioral health settings, they were most likely to work in behavioral health clinics, psychiatric hospitals, and social service agencies. They were much less likely to be in private practice. Interestingly, more than a fourth of these social workers were employed in settings other than those listed below. BSWs were most likely to be employed in the non-profit sector (41%) and the public sector (39%).

Table 1. Primary Employment Settings of BSWs and MSWs in Mental Health

Primary Employment Setting	BSW	MSW
Private solo practice	0%	31%
Private group practice	5%	8%
Hospital/medical center	3%	6%
Psychiatric hospital	14%	8%
Health clinic	8%	8%
Behavioral health clinic	19%	21%
Social service agency	14%	4%
Nursing home	5%	0%
Criminal justice agency/court	5%	1%
Other	27%	13%

Like MSWs, the role most commonly performed by virtually all BSWs in the sample was the provision of direct services to clients (98% and 95%). It was also the role they were most likely to perform 20 hours per week or more (59% and 58%). However, the tasks these two groups perform varied, as seen below.

Table 2. Percentages of Mental Health BSWs and MSWs Performing Selected Tasks

	BSW	MSW
Information/referral	84%	72%
Crisis intervention	81%	69%
Screening/assessment	76%	77%
Treatment planning	70%	76%
Case management	68%	47%
Client education	68%	57%
Individual counseling	62%	78%
Home visits	57%	17%
Advocacy	51%	23%
Discharge planning	51%	34%
Medication adherence	49%	36%
Program development	43%	28%
Family counseling	38%	55%
Group counseling	35%	33%
Psychoeducation	32%	60%
Supervision	32%	28%
Program management	30%	25%
Psychotherapy	19%	74%
Couples counseling	11%	50%

The profile of client problems differed between BSWs and MSWs. BSWs were more likely to report serving “many” clients with mental health (87% versus 62%) and substance abuse problems (37% versus 29%), while MSWs were more likely to report serving “many” with affective conditions (58% versus 39%). BSWs were more likely to serve older adults than MSWs in Mental Health (23% versus 7%). Their clients were more likely receive health coverage through Medicaid (67% versus 32%), and notably, none were covered through private insurance.

BSWs were most likely to work full time for one employer (75%). Nineteen percent worked for multiple employers in social work, and 6% worked part time. The median salary of full time BSWs in Mental Health working for one employer was \$34,307, as compared to a median of \$50,681 for MSWs in Mental Health. These BSWs were less likely to see their compensation as very adequate, as compared to MSWs (7% versus 17%).

BSWs were more likely than MSWs to work in job settings where non-social workers were hired to fill social work roles (36% versus 29%), but were less likely to report that vacancies were difficult to fill in their agencies (16% versus 26%), and less likely to report that social work functions were outsourced (7% versus 18%). BSWs did not differ from MSWs in their reports that vacancies in their agencies were common (24% versus 23%). They were much more likely to report job safety issues in their jobs (70% versus 43%), though there were no differences in the percent of those reporting job safety issues who said that their issues were adequately addressed (73% of BSWs and 70% of MSWs).

BSWs were more likely than MSWs to report experiencing negative changes in practice in the past two years, including increases in paperwork (91% versus 73%), severity of client problems (74% versus 68%), caseload size (71% versus 65%), waiting lists for services (67% versus 57%), and level of oversight (61% versus 55%).

BSWs were less likely than MSWs in Mental Health to plan to remain in their jobs (57% versus 72%). The most common reasons BSWs reported for consideration of potential job changes were higher salary (84% versus 70% for MSWs), job stress (51% versus 33%), and lifestyle/family concerns (43% versus 55%).

Appendix B. Methodology

Data were collected from 4,489 licensed social workers from 48 states and the District of Columbia through a mailed survey instrument. These responses resulted from surveys distributed to a stratified random sample of 10,000 licensed social workers across the U.S. Details of the sampling procedure are provided below.

Survey design. The design of the instrument was informed by extensive interviews and focus groups with practicing social workers, including a number of social workers specifically drawn from the areas of Child Welfare/Family Social Work, Aging, and Behavioral Health.

The core survey had four sections: **Background**, which included questions on demographics and education/training; **Social Work Practice**, which included questions on hours worked, roles, setting, practice area, and salary; **Services to Clients**, which included questions on tasks and caseload; and **Workplace Issues**, which included questions about changes in the practice of social work, satisfaction, and career plans.

Additionally, special supplements were included in the instrument for social workers who serve older adults (age 55 and older) or children and adolescents (age 21 or younger). These supplements gathered more detailed information on working with these populations.

Sampling and survey administration. A database was constructed from approximately 255,000 names of licensed social workers from state licensure and registration lists. These lists included anyone credentialed by the state as a social worker, regardless of whether the state title was licensed social worker, certified social worker, registered social worker, or any other. The master list was then presented to an address-cleaning service to obtain updated address information.

The list was then stratified by Census division. The U.S. Bureau of the Census recognizes nine such divisions: New England, Middle Atlantic, East North Central, West North Central, South Atlantic, East South Central, West South Central, Mountain, and Pacific. The purpose of the stratification was to draw equal-sized samples from regions of the country that are both heavily and sparsely populated. This strategy resulted in a sample in which social workers in less-populated divisions were overrepresented, which was desirable because it allowed large enough samples from each division to permit meaningful analysis of regional and rural/urban differences.

A random sample of 9,999 social workers was drawn from this master list (1,111 from each of the nine Census Divisions). The sample was then analyzed for duplicate names, which were eliminated and replaced with other randomly selected names from the same Census division.

Table 3 shows that the final sample represented approximately 4% of the master list. However, this represented very different proportions of the social workers in each division -- from 8% of social workers in the East South Central division to 2% of social workers in the South Atlantic division.

Table 3. Sampling Rates for Census Regions for 2004 Licensed Social Worker Survey

Census Region	Total number	Percent	Number	Percent of total
New England	14,436	5.67	1,111	7.7%
Middle Atlantic	25,267	9.93	1,111	4.4%
East North Central	57,174	22.46	1,111	1.9%
West North Central	24,904	9.78	1,111	4.5%
South Atlantic	56,265	22.11	1,111	2.0%
East South Central	13,974	5.49	1,111	8.0%
West South Central	25,040	9.84	1,111	4.4%
Mountain	15,595	6.13	1,111	7.1%
Pacific	21,859	8.59	1,111	5.1%
Total	254,514	100	9,999	3.9%

Because many of the addresses were no longer valid, a number of surveys in the first mailing were returned undelivered. A supplementary sample was drawn to replace surveys that were returned undelivered in the first few weeks of the mailing cycle. The replacement sample was matched by Census division to the undeliverable addresses, and a total of 692 additional surveys were sent as part of the replacement sample.

Three mailings were sent to the social workers in the sample. The first mailing generated most of the valid responses (57%), although a third of the responses were generated by the second mailing (32%). Approximately one in ten (11%) of the responses resulted from the third mailing. One Census division, East North Central, only received two mailings due to a database error, although the overall response rates for this division were similar to others. Each mailing offered responses an opportunity to participate in a lottery drawing for varying amounts of money: \$1,000 for the first mailing, \$500 for the second mailing, and \$250 for the third mailing. Respondents who returned their surveys were eligible for each subsequent drawing.

Table 4. Response Patterns by Mailing

Mailing	Number	Percent of responses
First	2535	57%
Second	1445	32%
Third	510	11%

Response rates varied by Census division, with the highest response rate in the Middle Atlantic (53%) and the lowest in the South Atlantic (46%).

Table 5. Response Rates by Census Division

Census Division	Total -- all mailings			Response rate
	Responses	Removals	Total surveyed	
New England	476	273	1,261	48.2%
Middle Atlantic	564	115	1,183	52.8%
East North Central	471	197	1,204	46.8%
West North Central	488	113	1,067	51.2%
South Atlantic	469	190	1,205	46.2%
East South Central	501	173	1,200	48.8%
West South Central	504	62	1,135	47.0%
Mountain	521	198	1,202	51.9%
Pacific	495	210	1,191	50.5%
Total	4,489	1,531	10,648	49.2%

Survey analysis. Our strategy for analysis centered on variation by demographics, degree, and sector. Subsequent reports will analyze the data in more detail by practice area and setting. Only data from active social workers were used in the analyses unless otherwise specified.

A number of variables used in these analyses were created from the survey data. “**Active**” status was defined as working either a full time or a part time job in social work. “**Sector**”, which was asked in detail, was grouped into four categories: public sector (which included federal, state, and local government and military), private non-profit, private for-profit other than private practice, and private practice. Social workers were asked to indicate all degrees they held in both social work and another field. **Highest social work degree** was the most advanced of the social work degrees indicated, although some respondents held a higher degree in another field than they did in social work.

Age and income were asked as categorical variables, but an estimation procedure was used to assign exact values from within each category randomly to each respondent in that category. This procedure allows some statistical procedures, such as the estimation of mean values and the use of regression analysis, which would not be possible with categorical data. This procedure also allowed the calculation of an “**age at entry**,” which was defined as the estimated age of respondents in the year in which they reported receiving their first social work degree: the BSW (if applicable), or the MSW (if they did not hold a bachelor’s degree in social work). Age at entry could not be calculated for licensed social workers who did not hold a BSW or MSW.

Data limitations. Although these data represent an important contribution to knowledge of licensed social workers, there are a number of important limitations which need to be recognized. Perhaps the most serious of these is that the data are not generalizable to non-licensed social

workers, who may perform different functions and serve different populations. This lack of generalizability may be particularly important to two groups of social workers who are likely to be underrepresented among licensees: BSW-level social workers, who are not eligible to become licensed in many states; and social workers, who are not required to hold licenses. When statements are made about the percentage of social workers doing policy development, for example, the word “licensed” should always be understood even if not explicitly stated.

There is also the potential for some response bias even within the universe of licensed social workers. NASW members may have been more likely than other social workers to respond to the survey, which featured the NASW name and logo prominently. Also, because much of the instrument concentrated on the provision of direct services, social workers working in other capacities may have been less likely to feel that the survey was relevant to their work.

Another shortcoming of the data for the purposes of analyzing employment-related trends such as supply, demand, and turnover is that there is no data on the previous jobs held by social workers. It is therefore not possible to reliably estimate whether social workers are leaving certain sectors, settings, or practice areas for others.

A final caveat is that some data were collected on both primary and secondary employment: sector, setting, practice area, and caseload. This was intended to capture information about multiple jobholders, but subsequent analyses showed that most social workers who offered information about both primary and secondary employment only reported holding one social work job. Presumably, these social workers reported what they felt to be the second-most fitting information for their first job under “secondary.” For example, if they worked only one job treating addicted teenagers they may have indicated that the “primary” practice area was Addictions and that their “secondary” practice area was Adolescents. Due to this apparent misunderstanding of the survey instructions, data on secondary employment was not deemed valid for analyses of multiple jobholders, except (cautiously) when more than one social work job was indicated by the respondent.