Dismantling Structures That Impede Clinical Social Work Practice: Exploring the Relationship Between Hours of Supervised Experience and Licensure Violations

Dianna Cooper-Bolinskey

Abstract: *The current study examined the relationship between pre-licensure supervised experience requirements and license violations in order to ascertain whether jurisdictions requiring higher numbers of hours of supervised experience to obtain clinical social worker (CSW) licensure had fewer violations. The purpose of the study was to explore if there is a measure of "enough" supervised experience without compromising protection of the public. Three data files were used to complete the study: National Practitioner Data Bank (NPDB), Association of Social Work Boards (ASWB)'s Supervision Requirements per Jurisdiction Data, and ASWB's U.S. Social Work Licensee Data. Results indicated that jurisdictions requiring less than 4,000 hours of supervised experience reported fewer violations than would be expected, whereas jurisdictions requiring 4,000+ hours of supervised experience reported more violations than would be expected given the number of CSWs within the respective groups. Results question the practice of requiring higher amounts of supervised experience as a regulatory standard. Implications for social work regulation include support for nationally standardizing the required amounts of supervised experience outlined by Groshong (2011) and the ASWB (2018) Model Social Work Practice Act.*

Keywords: *Clinical social work, regulation, supervised experience requirements, violations*

Clinical social workers (CSWs) are regulated in every U.S. jurisdiction. The basic requirements for obtaining initial clinical licensure in each jurisdiction are similar and include earning a Master of Social Work (MSW) degree from a Council on Social Work Education (CSWE) accredited program, completing an application, paying an application fee, passing a specific Association of Social Work Boards (ASWB) examination, and acquiring post-degree supervised experience. However, there are some variations in requirements among jurisdictions; the more notable difference is the number of required hours of supervised experience, which ranges from 1,500 to over 5,000 hours.

The lack of consistent standards for licensure affects CSWs' abilities to practice through unnecessary delays in obtaining licensure, cost (Kleiner, 2006), and limits of practice portability (ASWB, 2021). Practice portability includes practitioner relocation to another state, practicing across jurisdictional borders, or virtual practice (ASWB, 2021). Examples of limits to CSW portability include veterans and spouses of veterans who relocate often, individuals who live near jurisdictional borders and practice in multiple jurisdictions concurrently, and experienced professionals who move across jurisdictions in life transitions. Establishing nationally standardized supervised experience requirements

Dianna Cooper-Bolinskey, DHSc, MSW, ACSW, LCSW(IN), LCAC(IN), Associate Professor, Carver School of Social Work, Campbellsville University, Campbellsville, KY.

facilitates portability. Although supervised experience requirements are not the only limiting variable on portability, they certainly represent one substantial barrier.

The current study reviews the broader context of CSW licensing requirements and explores the relationship between supervised experience requirements and CSW practice violations. The study used data from the U.S. Department of Health and Human Services' (USDHHS) National Practitioner Data Bank (NPDB; USDHHS, 2019) to review licensure violations by CSWs by jurisdiction. The study explored the relationship between jurisdictions' required number of hours of supervised experience (ASWB, 2019a) (categorized), number of licensed CSWs (ASWB, 2019b) (categorized), and cases of violations recorded in the NPDB.

Literature Review

There is a relative dearth of literature related to social work regulation and when the focus is narrowed to CSW practice the resultant literature is even more sparse. This serves as further evidence of need for more research on the effectiveness of social work regulation (Bibus & Boutté-Queen, 2011; Grise-Owens et al., 2016). A review of the extant literature can provide a basic context for understanding the need for the current study, its results, and its implications for regulating CSW practice.

Brief History of Social Work Becoming a Regulated Profession

Social work roots reach back into the days of 1910 when Jane Addams and Mary Richmond formed the National Federation of Charities and Corrections, later renamed the National Conference of Social Welfare (Groshong, 2011). Social workers were referred to as "friendly visitors," reaching out from faith-based organizations, to assure the well-being of children. Clinical social work emerged in the 1930s with a shift in focus to treating veterans returning from combat (American Board of Examiners in Clinical Social Work [ABECSW], 2018; Groshong, 2011). Although many different scopes of social work practice have emerged, clinical social work has consistently grown.

Social work was not readily recognized as a profession. According to Bibus and Boutté-Queen (2011), "Physicians were regulated in every state by 1900, teachers by 1930, and attorneys and dentists by 1940" (p. 8). Arne (1952) stated that as of the 1950s, additional regulated professions included medicine, engineering, pharmacy, nursing, and chemistry. Psychologists were regulated in all jurisdictions by 1977.

The first documented conversation of licensing social workers was in 1920 in California (Arne, 1952). Samuel Goldsmith presented a paper to the National Conference of Social Work in Minneapolis in 1931, proposing the regulation of social work (Bibus & Boutté-Queen, 2011). Social work was actually first regulated in Puerto Rico in 1934, but most jurisdictions did not know about it until much later (Bibus & Boutté-Queen, 2011; CSWE, 2018). The California Conference of Social Work worked with the legislature to establish regulation through Registered Social Workers (RSW) in 1945 (Bibus & Boutté-Queen, 2011; CSWE, 2018). The Council on Social Work Education (CSWE) was created in 1952 as the accrediting body for social work programs (Dyeson, 2004). The National

Association of Social Workers (NASW) was founded in 1955 and was responsible for creating and evolving the Code of Ethics (NASW, 2021) as well as advocating on behalf of practicing professional social workers (Dyeson, 2004). California passed new legislation in 1968 that formalized the first known regulation of CSWs (Goldstein, 1996). By the early 1970s schools of clinical social work were emerging, creating expanded practice specialties (ABECSW, 2018). In 1974, NASW issued a policy statement calling for the regulation of social work practice (ABECSW, 2018; Grise-Owens et al., 2016). In response to this call, ASWB was formed in 1978 as a non-profit organization whose focus was on regulation (ABECSW, 2018). ASWB began administering licensing exams in 1983 (ABECSW, 2018). The 1970s and 1980s were an active time for developing regulatory statutes; 13 jurisdictions established professional regulation of social work in the 1970s and 24 jurisdictions did so in the 1980s (Groshong, 2011). Some jurisdictions only regulated the master level of practice, some required two or three years of full-time supervised training, and passing the clinical exam while other jurisdictions required anyone working in the field of social work to be licensed (Dyeson, 2004).

Licensing Clinical Social Work

California licensing statutes in 1968 were among the first to formalize use of the title of CSW (Goldstein, 1996). By the 1970s, the drive for CSWs to become licensed increased with the need for access to reimbursement for mental health services (Bibus & Boutté-Queen, 2011). In 1976, NASW recognized CSWs by issuing a Registry of Clinical Social Work (Goldstein, 1996). NASW recognized CSWs as "those who, by education and experience, were qualified at an autonomous level of practice to provide direct, diagnostic, preventive, and treatment services to individuals, families, and groups …" (Goldstein, 1996, p. 92). This demand resulted in all fifty states establishing CSW licensing by 1992 (Bibus & Boutté-Queen, 2011). Groshong (2011) reported that CSWs were the largest professional group providing mental health services in the U.S. Further, the NASW Workforce Study reported that most CSWs were in private practice or working within for-profit agencies (29%), private non-profit agencies (42%), and public agencies (28%) (Groshong, 2011).

Tosone (2016) compared definitions of CSW as defined by NASW, CSWE, and ABECSW. Tosone (2016) explained that the ABECSW definition was perhaps most fitting, due to its focus on mental health practitioners who were educated in graduate school and trained under the supervision of an experienced social worker in order to develop mastery of key skills in serving people of all ages and backgrounds.

Regulation as a Means of Public Protection

Prior to the establishment of licensure laws, professional regulation had been occurring through professional organizational membership, primarily through NASW, and through public agency supervision (Bibus & Boutté-Queen, 2011). The NASW Code of Ethics served as the standard for professional review; NASW Chapter Committees on Inquiry served as the reviewers of behavior (Berlinger, 1989). The committee used a three-level adjudication process that was executed using a peer review model.

According to Arne (1952), in 1945, the public demanded professional competence of professionals who served them. State governments fulfilled the need by administering licensing and examination boards who set minimum standards and qualifications. In California, a seven-member board was created to regulate social work. Members were appointed by the governor to four-year terms. Standards included applicants completing at least one year of full-time graduate study from an approved school of social work and passing a written exam. The 1950s also brought forth the notion of qualifying professional exams and the establishment of hearings for professional misconduct. Minimum educational requirements were also raised.

The Supervised Experience Requirement

Bibus and Boutté-Queen (2011) reported that older professions, such as medicine, evolved from requiring no specialized formal training to establishing standards requiring at least two years of premedical college training. Goldsmith proposed that social work follow suit. Supervised experience was considered necessary for less advanced practitioners to develop their identity and to develop skills needed to practice effectively (ABECSW, 2018; Gray, 1990). Since the beginning of social work practice in the early 1900s, neophyte practitioners relied on the guidance and supervision of the more experienced (ABECSW, 2018; Hardcastle, 1977).

CSWs are required to complete an MSW, then be employed for at least two years in intensive post graduate supervision to qualify to practice autonomously (ABECSW, 2018; Gray, 1990). Hoffman (2002) explained the complexities that developed over time, including defining hours of supervision, individual vs group supervision, hours of supervised experience (hours vs years), and credentials of qualified supervisors. Emphasis on standards of supervised experience have evolved and were further developed in the NASW & ASWB (2013) Best Practices in Social Work Supervision.

National Practitioner Data Bank

The USDHHS (2011) maintains the NPDB which is essentially a collection of data about violations by health care practitioners. The NPDB collects information about malpractice, disciplinary actions, and board sanctions and reports the confidential data to hospitals, health care facilities, and state and federal agencies. These data are collected by authority of the NPDB statute 42 U.S.C. § 11137 (USDHHS, 2011).

The USDHHS provides access to the NPDB Public Use Data File (PUDF) to the public through the NPDB website, though individually identifying information is not published. The NPDB was created in 1986; the current version of the PUDF holds data relevant to 54 variables on 1.42 million cases (USDHHS, 2019). Examples of the variables include record type (board sanctions, malpractice claims, etc.), year of report, practitioner demographics and work state, state of license, age group of practitioner, malpractice allegation group, specific allegations, severity of malpractice injury, payment amount, age group of patient, gender of patient, adverse action classification, basis for action, adverse action length of penalty, number of licensure reports, number of exclusion reports, number of government

administrative reports, number of contract termination reports, and state patient compensation (USDHHS, 2019).

The NPDB fulfills a great purpose, but as with most data sources, it is not without fault. Boland-Prom et al. (2015) reported that 46 of 50 state boards regulating CSWs were in compliance with the federal mandatory reporting statutes. Boland-Prom (2009) also reported that there are discrepancies in data between state board reports and results in the NPDB.

Licensure Violations in Clinical Social Work

ASWB (2011) stated that social work boards were empowered to regulate social work practice within the jurisdiction by imposing disciplinary sanctions. Some boards function in a public forum while others utilized closed sessions. National level data about licensure violations, sanctions, and board actions can be nearly impossible to access.

As a matter of benchmark data relevant to the current study, three studies discussed ethical (not licensure) violations. NASW's Chapter Commission on Inquiry (COI) review of ethical behavior was a precursor to jurisdictional board regulation of violations. Since there is relatively no literature of this nature, this section is reviewed to help formulate some context for the study.

Berlinger (1989) reported that the NASW Chapter COI reviewed individual cases between 1979-1985. The committee reported 292 cases on file; 34 of the 55 chapters had filed at least one complaint. Of the cases reviewed, 41% were determined to have substantiated claims and three fourths of the cases had more than one issue. Kleiner (2006) stated that during a 22-year period between 1955 and 1977, a total of 154 complaints were processed; 40% were handled in two years (1976 and 1977). Boland-Prom (2009) reported on findings from five studies published by the NASW ethics committee. The report focused mainly on types of violations and changes in the types of violations over time; specific numbers of cases were not included in the article.

Current Study

This study explored the relationship between hours of supervised experience necessary to obtain CSW licensure and reported practice violations. Although jurisdictions requiring a higher number of supervision hours for licensure may have done so on the assumption that more is better, there has been no research examining whether this assumption is supported by evidence. The goal, then, was to examine whether increased supervision requirements are, indeed, associated with fewer licensure violation reports. If this were found to be the case, it would suggest that other states should adopt more rigorous pre-licensure supervision requirements as a potential public-safety measure. The failure to find such a relationship, however, could also have important public policy implications as it might suggest that increased supervision hours present an unnecessary burden on young professionals and may be viewed as an unfair restriction of trade. A corollary purpose of the study was to identify the measure of "enough" supervised experience necessary for safe

practice (i.e., without potentially compromising public protection) without placing an undue burden on developing professionals and their clinical supervisors.

Method

The study used three datasets: The NPDB PUDF as of December 2019 (USDHHS, 2019), ASWB's Supervision Requirements per Jurisdiction Data as of 2019 (ASWB, 2019a), and ASWB's U.S. Social Work Licensee Data as of 2019 (ASWB, 2019b). The basic premise of the study was that these three datasets would provide the relevant data needed to answer the research question, and then to fulfill the purpose of the study. As one might expect, some data cleaning was necessary to standardize measures for analysis.

The NPDB PUDF Data (USDHHS, 2019)

The NPDB PUDF contained 1,478,943 cases collected between September 1990 and December 2019. CSW is one of the 160 categories of professions/facilities listed in the databank, and included 12,621 cases (0.8% of total cases). Each U.S. jurisdiction included at least one case, indicating that all jurisdictions had reported violations. The highest percent of cases were against allopathic physicians (MD; 32.5%) with registered nurses (RN) having the second highest percent (17.6%). The nature of violations was included in the data file, but these data were not used in the analysis for this study. To give some context for the discussion later, the most common categories of allegations against CSWs were failure to comply with continuing education requirements (10.9%), other (not classified; 6.9%), unprofessional conduct (6.3%), criminal conviction (6.1%), practicing without a license or with an expired license (9.6%), and fraud (4.1%). Sexual misconduct was found in 3.4% of the cases.

Supervision Requirements per Jurisdiction Data (ASWB, 2019a)

The ASWB 2019 data file was used to record the number of required hours of supervised experience to become a licensed CSW, per jurisdiction. As with the other data sets, this one also required some adjustments for standardization. First, Iowa required supervised experience, but a specific number of hours was not defined, so it was omitted from the study. Next, four jurisdictions (AL, IN, MS, SD) defined "two years" or "24 months" of full-time supervised work experience, but other jurisdictions defined specific numbers of hours. For these jurisdictions, adjusted hours were calculated based on multiplying 40 hours per week, 50 weeks per year (accounting a reduction for paid time off), and two years to equal 4,000 hours. Jurisdictions defining associate or conditional CSW licenses with reduced numbers of hours (CA, IL, ME, NE, NC) were not categorized dually, just with the full CSW licensing requirements. The jurisdiction requiring the fewest hours of supervised experience was Florida (1,500 hours); the jurisdiction requiring the most hours of supervised experience was Louisiana (5,760 hours). Once standardized to hours of supervised experience, the categories were created for use in analysis as outlined in Table 1.

Table 1. *Categories of Supervised Experience*

		Jurisdictions	
Category	Hours	States	# (%)
1	<3,000	FL, IA, NY	3 (6%)
2	3,000-3,999	AK, AZ, CA, CO, CT, DE, DC, GA, HI, ID, IL, KS, KY, ME, MD, MA, MO, MT, NE, NV, NH, NJ, NM, NC, ND, OH, OR, PA, RI, SC, TN, TX, VT, VA, WI, WY	36 (71%)
3	4,000-4,999	AL, AR, IN, MI, MN, MS, OK, SD, AT, WA, WV	11 (22%)
4	5,000 >	LA	1 (2%)

U.S. Social Work Licensee Data (ASWB, 2019b)

To examine how well the observed distribution of reported violations for each category of supervision hours fits the expected distribution, it was necessary to know the number of CSWs per jurisdiction. ASWB collects data on licensed social workers in each jurisdiction, and their 2019 data file was used in this study. ASWB collects five categories of data, per jurisdiction, with one category being MSW (Clinical). ASWB received this data from licensing board reports, so there was no means of verifying numbers. As one might expect, there was some missing data, which was usually in the form of not separating social workers into each of the five reporting categories.

The MSW (Clinical) data were recorded for 45 jurisdictions; however, six jurisdictions (AL, CA, CT, IN, MI, WI) were missing data; as noted above, Iowa was omitted from these analyses due not having a specified number of required hours. For states that had missing or incomplete reporting, the number of CSWs was estimated from the available data. Table 2 shows jurisdictions and their actual data, from the ASWB data file. Alabama demonstrates the first adjustment necessary in the data file. Alabama's MSW (Other) number (1,681) was used to represent CSWs. For the other states (CA, CT, IN, MI, WI) that did not distinguish between clinical and non-clinical master's level social workers, an estimate based on the computed average of the CSWs among the total number of licensed social workers in the U.S. was used (41.9%). It is assumed the adjusted number is slightly lower than actual, but is representative overall.

Table 2. *ASWB U.S. Social Work Licensee Data*

Jurisdiction	**Non-SW**	**BSW**	**MSW (no exp.)**	**MSW (Clinical)**	**MSW (Other)**	**US**
(Total by category)	*6,963*	*58,188*	*186,673*	*208,204*	*36,919*	*541,116*
Alabama		1,906	1,736	*1,681*	1,681	7,004
Alaska		53	173	671		897
Arizona		106	2,640	2,562		5,308
Arkansas		428	1,099	2,031		3,558
California		15,743	26,978	*17,899*		60,620
Colorado			1,203	1,250	87	2,540
Connecticut				*4,004*	9,558	13,562
D. of Columbia		75	1,375	3,396	51	4,897

Jurisdiction	Non-SW	BSW	MSW (no exp.)	MSW (Clinical)	MSW (Other)	US
Delaware				967		967
Florida				15,122	19	15,141
Georgia			2,890	4,036		6,926
Hawaii		14	1,064	1,058		2,136
Idaho		1,061	1,299	1,685		4,045
Illinois		194	4,111	12,998		17,303
Indiana				*3,250*	7,756	11,006
Kansas	21	1,773	3,743	2,068		7,605
Kentucky		576	2,525	2,825		5,926
Louisiana		1,703	2,799	3,123		7,625
Maine	25	1,570	182	545	2,965	5,287
Maryland		553	4,275	9,341	318	14,487
Massachusetts	2,682	3,349	6,278	15,000		27,309
Michigan	1,313	5,112	22,253	*12,015*		40,693
Minnesota		6,072	2,955	6,125	745	15,897
Mississippi		1,788	1,115	909		3,812
Missouri		76	1,759	5,987		7,822
Montana		315		2,095		2,410
Nebraska		598	1,388	5,688		7,674
Nevada	78		1,820	1,008	18	2,924
New Hampshire				1,158		1,158
New Jersey		2,842	7,975	10,008		20,825
New Mexico		554	1,543	1,990		4,087
New York			29,339	28,205		57,544
North Carolina		80	177	11,365	11	11,633
North Dakota		1,577	389	414		2,380
Ohio	953		17,596	9,566		28,115
Oklahoma		18	421	1,704	41	2,184
Oregon		48	1,404	4,446		5,898
Pennsylvania			10,427	6,673		17,100
Rhode Island			594	1,869		2,463
South Carolina		702	2,380	1,486	85	4,653
South Dakota	122	300	263	397		1,082
Tennessee		581	3,006	2,934	267	6,788
Texas		5,298	10,612	8,316	309	24,535
Utah	1,257	725	1,354	3,952		7,288
Vermont			5	1,234		1,239
Virginia			739	6,458		7,197
Washington			1,909	4,417		6,326
West Virginia	512	2,308	751	535	309	4,415
Wisconsin				*5,320*	12,699	18,019
Wyoming		90	129	587		806

Following the estimations to fill in missing data, the study was completed using an estimated total of 252,373 licensed CSWs, which includes representation from every U.S. jurisdiction except Iowa.

Procedures

With each of the three data sets standardized, actual cases of violations were then computed, per jurisdiction (omitting Iowa), and within the categories of supervised experience requirements. Expected case counts for each jurisdiction were computed by multiplying the total number of cases (12,424) by that jurisdiction's proportion of the total estimated number of social workers derived above. For example, AZ had 2,562 reported CSWs, which was 1.02% of the actual total of CSWs; thus, the expected number of cases for AZ was 1.02% of 12,424, or 126.12. Table 3 demonstrates this calculation for all jurisdictions.

Table 3. *Expected # of Cases of Violations*

Jurisdiction	# CSWs	% of Total CSWs	Expected # Cases
Alabama	1681	0.67%	82.75
Alaska	671	0.27%	33.03
Arizona	2562	1.02%	126.12
Arkansas	2031	0.80%	99.98
California	17899	7.09%	881.13
Colorado	1250	0.50%	61.54
Connecticut	4004	1.59%	197.14
D. of Columbia	3396	1.35%	167.18
Delaware	967	0.38%	47.60
Florida	15122	5.99%	744.44
Georgia	4036	1.60%	198.69
Hawaii	1058	0.42%	52.08
Idaho	1685	0.67%	82.95
Illinois	12998	5.15%	639.87
Indiana	3250	1.29%	159.97
Kansas	2068	0.82%	101.80
Kentucky	2825	1.12%	139.07
Louisiana	3123	1.24%	153.74
Maine	545	0.22%	26.83
Maryland	9341	3.70%	459.85
Massachusetts	15000	5.94%	738.43
Michigan	12015	4.76%	591.49
Minnesota	6125	2.43%	301.53
Mississippi	909	0.36%	44.75
Missouri	5987	2.37%	294.73
Montana	2095	0.83%	103.13
Nebraska	5688	2.25%	280.01
Nevada	1008	0.40%	49.62
New Hampshire	1158	0.46%	57.01
New Jersey	10008	3.97%	492.68
New Mexico	1990	0.79%	97.97
New York	28205	11.18%	1388.49
North Carolina	11365	4.50%	559.48
North Dakota	414	0.16%	20.38

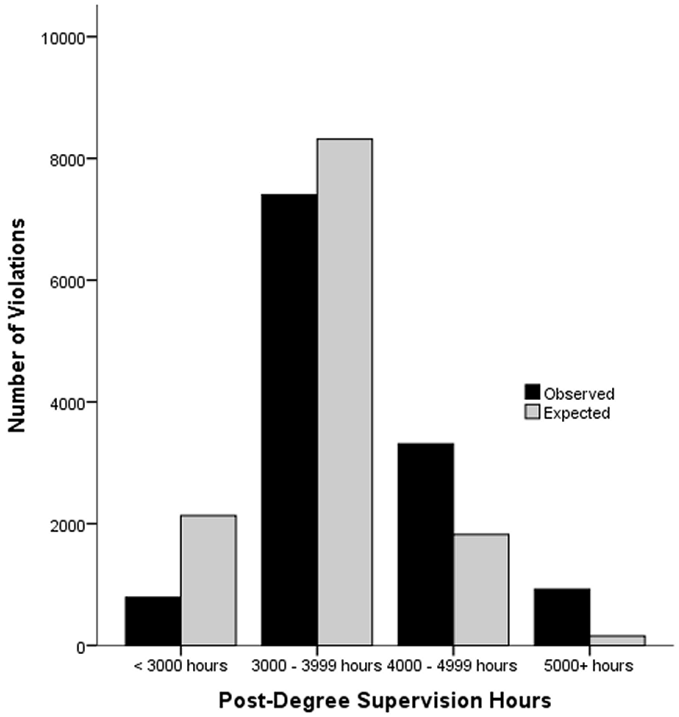
Jurisdiction	# CSWs	% of Total CSWs	Expected # Cases
Ohio	9566	3.79%	470.92
Oklahoma	1704	0.68%	83.89
Oregon	4446	1.76%	218.87
Pennsylvania	6673	2.64%	328.50
Rhode Island	1869	0.74%	92.01
South Carolina	1486	0.59%	73.15
South Dakota	397	0.16%	19.54
Tennessee	2934	1.16%	144.44
Texas	8316	3.30%	409.39
Utah	3952	1.57%	194.55
Vermont	1234	0.49%	60.75
Virginia	6458	2.56%	317.92
Washington	4417	1.75%	217.44
West Virginia	535	0.21%	26.34
Wisconsin	5320	2.11%	261.92
Wyoming	587	0.23%	28.90
Total	**252373**	**100.00%**	**12424.00**

The total numbers of expected cases for each supervision category were created by summing expected frequencies for each jurisdiction within each category as shown in Table 2. Calculations to standardize data were computed using Excel; SPSS was used to analyze the overall data for the study.

Results

Results of a χ^2 test for goodness of fit revealed that the distribution of observed violations by required hours of supervised experience differed quite substantially from the expected distribution, χ^2 (3) = 6016.5, $p < .001$. Given the unstructured nature of the source datasets, it was necessary to assure goodness of fit. Jurisdictions requiring less than 4,000 hours of supervised experience had fewer violations than would be expected, whereas jurisdictions requiring 4,000+ hours of supervised experience had more reported violations than would be expected given the number of CSWs within those respective groups. Further, the significance of this finding was not a statistical artifact of the large samples, as the effect size was large, $\varphi = .70$. A graph of the expected and observed distributions is shown in Figure 1.

Figure 1. *Expected vs Actual Violations, Categorized by Supervised Experience Hours*



Discussion

The first, and most obvious, point of discussion is that results indicated fewer actual than expected reported violations in the two categories encompassing less than 4,000 hours of supervised experience, as compared to the greater actual than expected violations in the two categories encompassing 4,000 or more hours. Although this result is the converse of what one might expect, it should be noted that it in no way implies that increased supervised experience causes increased practice violations, as any number of unmeasured factors may be associated with this relationship. However, it is important to explore possible explanations for this result. Obviously, there is not a clear explanation, but some assumptions can be made. It remains an assumption that the data are relatively representative, despite the fact that some estimation algorithms were used to standardize the data; the strength of the effect size and goodness of fit test support this notion.

One possible explanation for this result could be that the jurisdictions with higher-than-expected violations have laws that yield more violations than others, have more rigorous reporting requirements, or are more likely to follow reporting requirements of violations. This line of reasoning would suggest that the more stringent oversight of potential CSWs extends to more stringent oversight of actual CSWs. For the purposes of this study, however, this hypothesis cannot be tested as there are no known ways to compare the rigor of laws, or to verify jurisdictional reporting practices. Thus, this study operated on the

assumption that there is no relationship between reporting standards and required supervision hours among jurisdictions.

It is also possible, even probable, that there are some errors in the NPDB cases of violations data. The laws requiring that violations and misconduct data be reported to the NPDB were established in the Health Care Quality Improvement Act of 1986 and the NPDB began accepting data in 1990 (Boland-Prom, 2009; US DHHS Health Resources and Services Administration, 2018). It is possible that some more established jurisdictions began reporting sooner than others, so the records for those jurisdictions may be more comprehensive. The bottom line is that data regarding violations are difficult to obtain, and the NPDB data file is the best we have. When designing this study, ASWB was approached about using data from their Public Protection Database (PPD) and using the NPDB was recommended because multiple entities (hospitals, health plans, jurisdictional licensing boards, medical malpractice payers, and other healthcare entitles) are required by law to report. Reporting to the ASWB PPD is voluntary by jurisdictional boards.

The author recognizes that hours of supervised experience is an oversimplification of the relationship between supervision and licensure violations. Supervision involves many activities that affect the quality of the experience. It is beyond the scope of this study to explore quality and content of the supervisory experience itself.

The study was designed to explore the relationship between hours of supervised experience requirements and licensure violations. It is by no means suggested that supervision, whether higher or lower amounts of hours, better or lesser quality, or any other aspect of supervision causes licensure violations. Exploring the relationship was simply a way of considering if there is a "sweet spot" in the requirements, and if so, what it might be.

Limitations

Each of the three data files used to complete the study may have included errors, and each required some standardization in order to complete the study. Using expected numbers of violations compared to actual violations was not an exact science and left room for error. In spite of these extrapolations of data, the trends were real. The errors in estimations were not stronger than the trends seen in the results.

The study was created with an underlying assumption that violations equate to unethical practice that ultimately affects public protection. Under or over reporting of violations was a valid concern; however, there was no know way to control for this variable. Variables other than supervised experience affect practice violations. The scope of this study did not include this type of analysis.

Implications

An underlying assumption of the study was that higher amounts of required supervised experience would yield fewer practice violations. This assumption perhaps serves as an explanation for the range of supervised experience requirements among jurisdictions.

Results of this study do not demonstrate an association between higher amounts of required supervised experience prior to licensure as a CSW.

The discussion then shifts to the issue of "enough" supervised experience to support a safe level of practice. First, Florida (with 1,500 hours) and New York (with 2,000 hours) had notably fewer actual violations than expected. One might argue, then, that the data suggest that this represents "enough" supervision to adequately protect the public. Even though Florida measures direct contact hours, their defined hours requirements are low. Supervisees may get more hours, but this was not measured in the context of this study. However, it can also be seen that 4,000 hours of supervised experience is the point at which actual violations shifted above expected violations. Perhaps just under 4,000 hours of supervised experience is "enough." Interestingly, Groshong (2011) recommended 3,200 hours of experience in clinical social work in a supervised setting. The Model Social Work Practice Act (ASWB, 2018) outlined CSW eligibility criteria to include 3,000 hours of supervised clinical social work practice over a minimum two-year and maximum four-year period. One might interpret the results of this study as supportive of the hours of supervised experience suggested by both Groshong and the Model Social Work Practice Act.

Why should the profession of social work be concerned about this issue of required hours of supervised experience prior to licensure? With CSWs providing more mental health services than all of the other professions (psychologists, mental health counselors, and marriage and family therapists) combined (Groshong, 2011), the time required of an entry-level professional to obtain licensure has a direct impact on the availability of mental health care – especially in rural or traditionally underserved areas. Given the shortage in the workforce that provides mental health care, standardizing supervised experience requirements could result in shortened time to become licensed; the impact to individuals in need of care may include shorter wait times and more availability of care.

The amount of time it takes to get licensed has a meaningful effect on CSWs through limited employment options, as well as cost and time to complete supervised experience. Many employers only hire licensed CSWs because of the revenue stream generated with billable services. Employers who hire unlicensed CSWs may pay less or be more demanding. Some employers offer supervision that qualifies for licensure whereas others do not, leaving the CSW to seek and pay for supervision on their own. When in-house supervision is not available, some employers pay for external supervision, but this is not the usual practice. Private practice is usually reserved for licensed CSWs who can practice independently.

Supervised experience requirements also have an ongoing effect on CSWs, well after initial licensure is achieved. Active military members, veterans, spouses, and other individuals who relocate after earning licensure must deal with differing jurisdictional licensure requirements. These issues also affect CSWs who want to practice in multiple jurisdictions, including the current explosion of telehealth services that easily cross into many jurisdictions. As stated previously, the current range of required supervised experience spans 1,500 to over 5,000 hours. Some jurisdictions have provisions to support portability while others do not. For jurisdictions who do not have laws that support portability, the supervised experience requirements must be met in order to become

licensed. If a CSW completed supervised experience in a jurisdiction requiring fewer hours, then additional hours may be required to become licensed in another jurisdiction. This debacle can escalate, in some cases leaving a CSW with need for full-time employment to get supervised experience, as a new practitioner again.

ASWB and the Department of Defense are working with the Council on State Governments to create a social work compact at the same time this article is being published. Clearly, the issues are real, and the time is now. Dismantling the structures that support a broad range of supervised experience requirements is reasonably supported, timely, and relevant.

References

American Board of Examiners in Clinical Social Work. (2018). *Clinical supervision: A practice specialty of clinical social work.* https://www.abcsw.org/assets/Clinical%20Supervision.pdf

Arne, R. (1952). Protection of the public through licensing of social workers. *Social Work Journal*, 33(4), 184-190.

Association of Social Work Boards [ASWB]. (2011). *Guidebook for social work disciplinary actions.* https://www.aswb.org/wp-content/uploads/2021/01/ASWBDisciplinaryGuidebook.pdf

ASWB. (2018). *Model social work practice act*. https://www.aswb.org/wp-content/uploads/2020/12/Model-law-for-web.pdf

ASWB. (2019a). *Supervision requirements per jurisdiction data* (as of 2019) [Unpublished report]. ASWB.

ASWB. (2019b). *U.S. social work licensee data* (as of 2019) [Unpublished report]. ASWB.

ASWB. (2021). *Social work practice portability*. https://movingsocialwork.org/

Berlinger, A. (1989). Misconduct in social work practice. *Social Work, 34*(1), 69-72. https://www.jstor.org/stable/23715623?seq=1#metadata_info_tab_contents

Bibus, A., & Boutté-Queen, N. (2011). *Regulating social work: A primer on licensing practice.* Lyceum Books, Inc.

Boland-Prom, K. (2009). Results from a national study of social workers sanctioned by state licensing boards. *Social Work, 54*(4), 351-360. https://doi.org/10.1093/sw/54.4.351

Boland-Prom, K., Johnson, J., & Gunaganti, G. (2015). Sanctioning patterns of social work licensing boards. *Journal of Human Behavior in the Social Environment, 25*, 126-136. https://doi.org/10.1080/10911359.2014.947464

Council on Social Work Education [CSWE]. (2015). *Educational policies and standards.* https://www.cswe.org/getattachment/Accreditation/Standards-and-Policies/2015-EPAS/2015EPASandGlossary.pdf

CWSE. (2018). *Curricular guide for licensing and regulation: 2015 EPAS curricular guide resource series. Sponsored by CSWE, ASWB, and NASW Assurance.*

https://www.cswe.org/getattachment/e8bf5aa1-4a57-4079-991a-a0544c359e52/CSWE-Licensing-Regulation-Curricular-Guide.pdf?lang=en-US

Dyeson, T. (2004). Social work licensure: A brief history and description. *Home Health Care Management and Practice, 16*(5), 408-411. https://doi.org/10.1177/1084822304264657

Goldstein, E. (1996). What is clinical social work? Looking back to move ahead. *Clinical Social Work Journal, 24*(1), 89-104. https://doi.org/10.1007/BF02189944

Gray, S. (1990). The interplay of social work licensure and supervision: An exploratory study. *The Clinical Supervisor, 8*(1), 53-65. https://doi.org/10.1300/J001v08n01_05

Grise-Owens, E., Owens, L., & Miller, J. (2016). Recasting licensing in social work: Something more for professionalism. *Journal of Social Work Education, 52*(1), 126-133. https://doi.org/10.1080/10437797.2016.1174641

Groshong, L. (2011). *Clinical social work practice and regulation: An overview*. University Press of America, Inc.

Hardcastle, D. (1977). Public regulation of social work. *Social Work*, *20*(2), 14-20. https://doi.org/10.1177/002087287702000204

Hoffman, K. (2002). The basics of social work licensing. *The New Social Worker*, *Spring,* 28-30.

Kleiner, M. (2006). *Licensing occupations: Ensuring quality or restricting competition?* W. E. Upjohn Institute for Employment Research. https://doi.org/10.17848/9781429454865

National Association of Social Workers. (2021). *Code of ethics*. NASW Press. https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English

NASW & ASWB. (2013). *Best practices in social work supervision.* NASW Press. https://www.socialworkers.org/LinkClick.aspx?fileticket=GBrLbl4BuwI%3D&portalid=

Tosone, C. (2016). Clinical social work practice and education: What would Flexner think now? *Journal of Social Work Education, 52*(1), 28-37. https://doi.org/10.1080/10437797.2016.1174649

U. S. Department of Health and Human Services [US DHHS]. (2011). *Statement of the national practitioner data bank*. https://www.npdb.hrsa.gov/resources/publicDataStatement.jsp

US DHHS. (2019). *National practitioner data bank public use data file*. https://www.npdb.hrsa.gov/resources/PublicUseDataFile-Format.pdf

US DHHS Health Resources and Services Administration. (2018). *National practitioner data bank guidebook.* https://www.npdb.hrsa.gov/resources/aboutGuidebooks.jsp

Author note: Address correspondence to Dianna Cooper-Bolinskey, Campbellsville University, Carver School of Social Work, 1 University Drive, Campbellsville, KY 42718. Email: drcooper@cam-pbellsville.edu