Virginia Department of Health Professions
Board of Social Work

Agenda
Full Board Meeting
September 27, 2024
9960 Mayland Dr.
2nd Floor, Board Room 2
10:00 a.m.

10:00 a.m. Call to Order – Teresa Reynolds, LCSW, Chairperson

- Welcome/Introductions
- Establishment of a Quorum
- Mission of the Board/Evacuation Procedures---------- Page 3

- Adoption of Agenda

Public Comment

The Board will receive public comment related to agenda items at this time. The Board will not receive comment on any pending regulation process for which a public comment period has closed or any pending or closed complaint or disciplinary matter.

Approval of Minutes

July 12, 2025 Board Meeting* ---------- Page 5

Agency Director Report (Verbal Report) - Arne Owens

Chair Report (Verbal Report) – Teresa Reynolds

Presentation

"Virginia's Licensed Clinical Social Worker Workforce: 2024"

Yetty Shobo, Ph.D, Executive Director, DHP Healthcare Workforce Data Center

Barbara Hodgdon, Ph.D., Executive Director, DHP Healthcare Workforce Data Center

- Licensed Clinical Social Worker Workforce: 2024 Survey Findings---------- Page 9
- Virginia's Licensed Clinical Social Worker Workforce: 2024---------- Page 35
- Virginia's licensed Master's Social Worker Survey: 2024---------- Page 69

Legislation and Regulatory Report – Matt Novak, DHP Policy and Economic Analyst

- Chart of Regulatory Actions---------- Page 94
- Adoption of Proposed Regulations to Accept APA Approved Trainings as Continuing Education*---------- Page 95
- Provide Definition of "Generalist Social Work"*---------- Page 100
- Adoption of NOIRA for Social Work Compact*---------- Page 105

Committee Reports

- Ad Hoc Committee (Verbal Report) – Sherwood Randolph, LCSW, and Martha Meadows, LCSW

New Business

- LBSW Applicants with Pending Accreditation Status

Staff Reports

- Executive Director's Report – Jaime Hoyle, JD, Executive Director, Boards of Counseling, Psychology, and Social Work "BSU"
    - Social Work Licensure Compact Commission Meeting
        - Agenda Packet ---------- Page119
        - Meeting Minutes ---------- Page 180
    - Association of Social Work Boards (ASWB) Reports ---------- Page 188
        - Exam Report No. 1 ---------- Page 192
        - Exam Report No. 2 ---------- Page 222
        - Exam Report No. 3 ---------- Page 246
- Discipline Report – Jennifer Lang, Deputy Director, BSU ---------- Page 285
- Licensure Report - Charlotte Lenart, BSU----------Page 292

Meeting Dates

- 2025 Meeting Dates
- Next Full Board Meeting: December 20, 2024

- **Consideration of Recommended Decision***

- **Meeting Adjournment**

12:30 p.m. Formal Hearing

*Indicates a Board vote is required.

This information is in **DRAFT** form and is subject to change. The official agenda and packet will be approved by the Board at the meeting. One printed copy of the agenda and packet will be available for the public to view at the meeting pursuant to Virginia Code Section 2.2-3707(F).

Virginia Department of
Health Professions
Board of Social Work

MISSION STATEMENT

Our mission is to ensure safe and competent patient care by licensing health professionals, enforcing standards of practice, and providing information to health care practitioners and the public.

EMERGENCY EGRESS

Please listen to the following instructions about exiting these premises in the event of an emergency.

In the event of a fire or other emergency requiring the evacuation of the building, alarms will sound. When the alarms sound, leave the room immediately. Follow any instructions given by the Security staff.

Board Room 1

Exit the room using one of the doors at the back of the room. (**Point**) Upon exiting the room, turn **RIGHT.** Follow the corridor to the emergency exit at the end of the hall.

Upon exiting the building, proceed straight ahead through the parking lot to the fence at the end of the lot. Wait there for further instructions.

Board Room 2

Exit the room using one of the doors at the back of the room. (Point) Upon exiting the room, turn **RIGHT.** Follow the corridor to the emergency exit at the end of the hall.

Upon exiting the building, proceed straight ahead through the parking lot to the fence at the end of the lot. Wait there for further instructions.

You may also exit the room using the side door (**Point**), turn **Right** out the door and make an immediate **Left**. Follow the corridor to the emergency exit at the end of the hall.

Upon exiting the building, proceed straight ahead through the parking lot to the fence at the end of the lot. Wait there for further instructions.

Board Rooms 3 and 4

Exit the room using one of the doors at the back of the room. (**Point**) Upon exiting the room, turn **RIGHT.** Follow the corridor to the emergency exit at the end of the hall.

Upon exiting the building, proceed straight ahead through the parking lot to the fence at the end of the lot. Wait there for further instructions.

Training Room 1

Exit the room using one of the doors at the back of the room. (**Point**) Upon exiting the room, turn **LEFT.** Follow the corridor to the emergency exit at the end of the hall.

Upon exiting the building, proceed straight ahead through the parking lot to the fence at the end of the lot. Wait there for further instructions.

Training Room 2

Exit the room using one of the doors at the back of the room. (**Point**) Upon exiting the doors, turn **LEFT.** Follow the corridor to the emergency exit at the end of the hall.

Upon exiting the building, proceed straight ahead through the parking lot to the fence at the end of the lot. Wait there for further instructions.

Virginia Department of Health Professions
Board of Social Work

Virginia Board of Social Work
Quarterly Board Meeting Minutes
Friday, July 12, 2024, at 10:00 a.m.
9960 Mayland Drive, Henrico, VA 23233
Board Room 1

PRESIDING OFFICER: Canek Aguirre, Citizen Member, Board Chairperson

BOARD MEMBERS PRESENT:
Elke Cox, MSW, LCSW
Martha Meadows, MSW, LCSW
Denise Purgold, MSW, LCSW
Sherwood Randolph, MSW, LCSW *(attended remotely from Pennsylvania due to a scheduling conflict)*
Teresa Reynolds, MSW, LCSW

BOARD MEMBERS ABSENT:
Gloria Manns, MSW, LCSW
Ruth Ann Smulik, Citizen Member

BOARD STAFF PRESENT:
Jaime Hoyle, JD, Executive Director
Shaderra Jefferson, Licensing Specialist
Jennifer Lang, Deputy Executive Director- Discipline
Sharniece Vaughan, Licensing Supervisor

DHP STAFF PRESENT:
Arne Owens, Agency Director, Department of Health Professions (DHP)
Erin Barrett, JD, Director of Legislative and Regulatory Affairs, DHP
Matt Novak, Policy & Economic Analyst, DHP

BOARD COUNSEL PRESENT: James Rutkowski, Assistant Attorney General

PUBLIC ATTENDEES:
Mark Smith, The Virginia Public Access Project
Ophelia von Ludwig, LCSW, OVL, LLC
Kim Young, LCSW, Dope Black Social Worker
A.J. Thomas
Denise Daly Konrad, Virginia Health Care Foundation (VHCF)
Kevin Holder, LCSW, Richmond Association of Black Social Workers
Nicole Hillman, VCU MSW student

CALL TO ORDER: Mr. Aguirre called the Board Meeting to order at 10:03 am.

ROLL CALL/ESTABLISHMENT OF A QUORUM: An introduction was done of all board members and staff**.** Six members of the board were present at roll call; therefore, a quorum was established.

MISSION STATEMENT: Mr. Aguirre read the mission statement of the Department of Health Professions, which was also the mission statement of the board.

ADOPTION OF AGENDA: The agenda was adopted as presented.

PUBLIC COMMENT: **Discussion (HB606 House Bill 606 Price, Clinical Social Workers, Licensure Exam Alternatives)**
Kimberly Young provided public comment on HB606 and discussed an alternative to taking the exam for licensure. Ms. Young stated that she does not wish to eliminate the exam but would like other options to show competency.

APPROVAL OF MINUTES: The board reviewed the minutes from the last meeting held on November 3, 2023. Mr. Aguirre noted a change to reflect "Mr. Randolph" instead of "Ms. Randolph".

Motion: Ms. Reynolds made a motion to approve the minutes as amended. The motion was properly seconded by Ms. Cox and passed unanimously.

AGENCY REPORT: Mr. Owens welcomed all members of the board. He informed the board about the new security measures that have taken place at the Perimeter Center and how everyone entering the building must now go through a safety screening, which includes passing items through an x-ray machine and walking through a magnetometer.

Mr. Owens informed the board that the state budget was signed on May 13, 2024. He reminded the board that while the Department of Health Professions does not get its funding from the General Fund through the General Assembly, but rather through licensure fees, the General Assembly still must approve the DHP budget. The Agency is already preparing for the 2025 General Assembly.

Mr. Owens also informed the board that an internal salary study is being conducted by Gallagher to ensure that salaries are comparable to other state agencies.

BOARD CHAIR REPORT: Mr. Aguirre stated that it was an honor to work with the Board of Social Work for more than 8 years and thanked board members and staff for their hard work and dedication.

LEGISLATION & REGULATORY REPORT:

- **Chart of Regulatory Actions**
  Ms. Barrett reviewed the current regulatory actions for the Board of Social Work as of June 14, 2024. A copy of the chart was included in the agenda packet.

- **General Assembly Update**
  Ms. Barrett provided an update on the 2024 General Assembly bills.

- **House Bill 606**
  Ms. Barrett advised that his matter will be discussed in more detail later in the meeting but noted that the letter from Senator Favola does not request the formation of a workgroup.

- **Petition for Rulemaking: Sophia Stephenson (LPCs Providing supervision in ROS)**
  The board discussed the petition but did not find that the requested changes would be necessary or beneficial due to differing levels of supervision between the two disciplines, existing availability of LCSW supervisors, changes in technology which allow virtual supervision with greater ease, and the advisability of maintaining consistency with the requirements of the Council on Social Work Education.

  Motion: Ms. Purgold made a motion to take no action on the petition, which Ms. Cox properly seconded. The motion passed unanimously.

- **Amendment to Guidance Document 140-9**
  Guidance Document 140-9 lists the supervision training requirements for Licensed Clinical Social Workers in Virginia. Due to the recent changes, there is a need to amend the guidance document to align with the new regulations. The changes require supervisors, after completing the initial 14 hours of continuing education in supervision, to obtain 7 additional hours of continuing education in supervision

every 5 years.

Motion: Ms. Purgold made a motion, which Ms. Reynolds properly seconded, to amend Guidance Document 140-9. The motion passed unanimously.

- **Discussion regarding paid internships**

Ms. Cox stated that the availability of paid internships depends on the employing agency and their funding, as some agencies will pay for education. Ms. Reynolds added that hiring interns requires a lot of hands-on management. She further noted that paying interns can create blurred lines, as the intern is then considered an employee rather than being part of an education program. Mr. Aguirre noted his support of paid internships but agreed that the available funding varies between organizations. He inquired about the board's ability to sponsor paid internships.

EXECUTIVE DIRECTOR'S REPORT:

Ms. Hoyle advised that Mr. Aguirre and Ms. Manns will complete their second terms on the board as of June 30, 2024 but will remain as current board members until they are replaced. She further advised of a seat vacancy following Ebony Buggs' resignation. Ms. Hoyle congratulated Ms. Vaughan for her new role as Licensing Supervisor for the Board of Social Work.

Ms. Hoyle advised that she will not receive a completed budget for the board until the September 2024 meeting. Currently, the board has $2,104,000 cash on hand, versus last year's $2,338,000, but this does not reflect revenue from renewals.

The Virginia Board of Social Work has received more out-of-state applications due to recent changes in the regulations. Ms. Hoyle attended a workgroup in Maryland to provide them with a better understanding of Virginia's licensure process. She also mentioned the need for board members to attend the ASWB conference in San Diego, California in November. Also, there is an ASWB new board member training in Washington, D.C. that she highly recommends new board members attend.

DISCIPLINE REPORT:

Ms. Lang referred to the discipline report in the meeting agenda. She thanked board members who have worked with staff to review cases for probable cause and advised that she recently filled the part-time position for a licensed case reviewer. She will still need board members to review cases periodically if the reviewer has a conflict of interest in specific matters.

In addition to the case reviewer, Ms. Lang also contracted an Agency Subordinate for the board and has been given a new FTE position for discipline. The Agency Subordinate is a former board member, John Salay, who will hear cases at informal conferences. All the Agency Subordinate's recommended decisions will be presented to the board for their consideration and vote at subsequent board meetings. Ms. Lang is currently working on the recruitment process for the new discipline FTE, a position that will be shared by the three BSU boards.

For the three Behavioral Science boards combined, staff is working on 501 open cases, with 153 complaints in the investigative process.

LICENSING REPORT:

Ms. Lang provided the licensing report on behalf of Ms. Lenart and referred to the licensing data included in the meeting agenda. She congratulated Sharniece Vaughan on her promotion to Licensing Supervisor, a position left vacant after Latasha Austin accepted a new position with the Board of Counseling and said that staff is excited to have her in this new role. Ms. Lang also discussed the satisfaction surveys from the 3rd quarter being at 95.4% which is higher than last quarter's 94.8%. The board

has a total of 16,200 active licenses and registrations in Virginia. From January 2024-May 2024, there have been 1,276 licenses and registrations issued.

COMMITTEE REPORTS:

Ad Hoc Committee
Mr. Randolph asked about the Ad Hoc Committee as he is now the only member of this committee since Ebony Bugg resigned.

SOCIAL WORK COMPACT:

Compact Commissioner
Ms. Hoyle advised that the General Assembly passed the Social Work Compact and that Virginia was one of the first 7 states to join. Currently, there are 20 states that have joined the compact. The Board discussed the requirement to appoint a Compact Commissioner and a Temporary Representative to attend meetings on the Commissioner's behalf when necessary.

Motion: Ms. Cox made a motion, which Ms. Reynolds properly seconded, to elect Jaime Hoyle as Commissioner and Jennifer Lang as the Temporary Representative. The motion passed unanimously.

NEW BUSINESS:

House Bill 606
The board discussed House Bill 606 and opined that further research is needed to include in the report, specifically pass rates based on race, use of antibias measures, any action the board has taken to increase diversity, the board's capacity to manage alternative pathways, alternative measures for oversight if the exam is eliminated, and a review of what other boards are doing to determine if the same actions can work in Virginia. Ms. Hoyle will reach out directly to CSWE, Dr. Stacey Hardy-Chandler with ASWB, social work programs, and other stakeholders for information. The board will form a subcommittee to address these issues on an ongoing basis but because of the tight timeframe for the report, the Committee will not have much opportunity to provide any immediate support for the report. Ms. Barrett reminded everyone that the board does not have control or jurisdiction over the educational programs.

Ms. Hoyle stated that she will complete a draft by the end of September to allow for agency review and approval. In addition, Ms. Barrett stated that the executive branch must approve the report prior to the November 1, 2024 deadline.

ELECTIONS:

Chairperson
Ms. Cox nominated Teresa Reynolds for the board chairperson position. With no other nominations submitted, Ms. Reynolds was elected by acclamation.

Vice-Chairperson
Ms. Reynolds nominated Elke Cox for the board vice-chairperson position. With no other nominations submitted, Ms. Cox was elected by acclamation.

NEXT MEETING DATES: The next meeting is scheduled for Friday, September 27, 2024.

ADJOURNMENT: Mr. Aguirre adjourned the meeting at 11:13 a.m.

_____
Canek Aguirre, Citizen Member, Chair

_____
Jaime Hoyle, JD, Executive Director

Virginia Department of
Health Professions

Licensed Clinical Social Worker Workforce: 2024 Survey Findings

Yetty Shobo, PhD
Director, Healthcare Workforce Data Center
and Data Analytics Division
Board of Social Work Meeting
September 27th, 2024

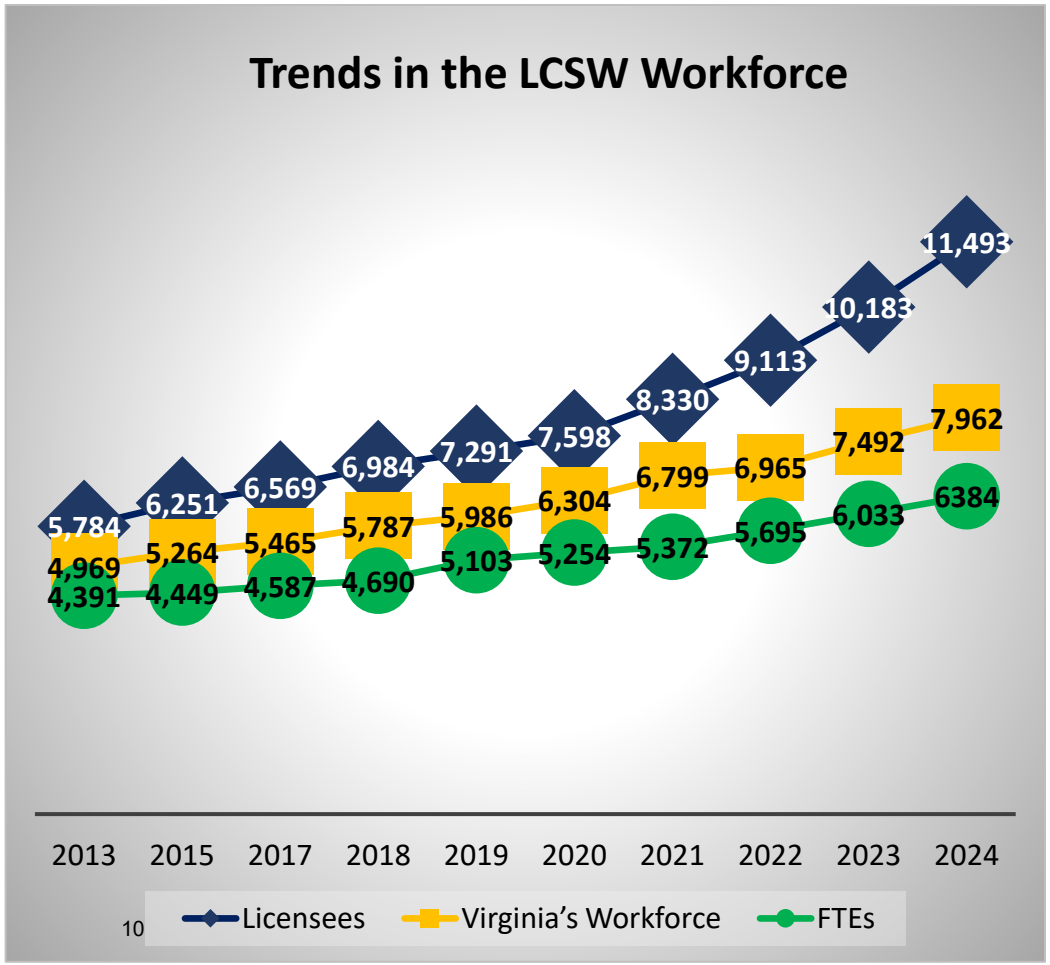
Virginia Department of
Health Professions

Trends in Licensees and Workforce

Increase in total licensees

Increase in VA's workforce

Increase in total FTEs



Virginia Department of
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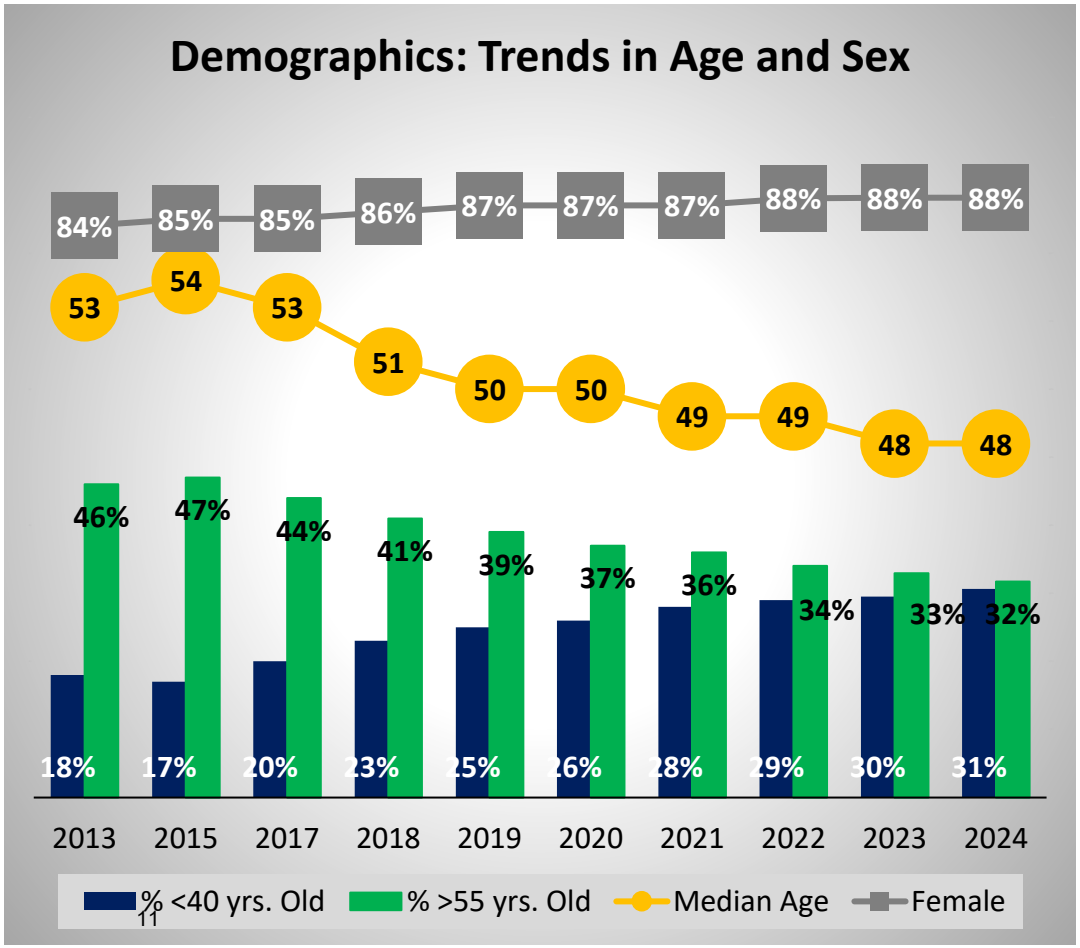
Trends in Demographics

Majority female workforce

Median age at 48 since 2023

Increase in % under 40 since 2015



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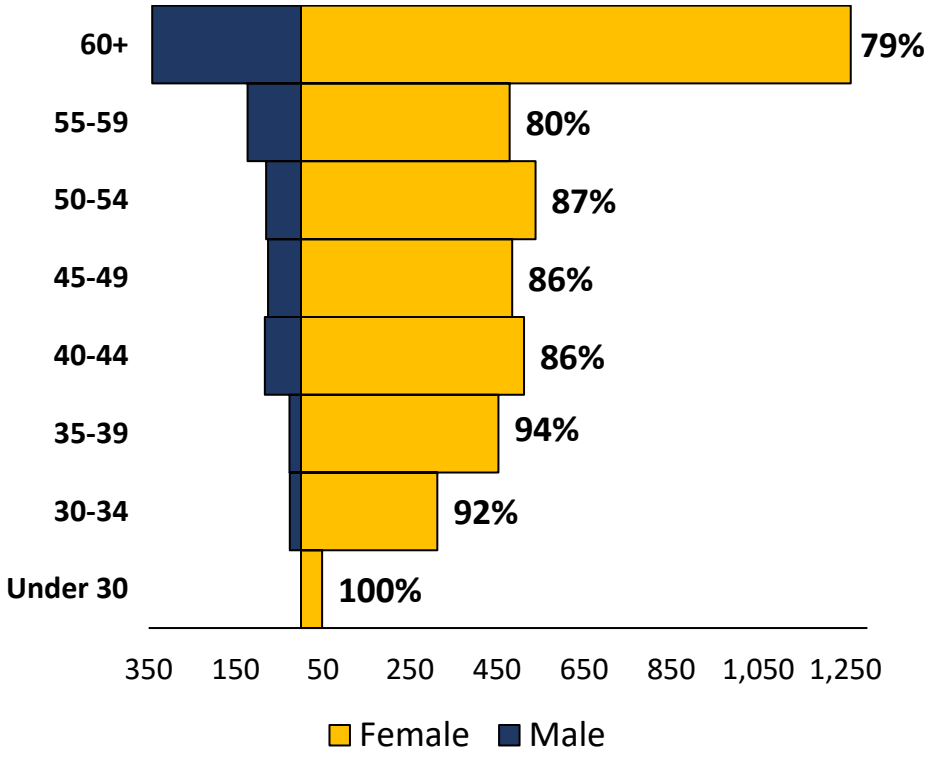
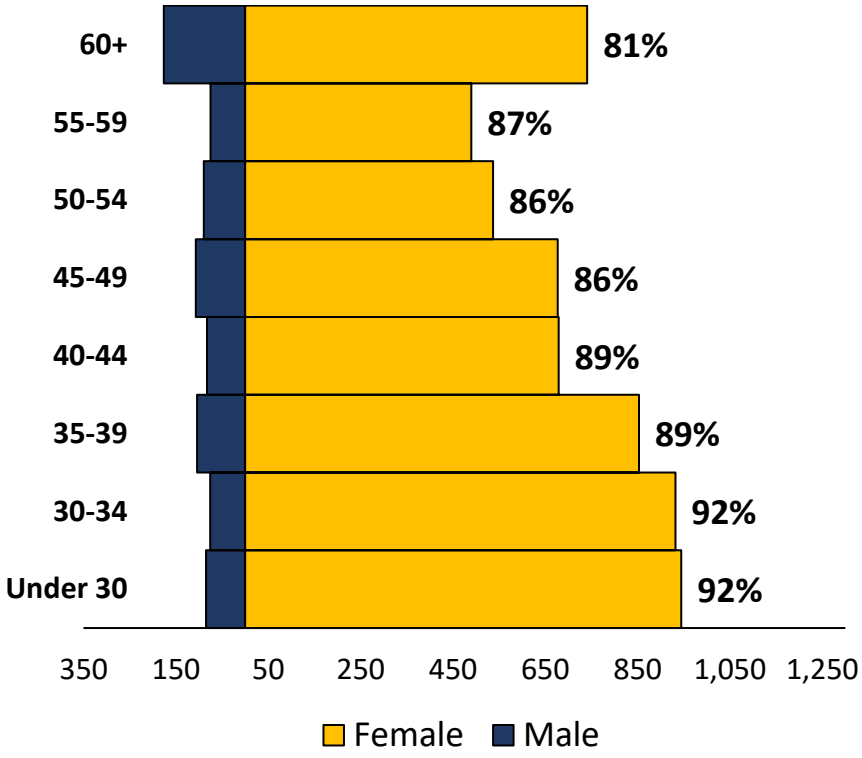
2013 LCSW Population Pyramid



2024 LCSW Population Pyramid



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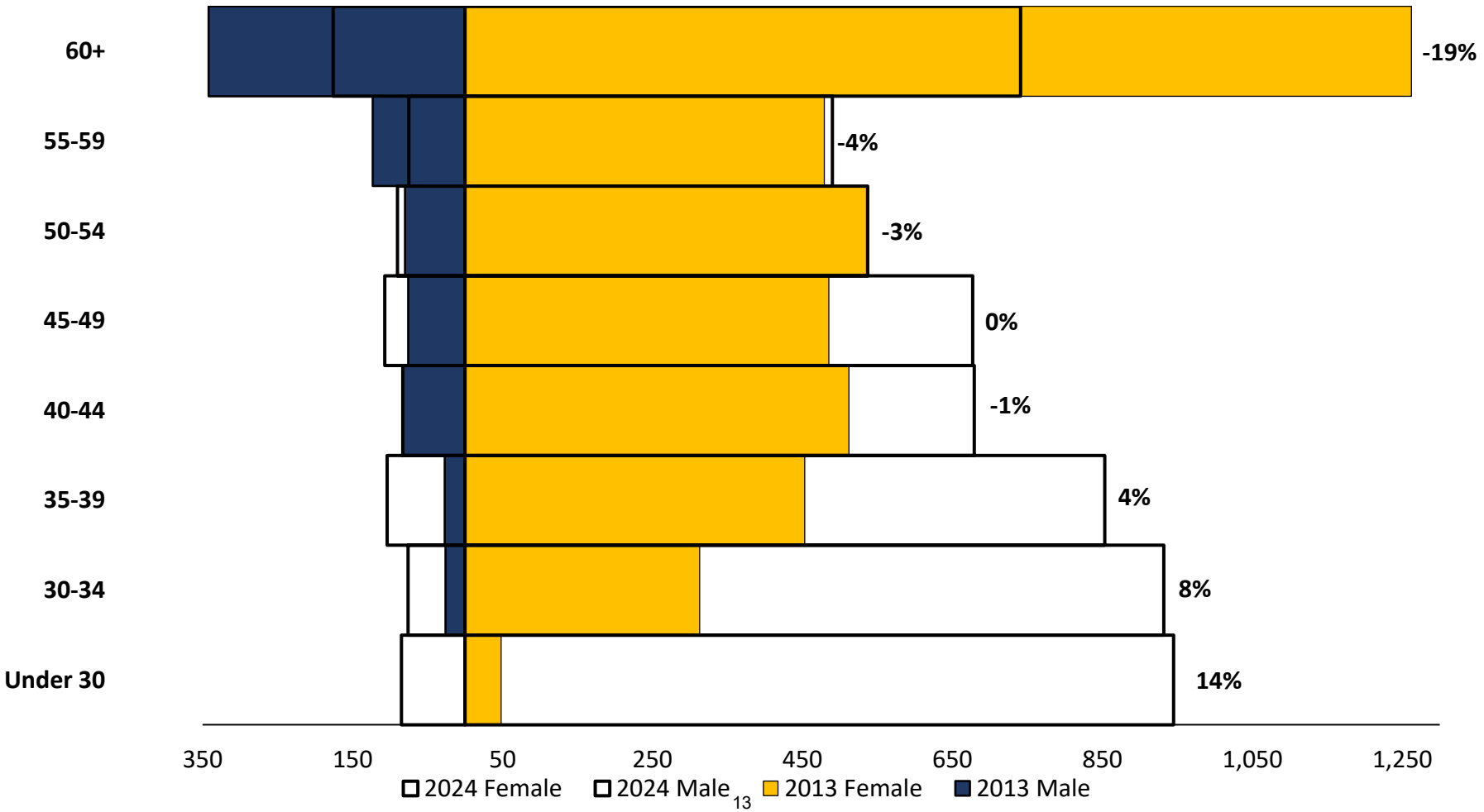
2013 versus 2024 LCSW Population Pyramid

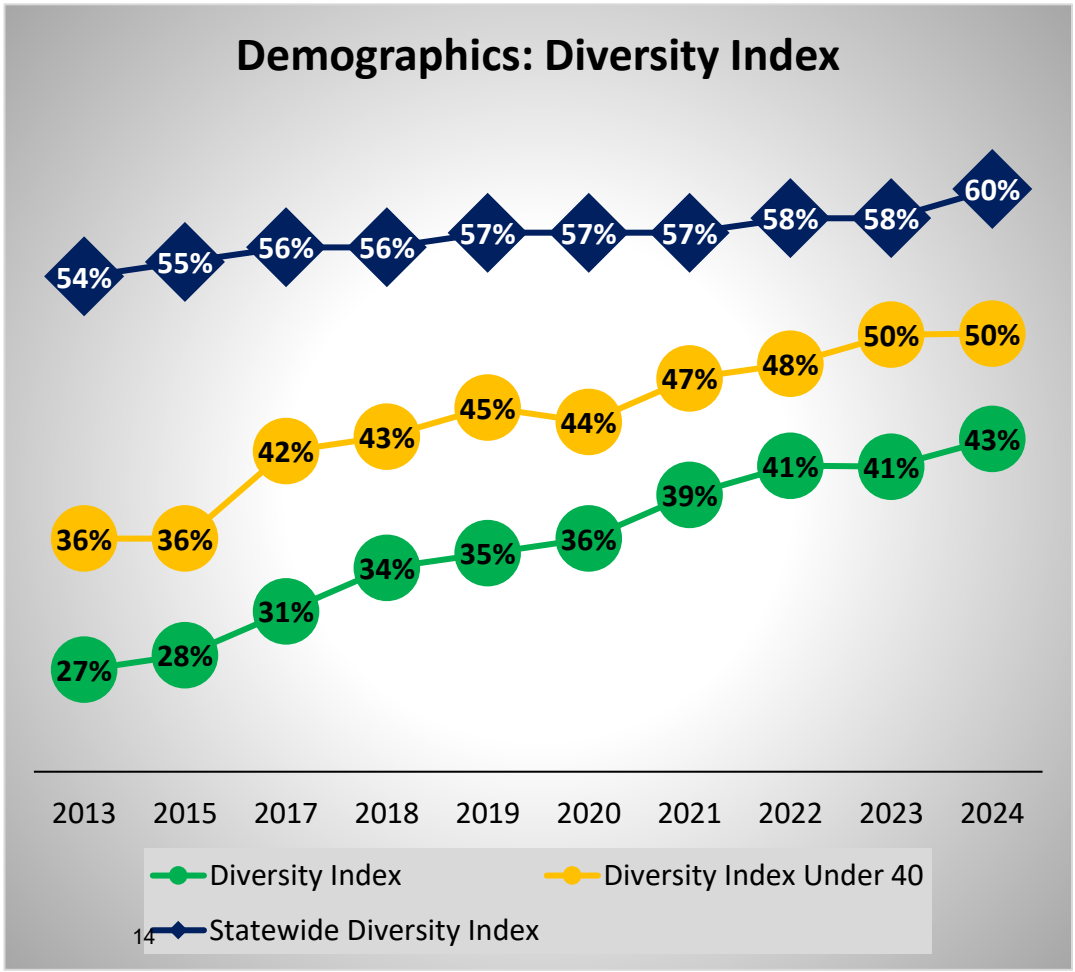


Virginia Department of Health Professions

Trends in Demographics

Diversity index increasing over time

Higher diversity index among those under 40



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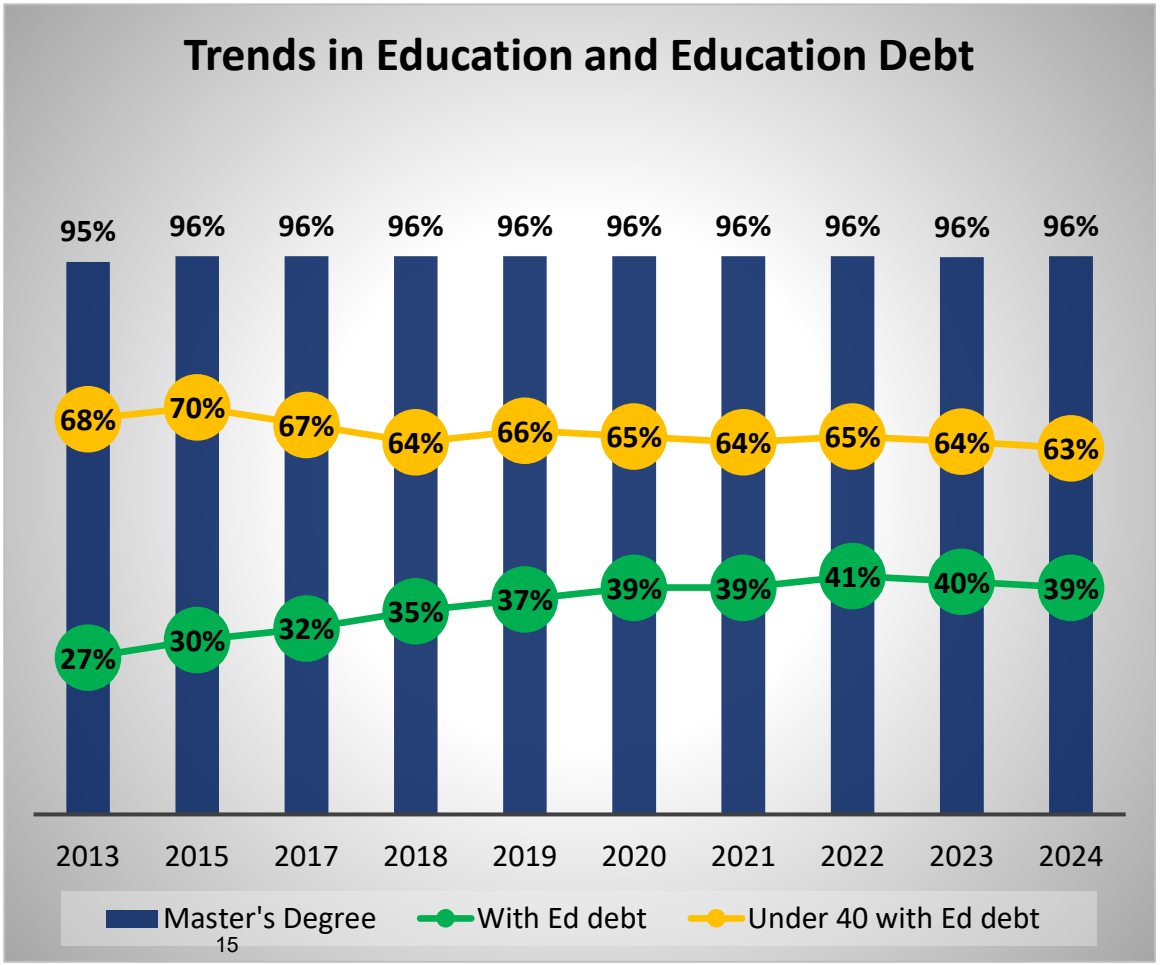
Trends in Education and Debt

Educational attainment stable

Slight decrease in % with ed. debt since 2022

More than 3 in 5 under 40 hold ed. debt



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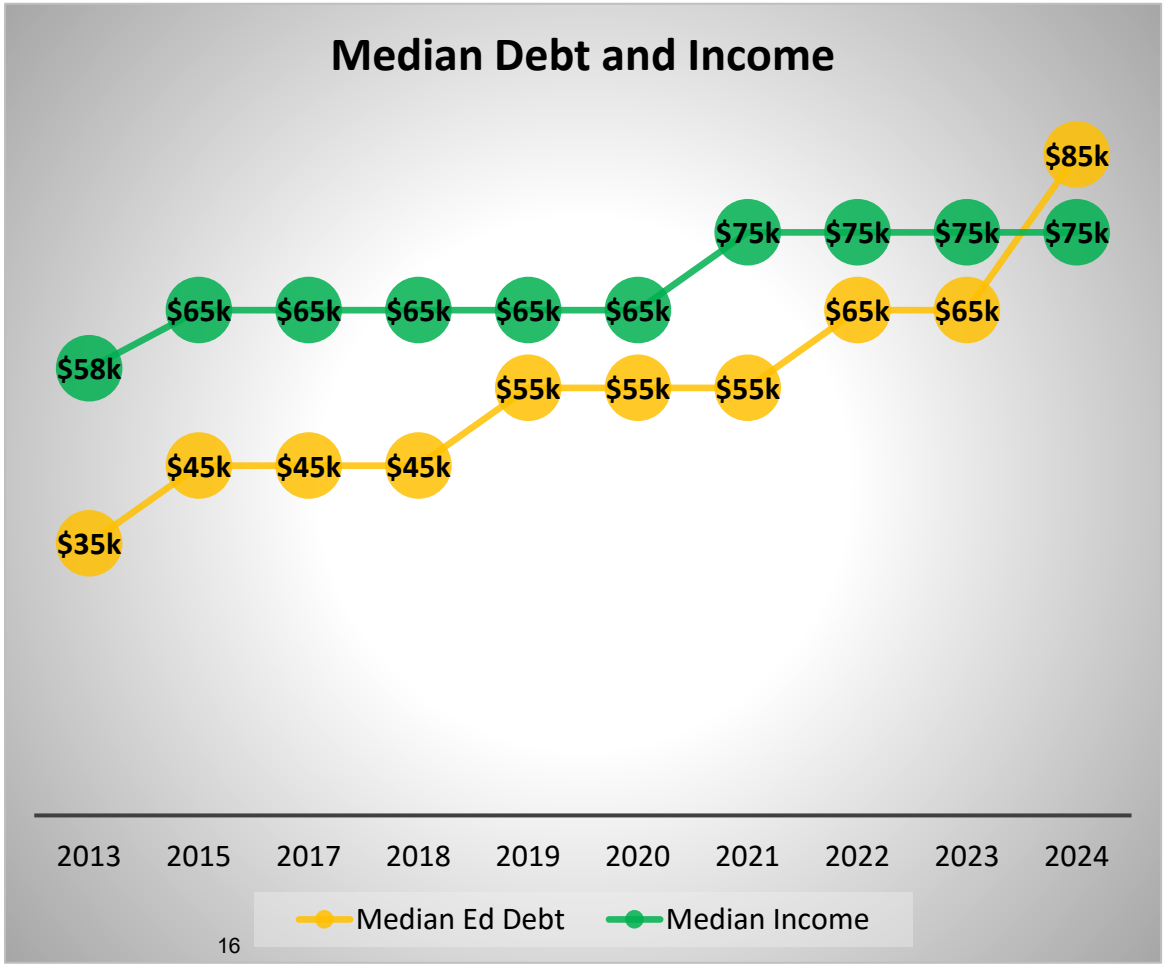
Trends in Income and Education Debt

Median income stable since 2021

Median ed. debt increasing over time

Median ed. debt higher than median income



Virginia Department of Health Professions

Language Services

Spanish most commonly offered language

Virtual translation is most often used to provide service

Language and Communication			
Languages Offered		**Means of Communication**	
Spanish	15%	Virtual Translation	55%
French	7%	Staff Member	41%
Arabic	7%		

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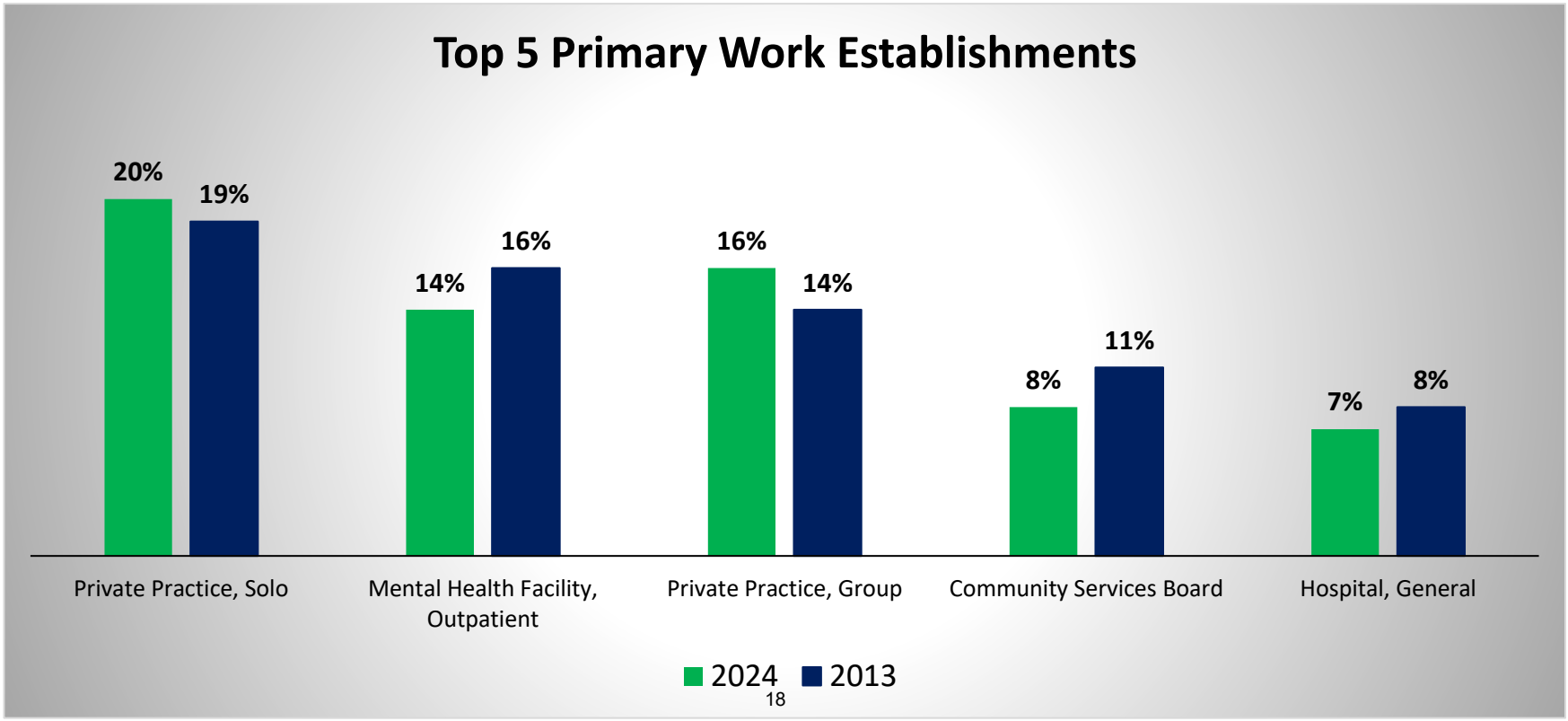
Virginia Department of Health Professions

Establishment Types

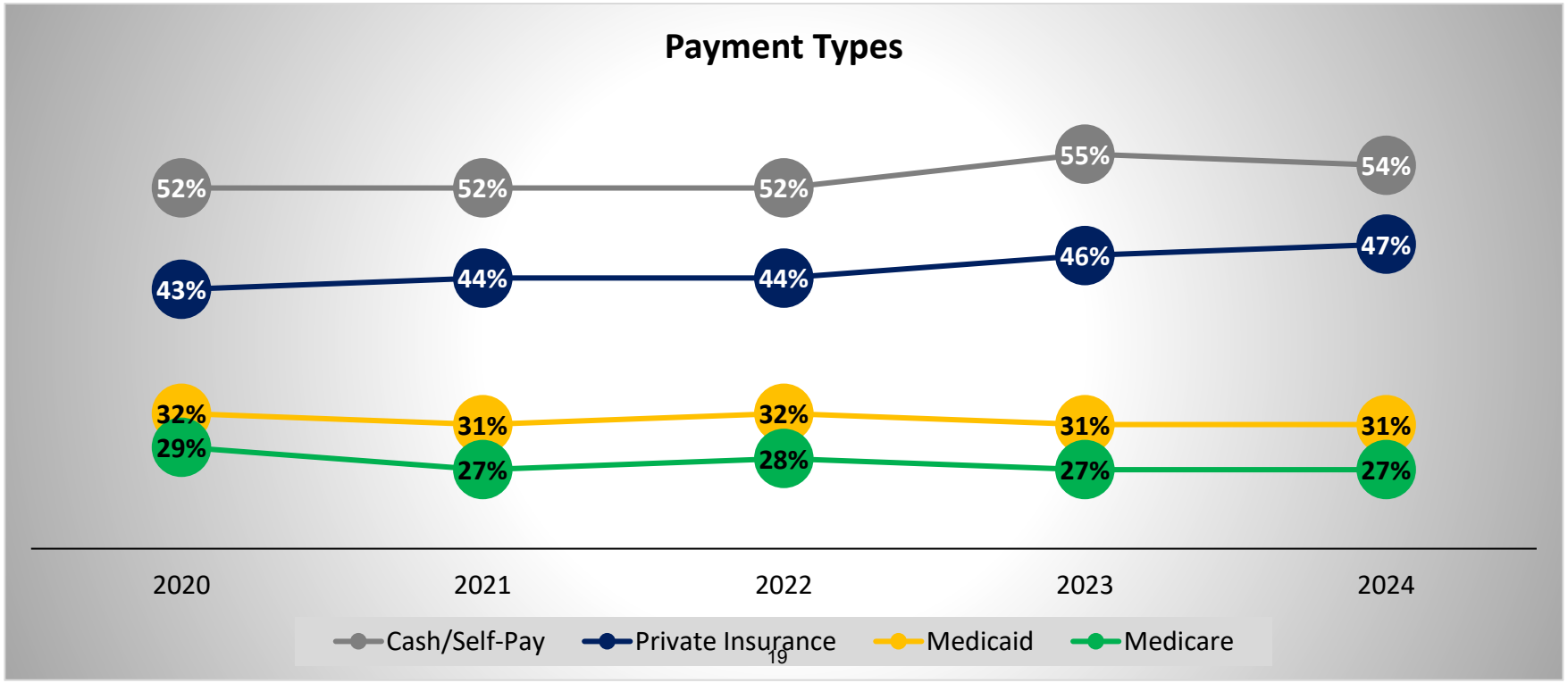
Increase in private solo and group practice



Client Payment Type

Majority accept cash or self-pay

Increase in % accepting private insurance

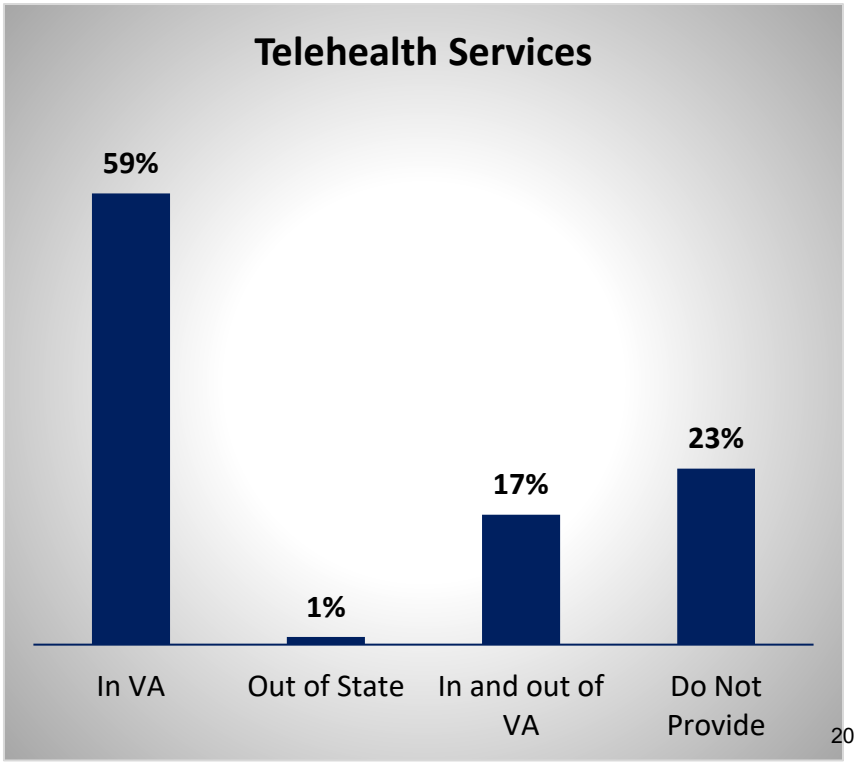


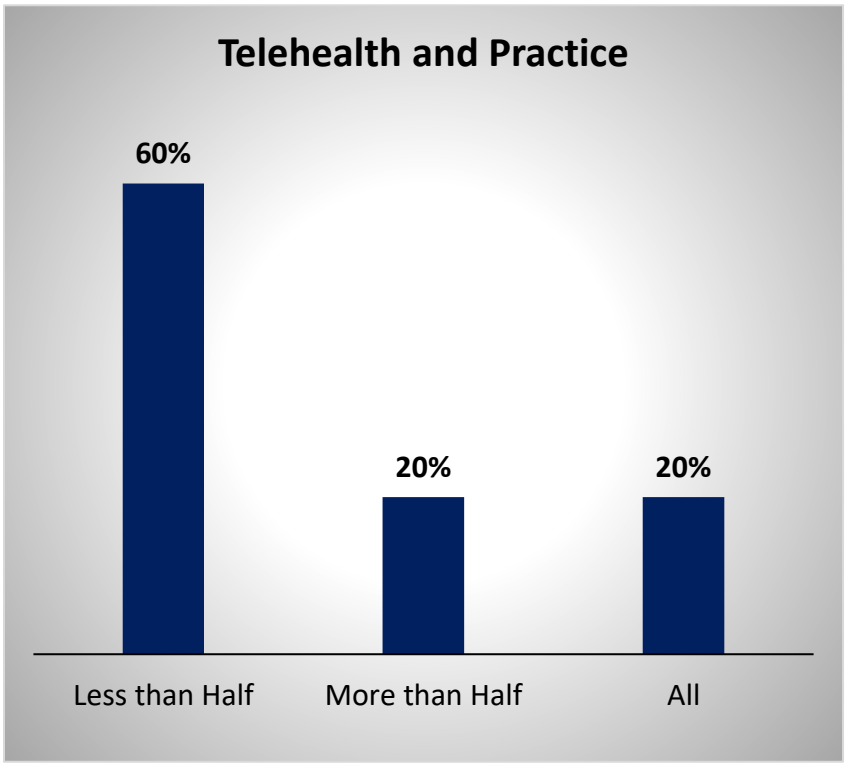
Virginia Department of Health Professions

Telehealth

Majority provide telehealth services in state

2 in 3 provide less than half of their practice via telehealth





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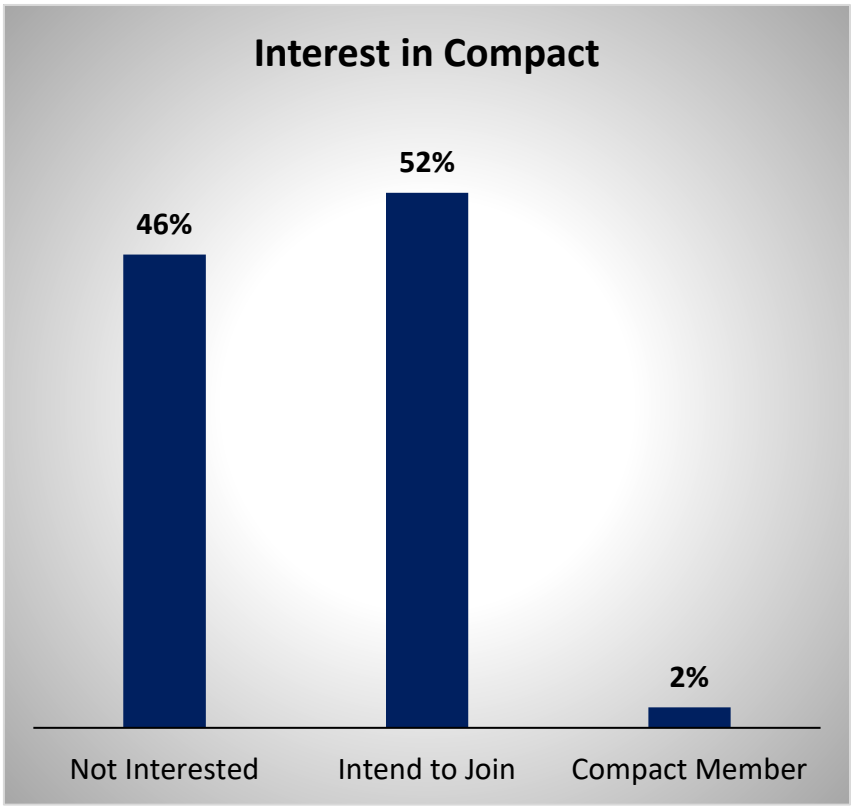
Compact

Majority intend to join a compact

About 4 in 5 intend to join the social work licensure



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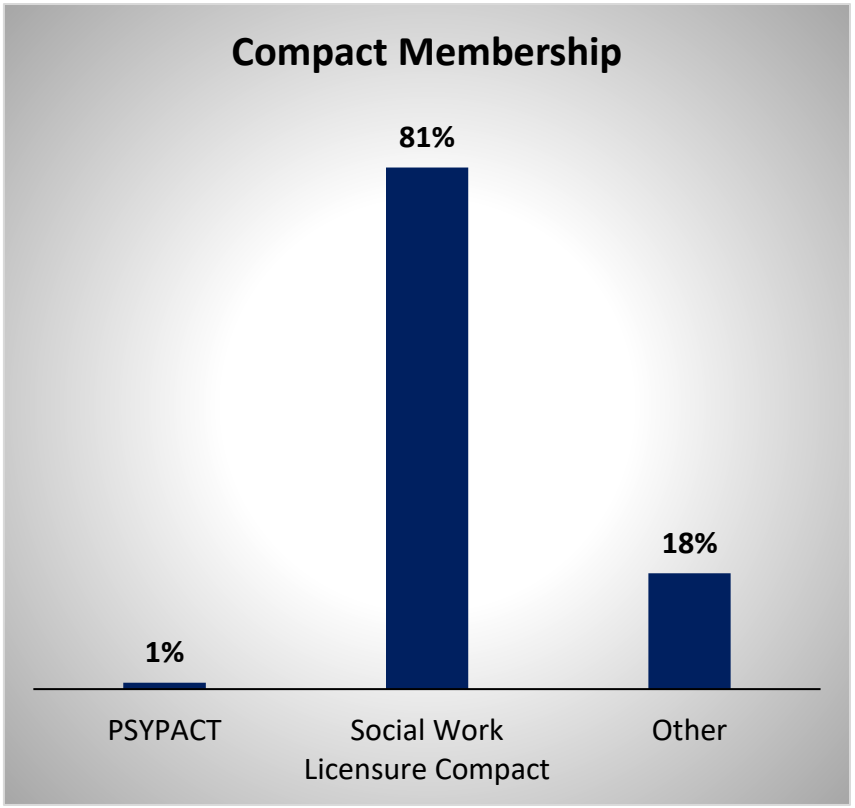

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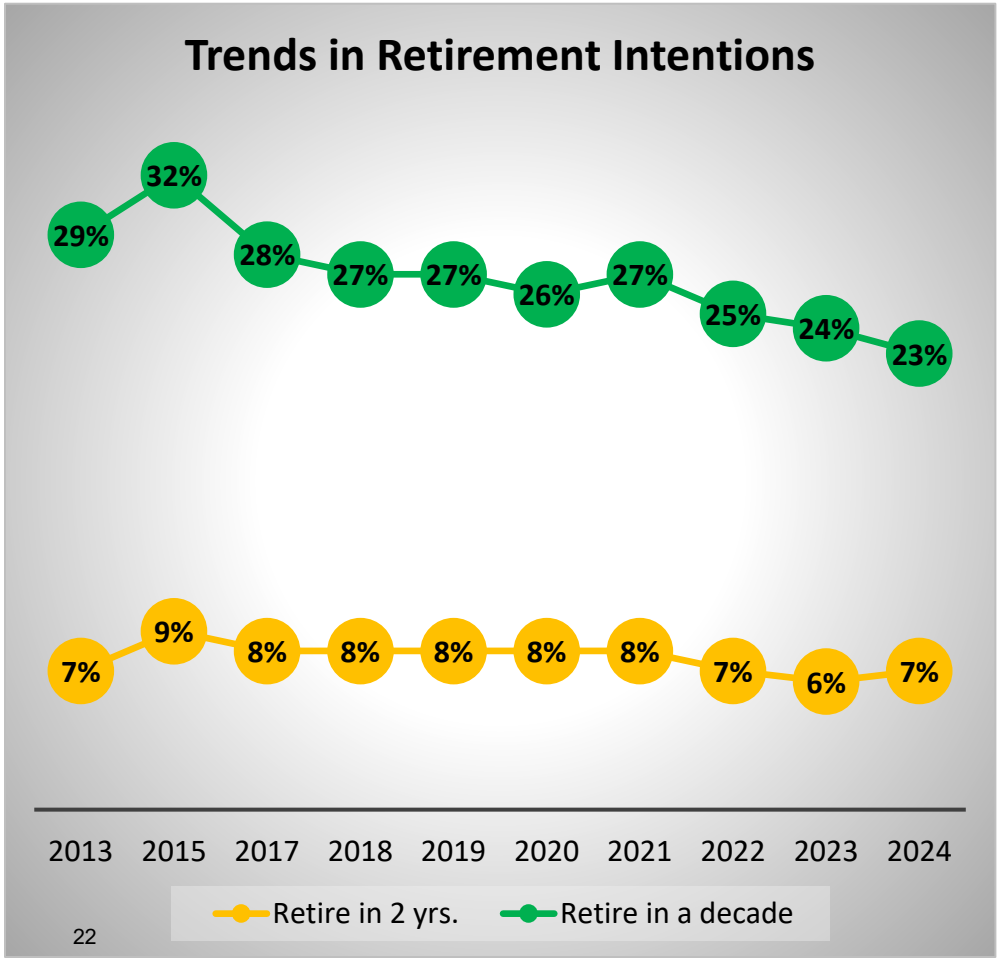
Retirement Intentions

Decrease in % intending to retire by 65 since 2021

Low % intending to retire in 2 years



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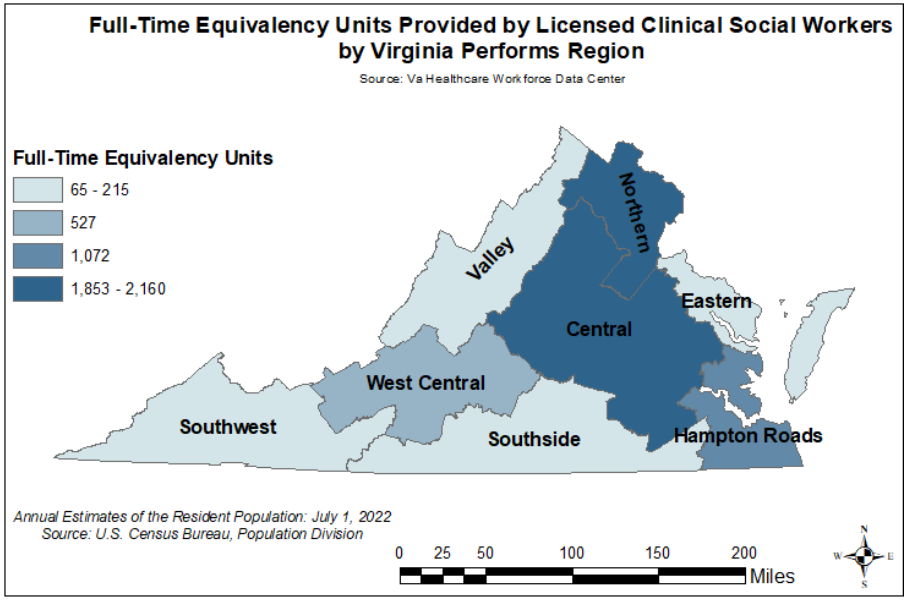
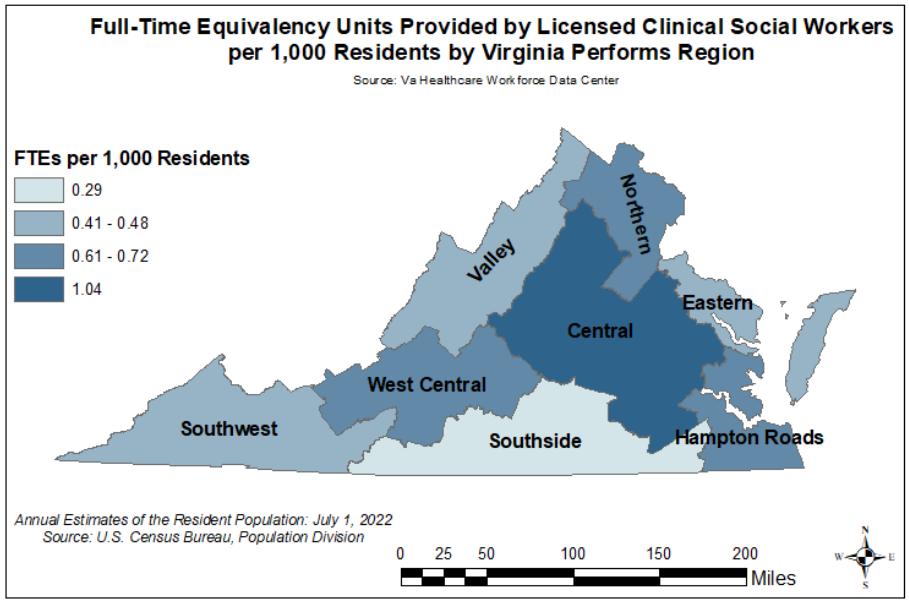
Geographical Distribution

Lowest concentrations of social workers in Southside VA





Virginia Department of
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Conclusion

Increase in licensees, VA's workforce, and FTEs

Younger age distribution and increasing diversity index

Median income higher than median education debt

Majority intend to join a compact; Highest % interested in joining social work licensure compact

Majority provide telehealth in state; Most provide less than half of practice via telehealth

Master's Social Worker Workforce: 2024 Survey Findings

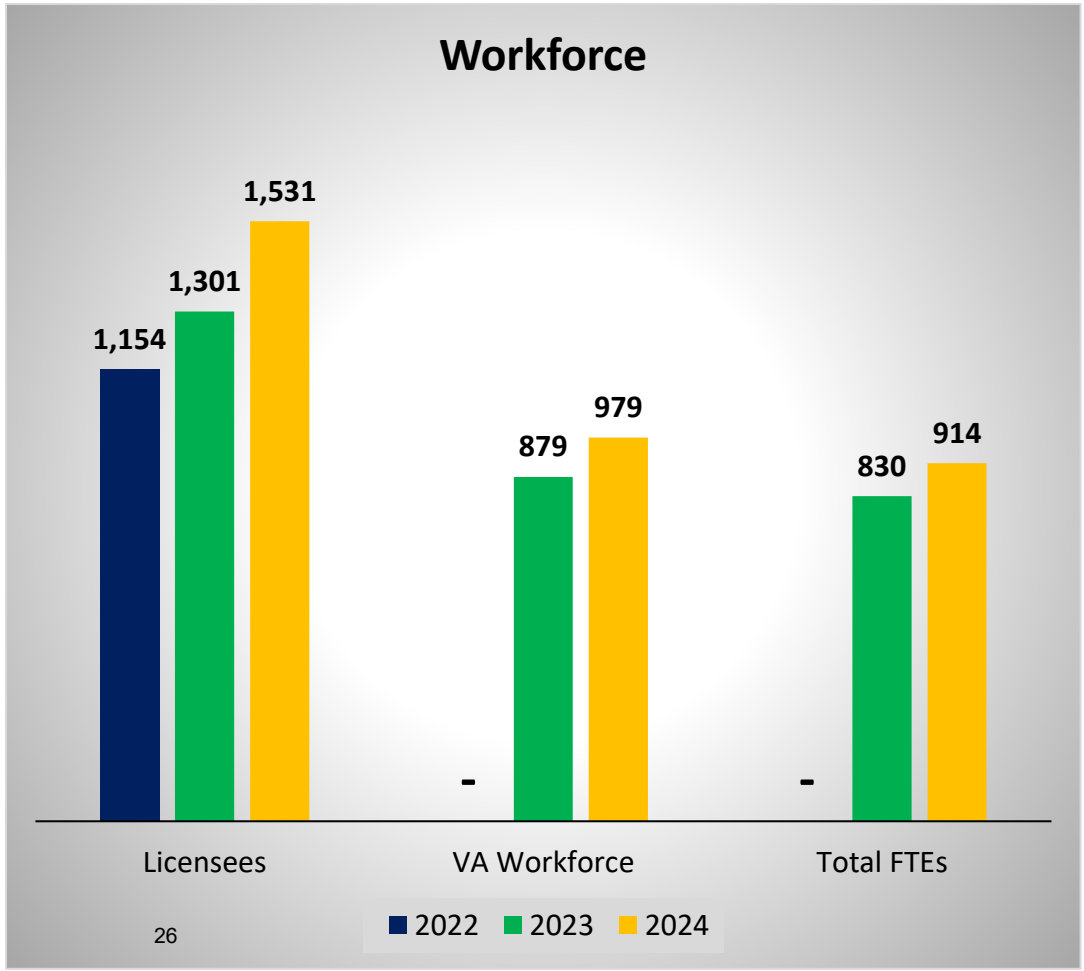
Virginia Department of
Health Professions

Workforce

Increase in licensees

Increase in VA's workforce

Increase in FTEs provided



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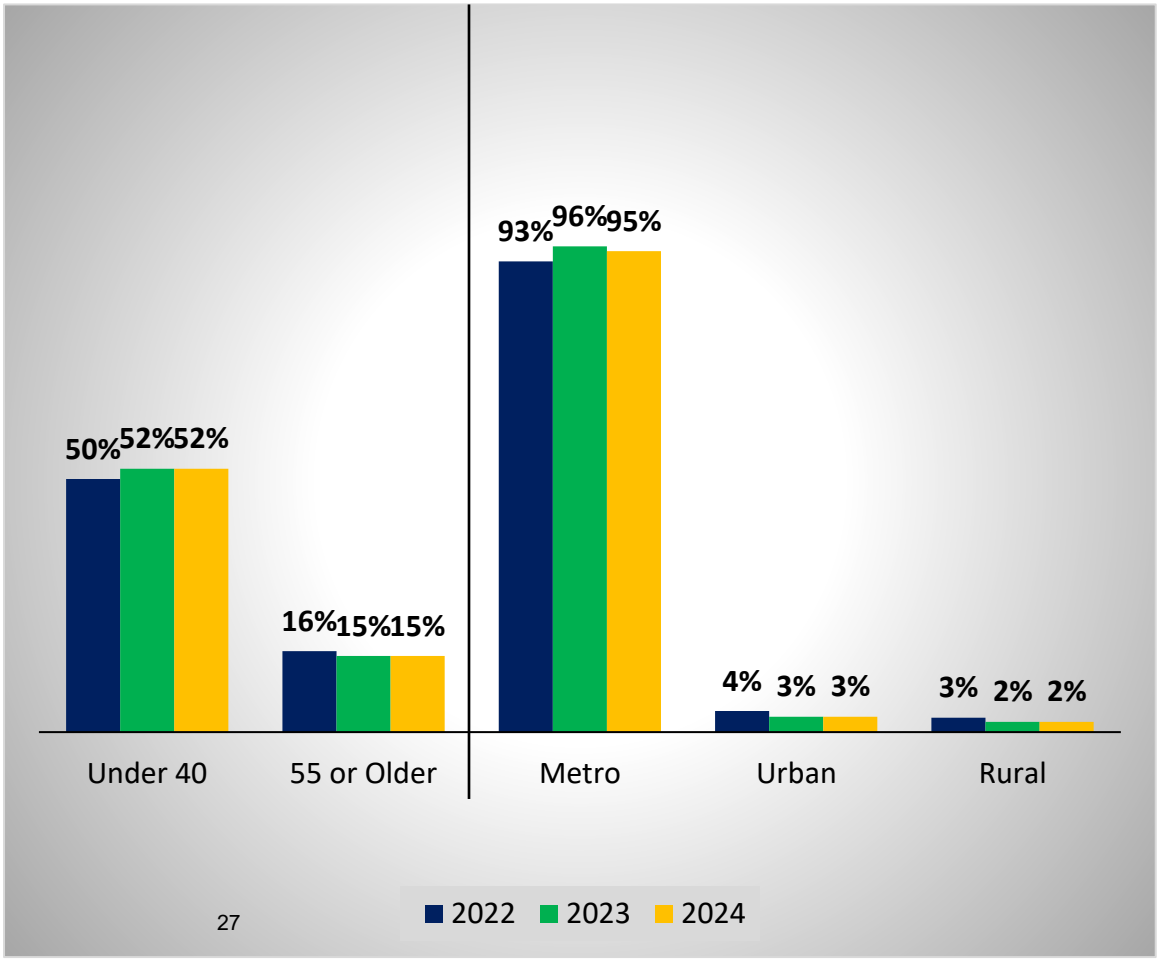
Age and Metro Status

Median age at 39 years

Majority under 40

Majority in Metro Area



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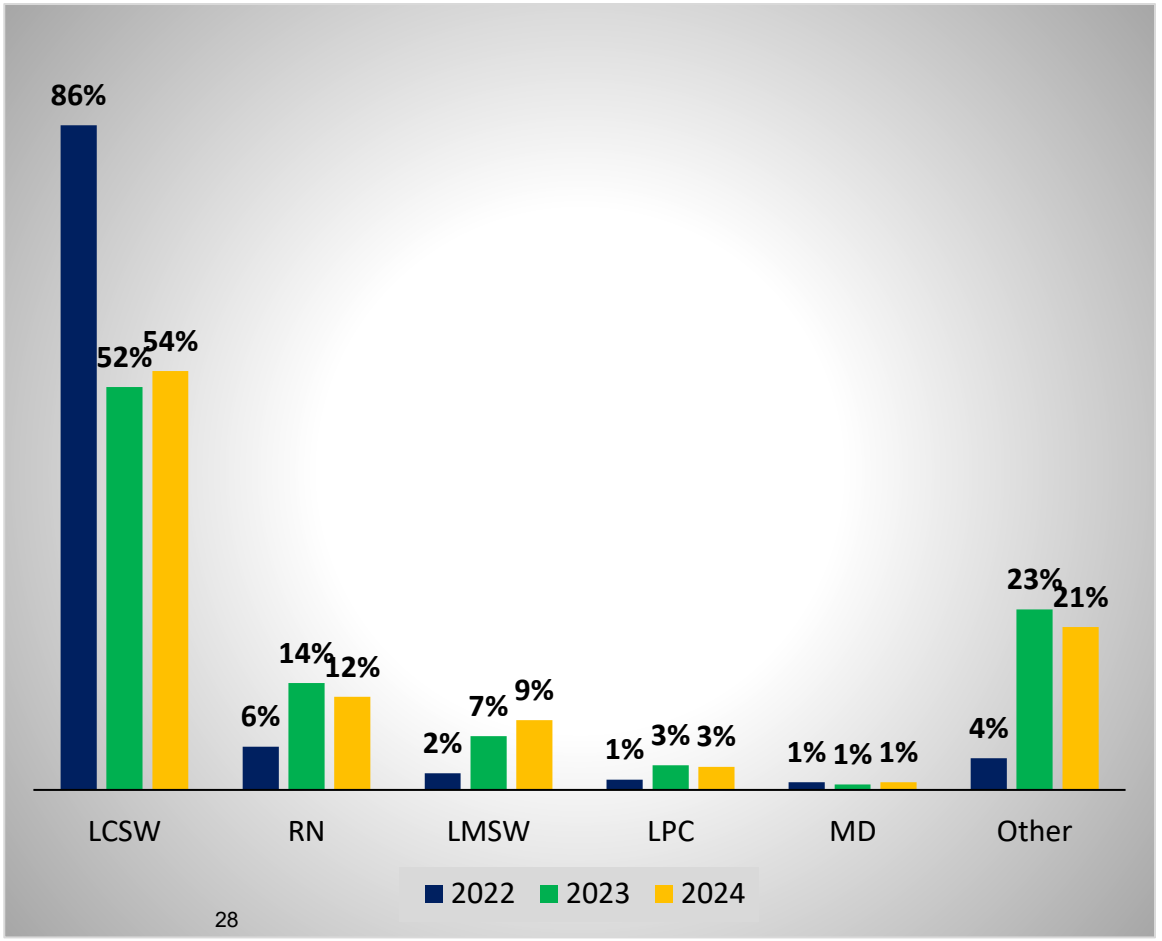
Supervisor Credentials

Majority hold LSCW

Increase in those with RN, LMSW, and LPC

Increase in those with "Other"



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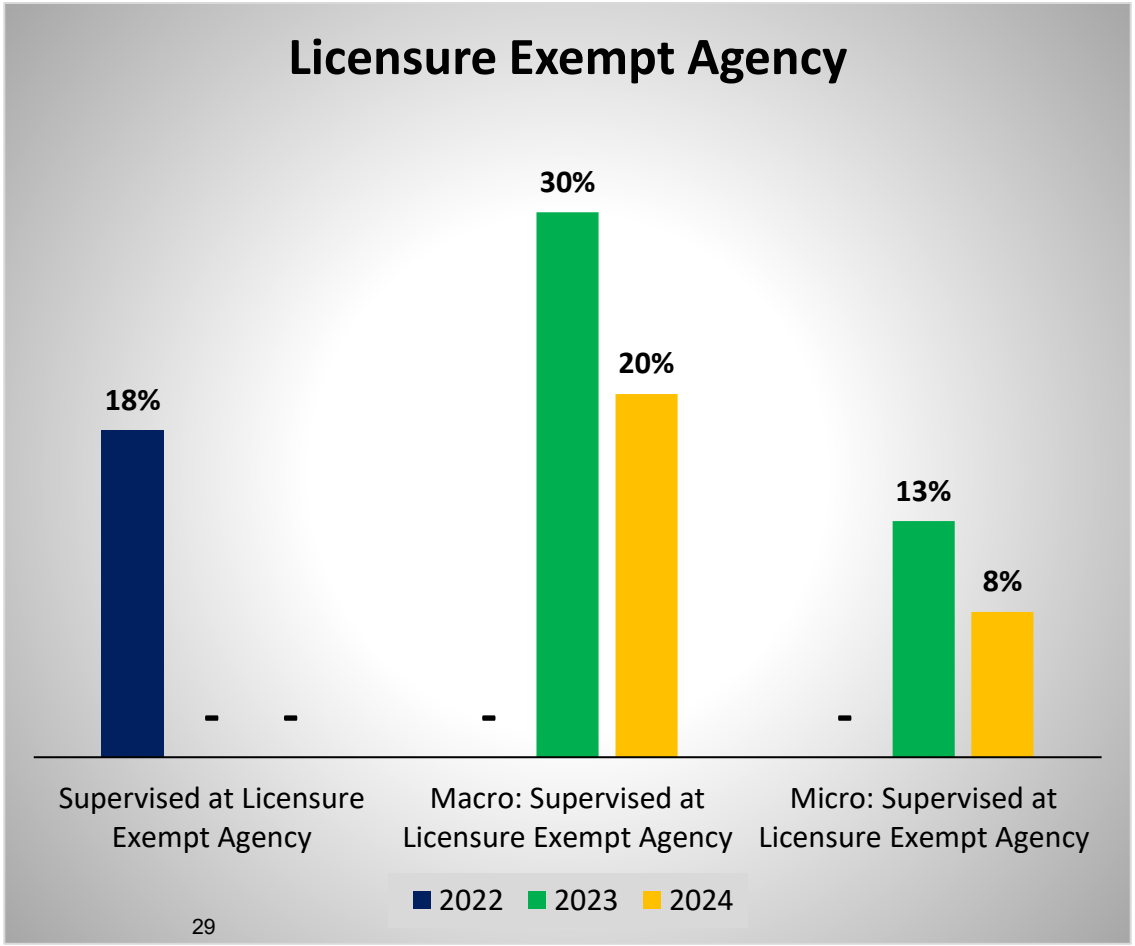
Virginia Department of Health Professions

Agency and Licensure

In 2022, 18% of all MSWs in exempt agency

30% of macro MSWs work in exempt agency

13% of micro MSWs work in exempt agency



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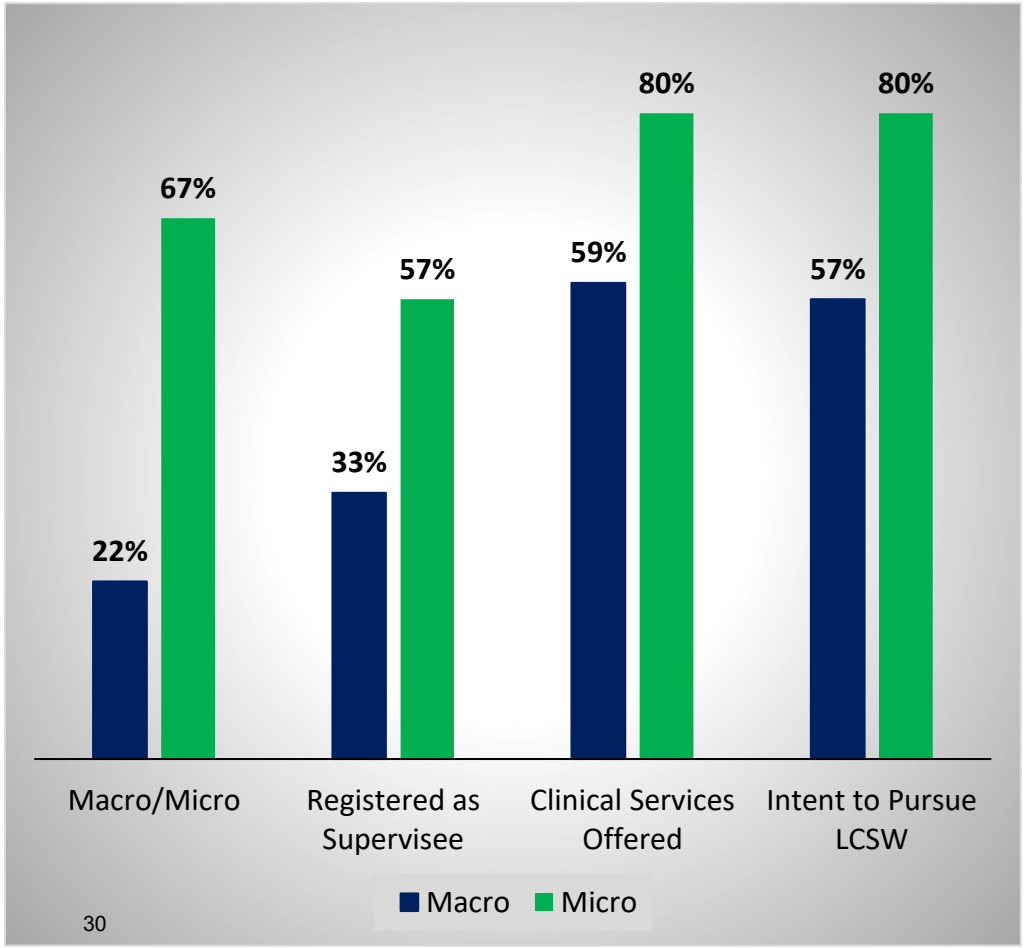
2024 Micro vs Macro Concentration

Majority of Micro MSWs are supervisees

A higher % of Micro MSWs offer clinical services

A higher % Micro MSWs intend to pursue LCSW



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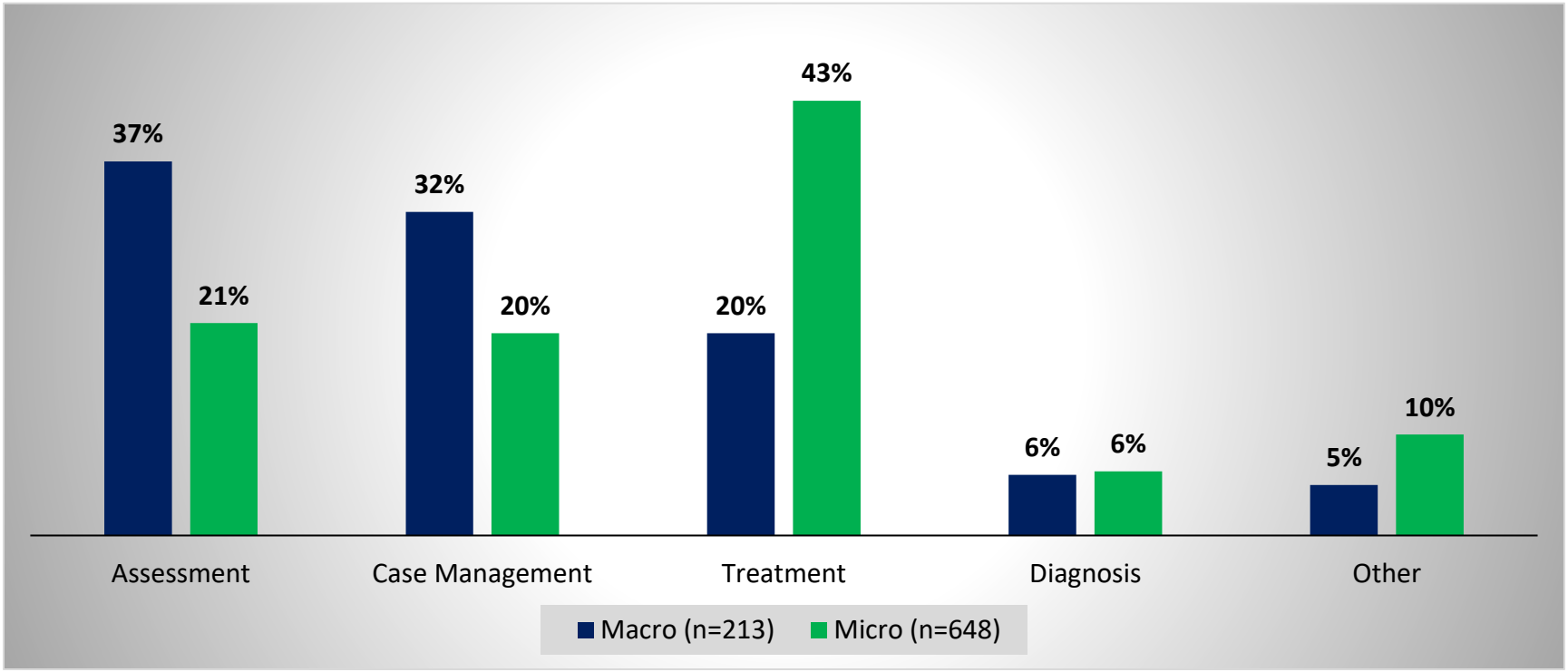
Clinical Services Provided



Majority of Macro provide assessment whereas the majority of Micro provide treatment

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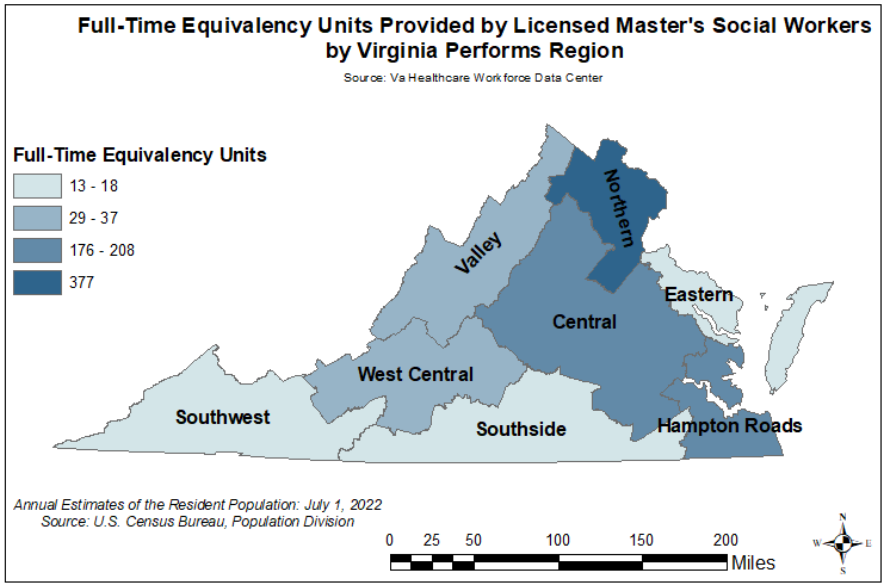
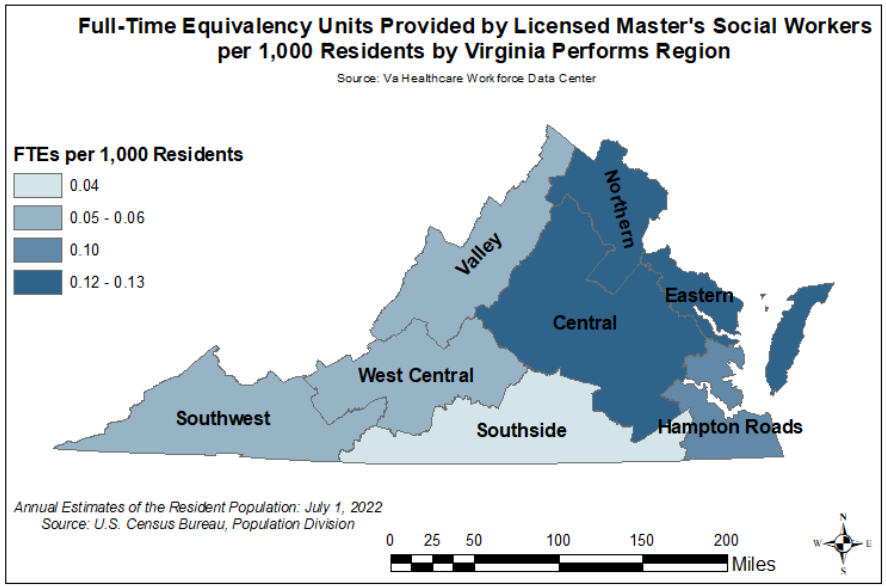
Geographic Distribution

Southside and Southwest VA have the lowest concentration





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Virginia Department of
Health Professions

Conclusion

Increase in licensees, VA's workforce, and FTEs

2/3 MSWs have a Micro concentration;
a little over 1/5 have a Macro concentration

59% of Macro MSWs provide clinical services vs
80% of Micro MSWs provide clinical Services

Lowest concentrations in Southside and Southwest VA

Thank you!

Virginia's Licensed Clinical Social Worker Workforce: 2024

Healthcare Workforce Data Center

July 2024

Virginia Department of Health Professions
Healthcare Workforce Data Center
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http://www.dhp.virginia.gov/PublicResources/HealthcareWorkforceDataCenter/ProfessionReports/

More than 9,700 Licensed Clinical Social Workers voluntarily participated in this survey. *Without their efforts, the work of the center would not be possible. The Department of Health Professions, the Healthcare Workforce Data Center, and the Board of Social Work express our sincerest appreciation for their ongoing cooperation.*

Thank You!

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Contents

The Licensed Clinical Social Worker Workforce At a Glance:

The Workforce

Licensees:	11,493
Virginia's Workforce:	7,962
FTEs:	6,384

Survey Response Rate

All Licensees:	85%
Renewing Practitioners:	97%

Demographics

Female:	88%
Diversity Index:	43%
Median Age:	48

Background

Rural Childhood:	23%
HS Degree in VA:	48%
Prof. Degree in VA:	51%

Education

Masters:	96%
Doctorate:	4%

Finances

Median Income:	$80k-$90k
Health Insurance:	65%
Under 40 w/ Ed. Debt:	63%

Current Employment

Employed in Prof.:	92%
Hold 1 Full-Time Job:	54%
Satisfied?:	96%

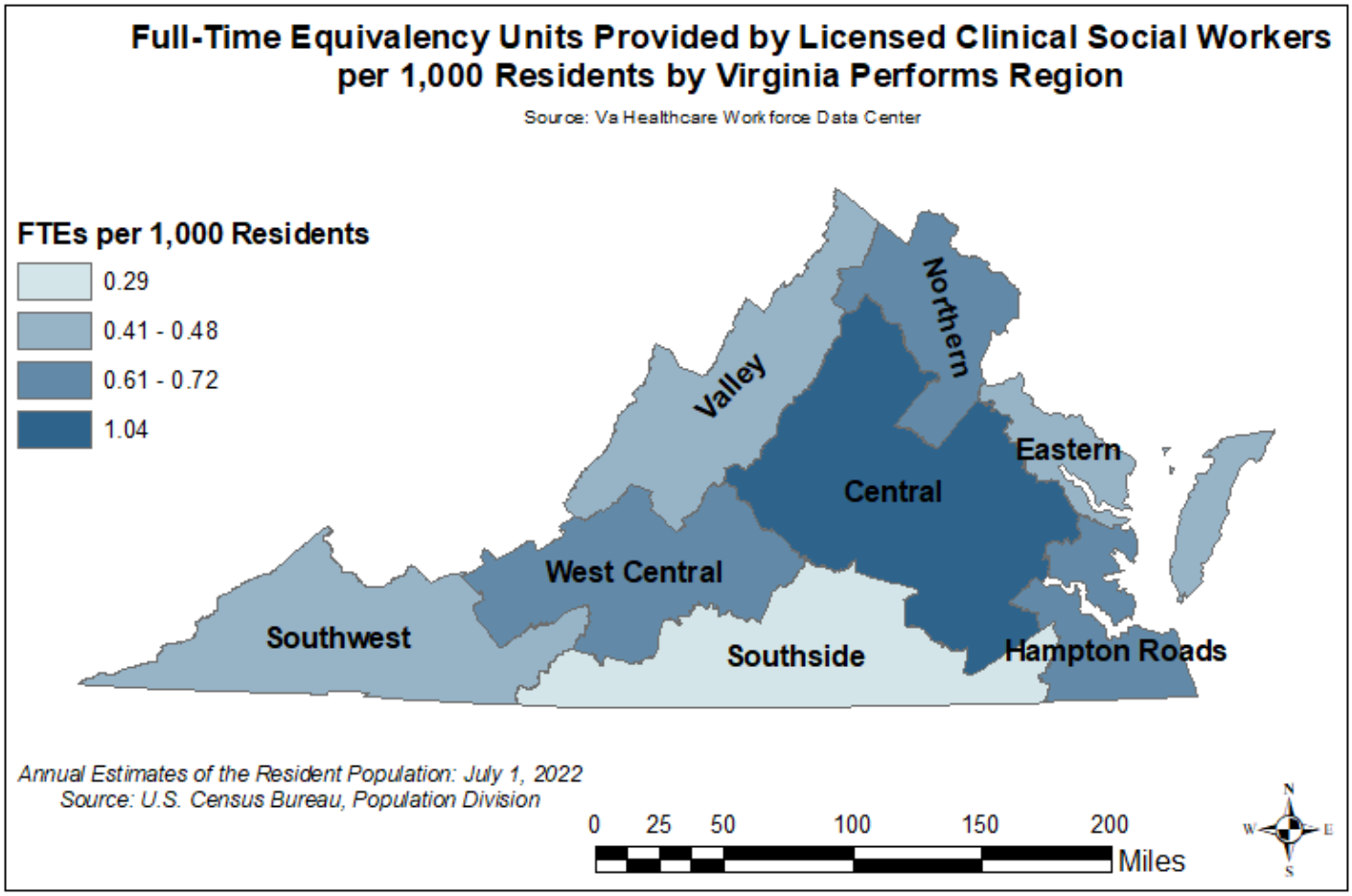
Job Turnover

Switched Jobs:	6%
Employed Over 2 Yrs.:	66%

Time Allocation

Patient Care:	70%-79%
Administration:	10%-19%
Patient Care Role:	63%

Source: Va. Healthcare Workforce Data Center



Results in Brief

This report contains the results of the 2024 Licensed Clinical Social Worker (LCSW) Workforce Survey. In total, 9,732 LCSWs voluntarily participated in this survey. The Virginia Department of Health Professions' Healthcare Workforce Data Center (HWDC) administers the survey during the license renewal process, which takes place every June for LCSWs. These survey respondents represent 85% of the 11,493 LCSWs licensed in the state and 97% of renewing practitioners.

The HWDC estimates that 7,962 LCSWs participated in Virginia's workforce during the survey period, which is defined as those LCSWs who worked at least a portion of the year in the state or who live in the state and intend to work as a LCSW at some point in the future. Over the past year, Virginia's LCSW workforce provided 6,384 "full-time equivalency units," which the HWDC defines simply as working 2,000 hours per year.

Nearly nine out of every ten LCSWs are female, and the median age of this workforce is 48. In a random encounter between two LCSWs, there is a 43% chance that they would be of different races or ethnicities, a measure known as the diversity index. This diversity index increases to 50% for those LCSWs who are under the age of 40. For Virginia's population as a whole, the comparable diversity index of 60%. Nearly one out of every four LCSWs grew up in a rural area, and 14% of LCSWs who grew up in a rural area currently work in a non-metro area of Virginia. In total, 5% of all LCSWs work in a non-metro area of the state.

Among all LCSWs, 92% are currently employed in the profession, 54% hold one full-time job, and 45% work between 40 and 49 hours per week. More than seven out of every ten LCSWs are employed in the private sector, including 54% who work in the for-profit sector. The median annual income of Virginia's LCSW workforce is between $80,000 and $90,000, and 59% receive this income in the form of a salary. In addition, 78% of wage and salaried LCSWs receive at least one employer sponsored benefit, including 65% who have access to health insurance. Among all LCSWs, 96% indicated that they are satisfied with their current work situation, including 68% who indicated they are "very satisfied."

Summary of Trends

In this section, all statistics for the current year are compared to the 2019 LCSW workforce. The number of licensed LCSWs in Virginia has increased by 58% (11,493 vs. 7,291). In addition, the size of Virginia's LCSW workforce has increased by 33% (7,962 vs. 5,986), and the number of FTEs provided by this workforce has increased by 25% (6,384 vs. 5,103). Virginia's renewing LCSWs are equally likely to respond to this survey (97%).

The median age of the LCSW workforce has fallen (48 vs. 50). At the same time, Virginia's LCSW workforce has become more diverse (43% vs. 35%), and this is also true among those LCSWs who are under the age of 40 (50% vs. 45%). LCSWs are slightly less likely to have grown up in a rural area (23% vs. 24%), and LCSWs who grew up in a rural area are also slightly less likely to work in a non-metro area of Virginia (14% vs. 15%). In addition, the percentage of all LCSWs who work in a non-metro area of the state has fallen slightly as well (5% vs. 6%).

While LCSWs are more likely to currently work in the profession (92% vs. 90%), they are also less likely to work either one full-time job (54% vs. 57%) or between 40 and 49 hours per week (45% vs. 49%). In addition, LCSWs are less likely to have been employed at their primary work location for at least two years (66% vs. 69%). Virginia's LCSWs are more likely to work in the for-profit sector (54% vs. 47%) than in the non-profit sector (18% vs. 22%).

LCSWs are more likely to carry education debt (39% vs. 37%), and the median outstanding balance among those LCSWs with education debt has increased ($70k-$80k vs. $50k-$60k). At the same time, the median annual income of Virginia's LCSW workforce has increased ($80k-$90k vs. $60k-$70k), and LCSWs are relatively more likely to receive this compensation in the form of either business income (18% vs. 17%) or an hourly wage (15% vs. 14%) instead of a salary (59% vs. 62%). In addition, wage and salaried LCSWs are slightly less likely to receive at least one employer-sponsored benefit (78% vs. 79%). Overall, LCSWs are slightly more likely to indicate that they are satisfied with their current work situation (96% vs. 95%). However, there was no change in the percentage of LCSWs who indicated that they are "very satisfied" with their current work situation (68%).

A Closer Look:

Licensees		
License Status	**#**	**%**
Renewing Practitioners	9,391	82%
New Licensees	1,529	13%
Non-Renewals	573	5%
All Licensees	**11,493**	**100%**

Source: Va. Healthcare Workforce Data Center

HWDC surveys tend to achieve very high response rates. Among all renewing LCSWs, 97% submitted a survey. These represent 85% of the 11,493 LCSWs who held a license at some point during the survey period.

Definitions

1. **The Survey Period:** The survey was conducted in June 2024.
2. **Target Population:** All LCSWs who held a Virginia license at some point between July 2023 and June 2024.
3. **Survey Population:** The survey was available to LCSWs who renewed their licenses online. It was not available to those who did not renew, including LCSWs newly licensed in 2024.

Response Rates			
Statistic	**Non Respondents**	**Respondents**	**Response Rate**
By Age			
Under 35	399	1,137	74%
35 to 39	289	1,424	83%
40 to 44	255	1,366	84%
45 to 49	182	1,219	87%
50 to 54	178	1,244	88%
55 to 59	109	1,023	90%
60 to 64	122	862	88%
65 and Over	227	1,457	87%
Total	**1,761**	**9,732**	**85%**
New Licenses			
Issued in Past Year	972	557	36%
Metro Status			
Non-Metro	83	468	85%
Metro	739	6,458	90%
Not in Virginia	939	2,806	75%

Source: Va. Healthcare Workforce Data Center

Response Rates	
Completed Surveys	**9,732**
Response Rate, All Licensees	**85%**
Response Rate, Renewals	**97%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Licensed LCSWs

Number:	11,493
New:	13%
Not Renewed:	5%

Response Rates

All Licensees:	85%
Renewing Practitioners:	97%

Source: Va. Healthcare Workforce Data Center

At a Glance:

Workforce

Virginia's LCSW Workforce:	7,962
FTEs:	6,384

Utilization Ratios

Licensees in VA Workforce:	69%
Licensees per FTE:	1.80
Workers per FTE:	1.25

Source: Va. Healthcare Workforce Data Center

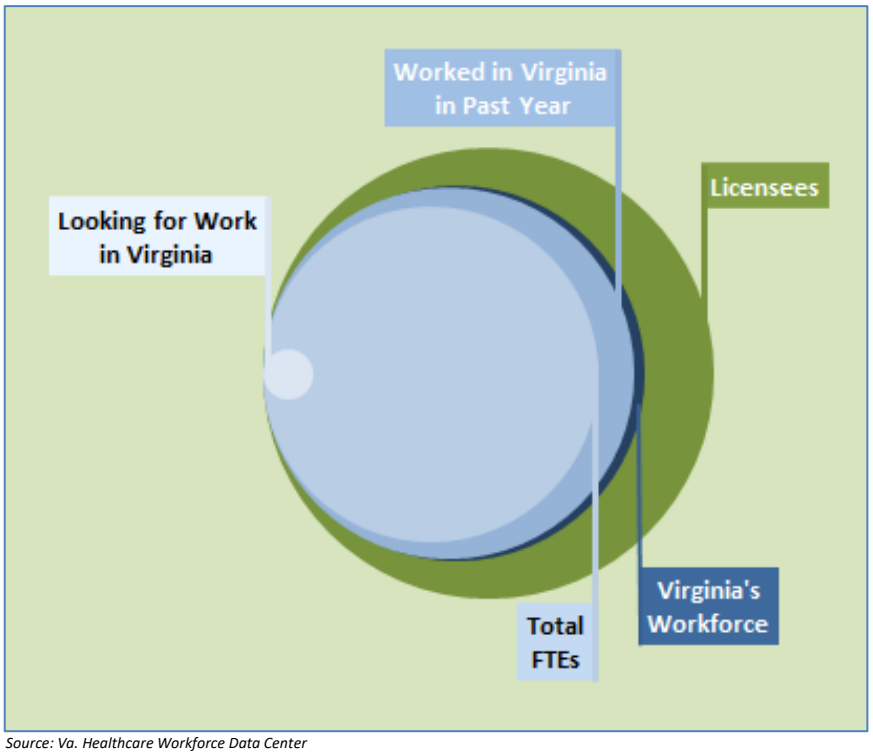
Definitions

1. **Virginia's Workforce:** A licensee with a primary or secondary work site in Virginia at any time in the past year or who indicated intent to return to Virginia's workforce at any point in the future.
2. **Full-Time Equivalency Unit (FTE):** The HWDC uses 2,000 (40 hours for 50 weeks) as its baseline measure for FTEs.
3. **Licensees in VA Workforce:** The proportion of licensees in Virginia's workforce.
4. **Licensees per FTE:** An indication of the number of licensees needed to create 1 FTE. Higher numbers indicate lower licensee participation.
5. **Workers per FTE:** An indication of the number of workers in Virginia's workforce needed to create 1 FTE. Higher numbers indicate lower utilization of available workers.

Virginia's LCSW Workforce		
Status	**#**	**%**
Worked in Virginia in Past Year	7,815	98%
Looking for Work in Virginia	147	2%
Virginia's Workforce	**7,962**	**100%**
Total FTEs	**6,384**	
Licensees	**11,493**	

Source: Va. Healthcare Workforce Data Center

Weighting is used to estimate the figures in this report. Unless otherwise noted, figures refer to the Virginia Workforce only. For more information on the HWDC's methodology, visit: https://www.dhp.virginia.gov/PublicResources/HealthcareWorkforceDataCenter/



Source: Va. Healthcare Workforce Data Center

A Closer Look:

Age & Gender						
Age	Male		Female		Total	
	#	% Male	#	% Female	#	% in Age Group
Under 35	85	8%	945	92%	1,030	15%
35 to 39	76	8%	932	92%	1,008	15%
40 to 44	104	11%	853	89%	957	14%
45 to 49	83	11%	679	89%	762	11%
50 to 54	107	14%	677	86%	784	12%
55 to 59	90	14%	537	86%	627	9%
60 to 64	75	13%	490	87%	565	8%
65 and Over	176	19%	741	81%	917	14%
Total	**796**	**12%**	**5,854**	**88%**	**6,651**	**100%**

Source: Va. Healthcare Workforce Data Center

Race & Ethnicity					
Race/ Ethnicity	Virginia*	LCSWs		LCSWs Under 40	
	%	#	%	#	%
White	59%	4,921	73%	1,378	67%
Black	18%	1,128	17%	414	20%
Asian	7%	149	2%	69	3%
Other Race	1%	36	1%	7	0%
Two or More Races	5%	164	2%	69	3%
Hispanic	10%	298	4%	110	5%
Total	**100%**	**6,696**	**100%**	**2,047**	**100%**

*Population data in this chart is from the U.S. Census, Annual Estimates of the Resident Population by Sex, Race, and Hispanic Origin for the United States, States, and Counties: July 1, 2022.

Source: Va. Healthcare Workforce Data Center

At a Glance:

Gender

% Female:	88%
% Under 40 Female:	92%

Age

Median Age:	48
% Under 40:	31%
% 55 and Over:	32%

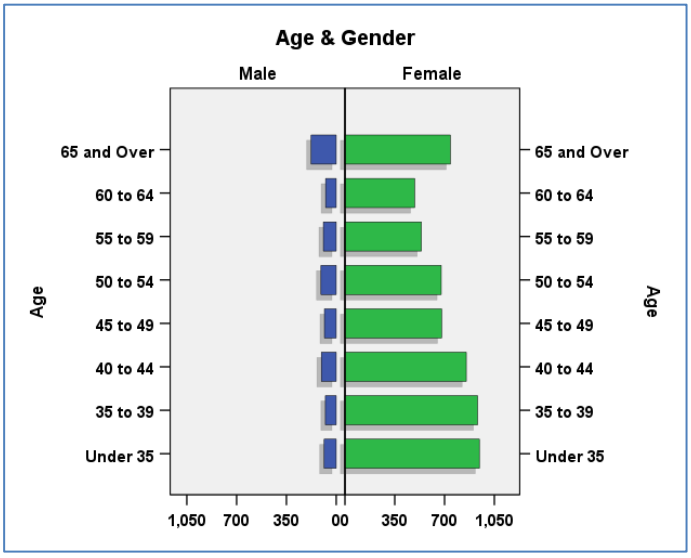
Diversity

Diversity Index:	43%
Under 40 Div. Index:	50%

Source: Va. Healthcare Workforce Data Center

In a chance encounter between two LCSWs, there is a 43% chance that they would be of different races or ethnicities, a measure known as the diversity index. For Virginia's population as a whole, the comparable diversity index is 60%.

Among all LCSWs, 31% are under the age of 40, and 92% of LCSWs who are under the age of 40 are female. In addition, the diversity index among LCSWs who are under the age of 40 is 50%.



Source: Va. Healthcare Workforce Data Center

At a Glance:

Childhood

Urban Childhood:	15%
Rural Childhood:	23%

Virginia Background

HS in Virginia:	48%
Prof. Edu. in VA:	51%
HS or Prof. Edu. in VA:	62%

Location Choice

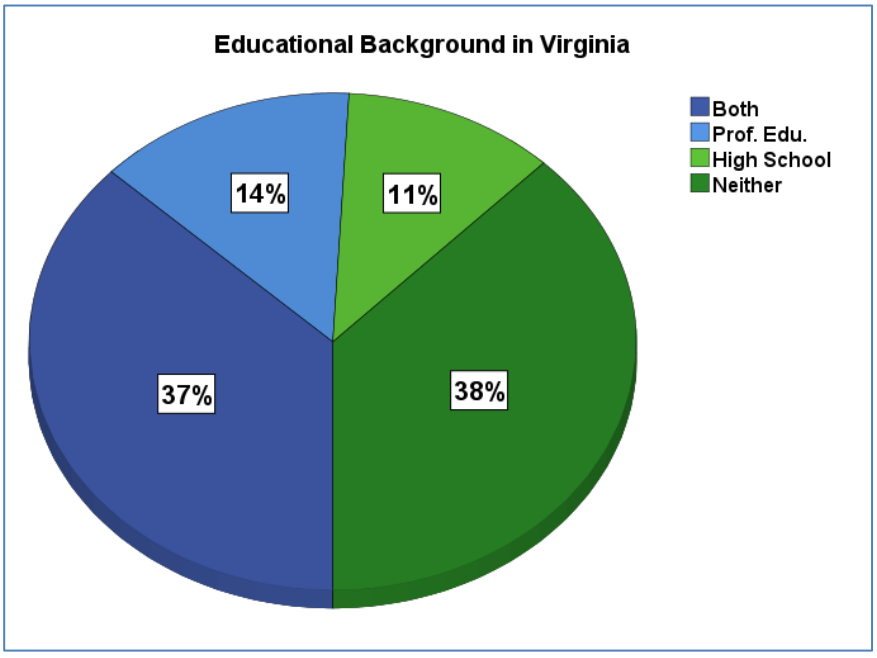
% Rural to Non-Metro:	14%
% Urban/Suburban to Non-Metro:	2%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Primary Location: USDA Rural Urban Continuum		Rural Status of Childhood Location		
Code	Description	Rural	Suburban	Urban
	Metro Counties			
1	Metro, 1 Million+	18%	67%	16%
2	Metro, 250,000 to 1 Million	46%	41%	13%
3	Metro, 250,000 or Less	31%	58%	11%
	Non-Metro Counties			
4	Urban, Pop. 20,000+, Metro Adjacent	70%	19%	11%
6	Urban, Pop. 2,500-19,999, Metro Adjacent	63%	28%	9%
7	Urban, Pop. 2,500-19,999, Non-Adjacent	86%	13%	1%
8	Rural, Metro Adjacent	33%	61%	6%
9	Rural, Non-Adjacent	48%	41%	11%
	Overall	**23%**	**62%**	**15%**

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

Among all LCSWs, 23% grew up in a self-described rural area, and 14% of LCSWs who grew up in a rural area currently work in a non-metro county. In total, 5% of all LCSWs in the state currently work in a non-metro county.

Top Ten States for Licensed Clinical Social Worker Recruitment

Rank	All LCSWs			
	High School	#	Init. Prof. Degree	#
1	Virginia	3,186	Virginia	3,351
2	New York	492	Washington, D.C.	437
3	Maryland	387	New York	415
4	New Jersey	247	Maryland	309
5	Pennsylvania	231	Massachusetts	215
6	North Carolina	228	Pennsylvania	178
7	Outside U.S./Canada	134	North Carolina	165
8	California	129	California	162
9	Florida	124	Florida	149
10	Michigan	111	Michigan	115

Source: Va. Healthcare Workforce Data Center

Among all LCSWs, 48% received their high school degree in Virginia, and 51% received their initial professional degree in the state.

Among LCSWs who have obtained their initial license in the past five years, 47% received their high school degree in Virginia, and 45% also received their initial professional degree in the state.

Rank	Licensed in the Past Five Years			
	High School	#	Init. Prof. Degree	#
1	Virginia	1,143	Virginia	1,083
2	New York	179	New York	178
3	Maryland	159	Maryland	122
4	North Carolina	99	Washington, D.C.	112
5	New Jersey	84	California	100
6	Florida	64	Massachusetts	92
7	California	61	Pennsylvania	78
8	Pennsylvania	59	Florida	78
9	Outside U.S./Canada	56	North Carolina	69
10	Connecticut	46	Texas	41

Source: Va. Healthcare Workforce Data Center

Nearly one-third of Virginia's licensees did not participate in the state's LCSW workforce during the past year. Among these LCSWs, 95% worked at some point in the past year, including 88% who currently work in a job related to the behavioral sciences.

At a Glance:

Not in VA Workforce

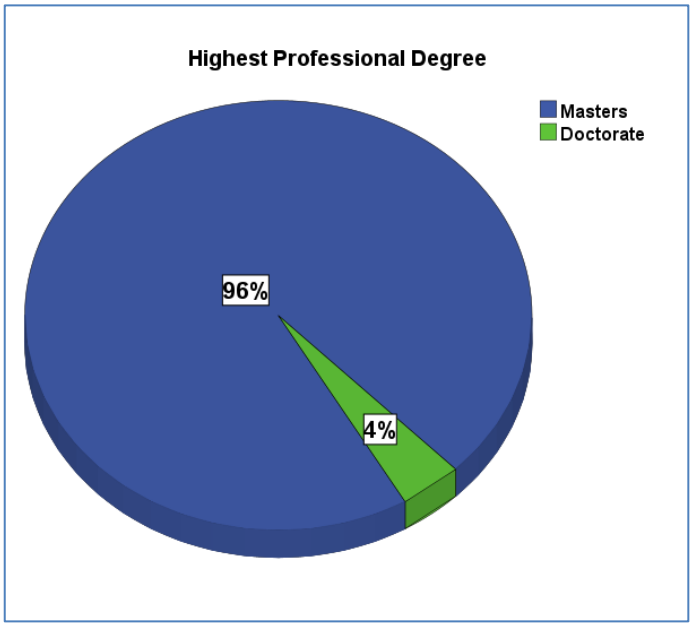
Total:	3,532
% of Licensees:	31%
Federal/Military:	13%
Va. Border State/DC:	25%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Highest Degree		
Degree	**#**	**%**
Bachelor's Degree	3	0%
Master's Degree	6,225	96%
Doctor of Psychology	44	1%
Other Doctorate	211	3%
Total	**6,484**	**100%**

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

Nearly two out of every five LCSWs carry education debt, including 63% of those LCSWs who are under the age of 40. For those LCSWs with education debt, the median outstanding balance is between $70,000 and $80,000.

At a Glance:

Education

Masters: 96%
Doctorate/PhD: 4%

Education Debt

Carry Debt: 39%
Under Age 40 w/ Debt: 63%
Median Debt: $70k-$80k

Source: Va. Healthcare Workforce Data Center

Education Debt				
Amount Carried	**All LCSWs**		**LCSWs Under 40**	
	#	**%**	**#**	**%**
None	3,367	61%	602	37%
Less than $10,000	192	3%	62	4%
$10,000-$29,999	343	6%	143	9%
$30,000-$49,999	279	5%	131	8%
$50,000-$69,999	259	5%	138	8%
$70,000-$89,999	275	5%	160	10%
$90,000-$109,999	276	5%	144	9%
$110,000-$129,999	193	3%	110	7%
$130,000-$149,999	109	2%	52	3%
$150,000 or More	240	4%	100	6%
Total	**5,533**	**100%**	**1,642**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Primary Specialty

Mental Health:	62%
Child:	6%
Health/Medical:	5%

Secondary Specialty

Mental Health:	16%
Behavioral Disorders:	12%
Substance Abuse:	10%

Source: Va. Healthcare Workforce Data Center

More than three out of every five LCSWs have a primary specialty in mental health. In addition, 16% of LCSWs have a secondary specialty in mental health.

A Closer Look:

Specialties				
Specialty	Primary		Secondary	
	#	%	#	%
Mental Health	3,985	62%	848	16%
Child	385	6%	496	9%
Health/Medical	348	5%	302	6%
Behavioral Disorders	308	5%	664	12%
School/Educational	224	3%	232	4%
Substance Abuse	213	3%	539	10%
Family	143	2%	375	7%
Gerontologic	96	1%	112	2%
Marriage	59	1%	169	3%
Forensic	37	1%	57	1%
Social	19	0%	87	2%
Sex Offender Treatment	17	0%	43	1%
Public Health	14	0%	40	1%
Vocational/Work Environment	13	0%	32	1%
Industrial-Organizational	9	0%	23	0%
Neurology/Neuropsychology	8	0%	17	0%
Rehabilitation	6	0%	15	0%
Experimental or Research	0	0%	7	0%
General Practice (Non-Specialty)	336	5%	966	18%
Other Specialty Area	218	3%	348	6%
Total	**6,440**	**100%**	**5,371**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Employment

Employed in Profession: 92%
Involuntarily Unemployed: < 1%

Positions Held

1 Full-Time: 54%
2 or More Positions: 26%

Weekly Hours:

40 to 49: 45%
60 or More: 4%
Less than 30: 20%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Current Work Status		
Status	**#**	**%**
Employed, Capacity Unknown	8	< 1%
Employed in a Behavioral Sciences-Related Capacity	5,882	92%
Employed, NOT in a Behavioral Sciences-Related Capacity	279	4%
Not Working, Reason Unknown	0	0%
Involuntarily Unemployed	7	< 1%
Voluntarily Unemployed	129	2%
Retired	120	2%
Total	**6,425**	**100%**

Source: Va. Healthcare Workforce Data Center

Among all LCSWs, 92% are currently employed in the profession, 54% hold one full-time job, and 45% work between 40 and 49 hours per week.

Current Weekly Hours		
Hours	**#**	**%**
0 Hours	256	4%
1 to 9 Hours	198	3%
10 to 19 Hours	409	7%
20 to 29 Hours	641	10%
30 to 39 Hours	1,106	18%
40 to 49 Hours	2,806	45%
50 to 59 Hours	629	10%
60 to 69 Hours	163	3%
70 to 79 Hours	42	1%
80 or More Hours	24	0%
Total	**6,274**	**100%**

Source: Va. Healthcare Workforce Data Center

Current Positions		
Positions	**#**	**%**
No Positions	256	4%
One Part-Time Position	972	15%
Two Part-Time Positions	294	5%
One Full-Time Position	3,415	54%
One Full-Time Position & One Part-Time Position	1,113	18%
Two Full-Time Positions	50	1%
More than Two Positions	180	3%
Total	**6,280**	**100%**

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Annual Income		
Income Level	**#**	**%**
Volunteer Work Only	47	1%
Less than $20,000	243	5%
$20,000-$29,999	158	3%
$30,000-$39,999	208	4%
$40,000-$49,999	212	4%
$50,000-$59,999	333	7%
$60,000-$69,999	495	10%
$70,000-$79,999	673	13%
$80,000-$89,999	659	13%
$90,000-$99,999	544	11%
$100,000 or More	1,449	29%
Total	**5,021**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Earnings
Median Income: $80k-$90k

Benefits
(Salary/Wage Employees Only)
Health Insurance: 65%
Retirement: 62%

Satisfaction
Satisfied: 96%
Very Satisfied: 68%

Source: Va. Healthcare Workforce Data Center

Job Satisfaction		
Level	**#**	**%**
Very Satisfied	4,170	68%
Somewhat Satisfied	1,729	28%
Somewhat Dissatisfied	220	4%
Very Dissatisfied	53	1%
Total	**6,172**	**100%**

Source: Va. Healthcare Workforce Data Center

The typical LCSW earns between $80,000 and $90,000 per year. Among LCSWs who receive either an hourly wage or a salary as compensation at their primary work location, 78% receive at least one employer-sponsored benefit, including 65% who have access to health insurance.

Employer-Sponsored Benefits			
Benefit	**#**	**%**	**% of Wage/Salary Employees**
Paid Vacation	3,097	53%	71%
Health Insurance	2,877	49%	65%
Retirement	2,778	47%	62%
Dental Insurance	2,758	47%	63%
Paid Sick Leave	2,756	47%	63%
Group Life Insurance	2,042	35%	47%
Signing/Retention Bonus	505	9%	11%
At Least One Benefit	**3,502**	**60%**	**78%**

*From any employer at time of survey.

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Employment Instability in the Past Year		
In the Past Year, Did You . . .?	**#**	**%**
Experienced Involuntary Unemployment?	34	< 1%
Experience Voluntary Unemployment?	315	4%
Work Part-Time or Temporary Positions, but Would Have Preferred a Full-Time/Permanent Position?	168	2%
Work Two or More Positions at the Same Time?	1,871	23%
Switch Employers or Practices?	473	6%
Experience at Least One?	**2,479**	**31%**

Source: Va. Healthcare Workforce Data Center

Less than 1% of Virginia's LCSWs experienced involuntary unemployment at some point during the past year. By comparison, Virginia's average monthly unemployment rate was 2.8% during the same time period.[1]

Location Tenure				
Tenure	**Primary**		**Secondary**	
	#	**%**	**#**	**%**
Not Currently Working at This Location	131	2%	59	4%
Less than 6 Months	260	4%	168	10%
6 Months to 1 Year	523	9%	193	12%
1 to 2 Years	1,164	19%	352	21%
3 to 5 Years	1,591	26%	470	29%
6 to 10 Years	1,075	18%	215	13%
More than 10 Years	1,338	22%	187	11%
Subtotal	**6,081**	**100%**	**1,644**	**100%**
Did Not Have Location	165		6,218	
Item Missing	1,716		100	
Total	**7,962**		**7,962**	

Source: Va. Healthcare Workforce Data Center

Nearly three out of every five LCSWs are salaried employees, while 18% receive income from their own business or practice.

At a Glance:

Unemployment Experience

Involuntarily Unemployed: < 1%
Underemployed: 2%

Turnover & Tenure

Switched Jobs: 6%
New Location: 19%
Over 2 Years: 66%
Over 2 Yrs., 2nd Location: 53%

Employment Type

Salary/Commission: 59%
Business/Practice Income: 18%

Source: Va. Healthcare Workforce Data Center

Two-thirds of all LCSWs have worked at their primary work location for more than two years.

Employment Type		
Primary Work Site	**#**	**%**
Salary/Commission	2,543	59%
Hourly Wage	661	15%
By Contract	323	7%
Business/Practice Income	778	18%
Unpaid	25	1%
Subtotal	**4,330**	**100%**
Did Not Have Location	165	
Item Missing	3,467	

Source: Va. Healthcare Workforce Data Center

[1] As reported by the U.S. Bureau of Labor Statistics. Over the past year, the non-seasonally adjusted monthly unemployment rate has fluctuated between a low of 2.3% and a high of 3.2%. At the time of publication, the unemployment rate for May 2024 was still preliminary, and the unemployment rate for June 2024 had not yet been released.

At a Glance:

Concentration

Top Region:	36%
Top 3 Regions:	81%
Lowest Region:	1%

Locations

2 or More (Past Year):	28%
2 or More (Now*):	26%

Source: Va. Healthcare Workforce Data Center

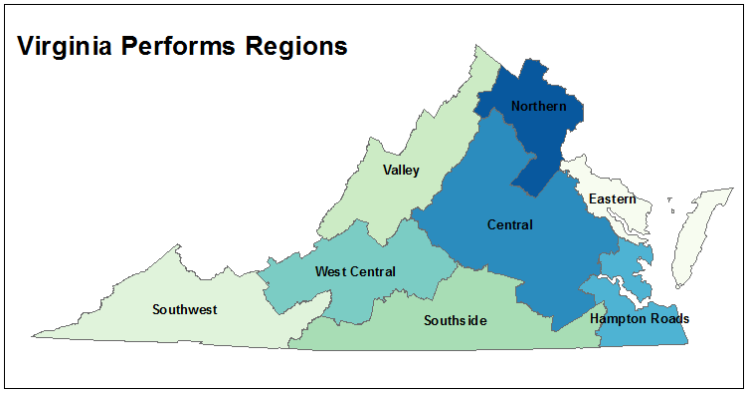
More than four out of every five LCSWs in the state work in Northern Virginia, Central Virginia, or Hampton Roads.

A Closer Look:

Regional Distribution of Work Locations

Virginia Performs Region	Primary Location		Secondary Location	
	#	%	#	%
Central	1,738	29%	424	25%
Eastern	69	1%	20	1%
Hampton Roads	978	16%	307	18%
Northern	2,203	36%	523	31%
Southside	97	2%	39	2%
Southwest	175	3%	41	2%
Valley	224	4%	57	3%
West Central	504	8%	138	8%
Virginia Border State/D.C.	47	1%	58	3%
Other U.S. State	58	1%	90	5%
Outside of the U.S.	2	0%	0	0%
Total	**6,095**	**100%**	**1,697**	**100%**
Item Missing	1,703		47	

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

Number of Work Locations

Locations	Work Locations in Past Year		Work Locations Now*	
	#	%	#	%
0	146	2%	247	4%
1	4,336	70%	4,372	70%
2	959	15%	936	15%
3	704	11%	624	10%
4	42	1%	22	0%
5	14	0%	9	0%
6 or More	20	0%	9	0%
Total	**6,220**	**100%**	**6,220**	**100%**

*At the time of survey completion, June 2024.

Source: Va. Healthcare Workforce Data Center

Among all LCSWs, 26% currently have multiple work locations, while 28% have had multiple work locations over the past year.

A Closer Look:

Location Sector				
Sector	Primary Location		Secondary Location	
	#	%	#	%
For-Profit	3,025	54%	1,135	76%
Non-Profit	1,014	18%	197	13%
State/Local Government	1,050	19%	135	9%
Veterans Administration	248	4%	20	1%
U.S. Military	163	3%	6	0%
Other Federal Government	77	1%	6	0%
Total	**5,577**	**100%**	**1,499**	**100%**
Did Not Have Location	165		6,218	
Item Missing	2,221		246	

Source: Va. Healthcare Workforce Data Center

At a Glance:
(Primary Locations)

Sector

For-Profit: 54%
Federal: 9%

Top Establishments

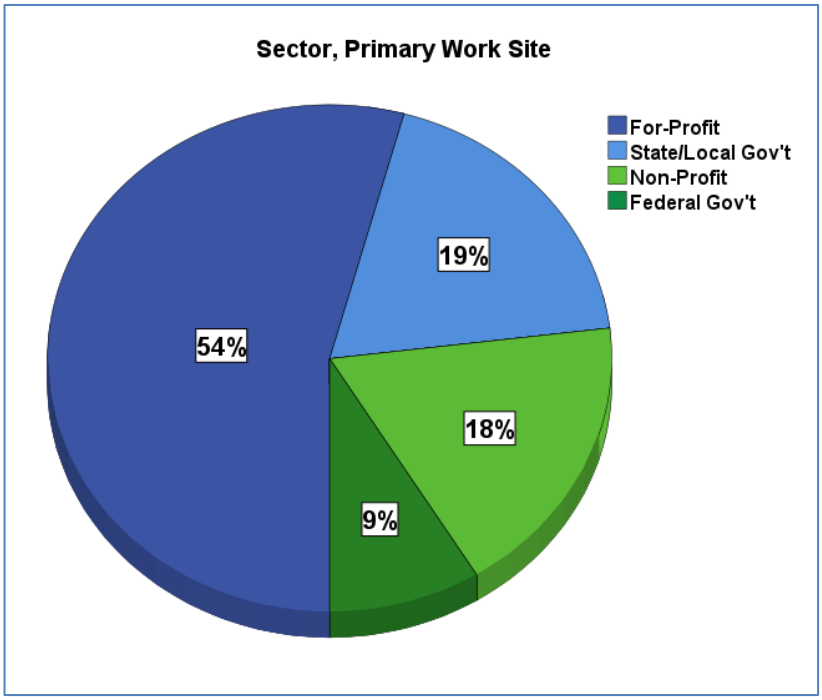
Private Practice, Solo: 20%
Private Practice, Group: 16%
Mental Health Facility (Outpatient): 14%

Payment Method

Cash/Self-Pay: 54%
Private Insurance: 47%

Source: Va. Healthcare Workforce Data Center

Among all LCSWs, 72% work in the private sector, including 54% who work in the for-profit sector. Another 19% of LCSWs work for a state or local government.



Source: Va. Healthcare Workforce Data Center

Location Type				
Establishment Type	Primary Location		Secondary Location	
	#	%	#	%
Private Practice, Solo	1,074	20%	329	23%
Private Practice, Group	894	16%	365	25%
Mental Health Facility, Outpatient	789	14%	224	16%
Community Services Board	459	8%	44	3%
School (Providing Care to Clients)	388	7%	16	1%
Hospital, General	385	7%	53	4%
Community-Based Clinic or Health Center	342	6%	95	7%
Hospital, Psychiatric	146	3%	24	2%
Residential Mental Health/Substance Abuse Facility	84	2%	20	1%
Administrative or Regulatory	74	1%	15	1%
Physician Office	65	1%	8	1%
Academic Institution (Teaching Health Professions Students)	61	1%	68	5%
Home Health Care	45	1%	17	1%
Corrections/Jail	40	1%	12	1%
Long-Term Care Facility, Nursing Home	33	1%	5	0%
Rehabilitation Facility	21	0%	5	0%
Residential Intellectual/Development Disability Facility	13	0%	3	0%
Other Practice Setting	531	10%	140	10%
Total	**5,444**	**100%**	**1,443**	**100%**
Did Not Have a Location	165		6,218	

Source: Va. Healthcare Workforce Data Center

Solo and group private practices employ 36% of all LCSWs in Virginia. Another 14% of LCSWs work at outpatient mental health facilities.

Among all LCSWs, 54% work at establishments that accept cash/self-pay as a form of payment for services rendered. This makes cash/self-pay the most commonly accepted form of payment among Virginia's LCSW workforce.

Accepted Forms of Payment		
Payment	#	% of Workforce
Cash/Self-Pay	4,285	54%
Private Insurance	3,717	47%
Medicaid	2,506	31%
Medicare	2,175	27%

Source: Va. Healthcare Workforce Data Center

At a Glance:
(Primary Locations)

Languages Offered

Spanish:	15%
French:	7%
Arabic:	7%

Means of Communication

Virtual Translation:	55%
Other Staff Member:	41%
Onsite Translation:	28%

Source: Va. Healthcare Workforce Data Center

Among all LCSWs, 15% are employed at a primary work location that offers Spanish language services for patients.

A Closer Look:

Languages Offered		
Language	**#**	**% of Workforce**
Spanish	1,225	15%
French	525	7%
Arabic	520	7%
Chinese	477	6%
Korean	470	6%
Vietnamese	462	6%
Hindi	443	6%
Urdu	433	5%
Persian	429	5%
Tagalog/Filipino	428	5%
Amharic, Somali, or Other Afro-Asiatic Languages	398	5%
Pashto	398	5%
Others	288	4%
At Least One Language	**1,399**	**18%**

Source: Va. Healthcare Workforce Data Center

Means of Language Communication		
Provision	**#**	**% of Workforce with Language Services**
Virtual Translation Service	766	55%
Other Staff Member is Proficient	580	41%
Onsite Translation Service	390	28%
Respondent is Proficient	323	23%
Other	50	4%

Source: Va. Healthcare Workforce Data Center

More than half of all LCSWs who are employed at a primary work location that offers language services for patients provide it by means of a virtual translation service.

At a Glance:
(Primary Locations)

Typical Time Allocation

Patient Care:	70%-79%
Administration:	10%-19%
Supervisory:	1%-9%

Roles

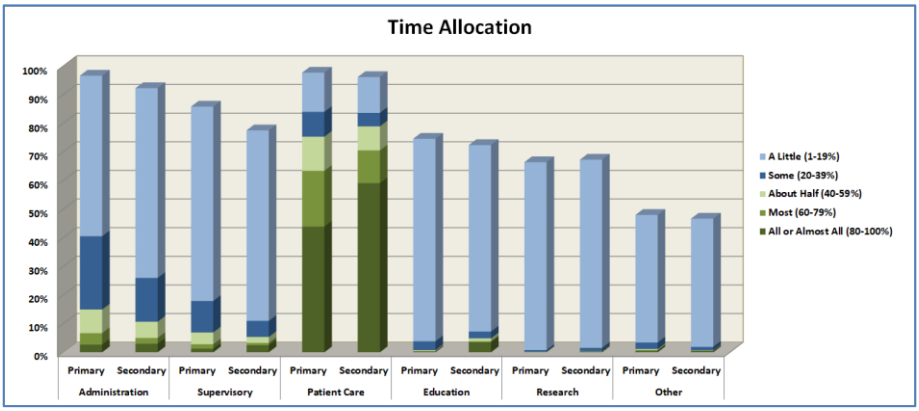
Patient Care:	63%
Administration:	7%
Supervisory:	3%

Patient Care LCSWs

Median Admin. Time:	10%-19%
Avg. Admin. Time:	10%-19%

Source: Va. Healthcare Workforce Data Center

A Closer Look:



Source: Va. Healthcare Workforce Data Center

LCSWs spend approximately three-quarters of their time treating patients. In fact, 63% of all LCSWs fill a patient care role, defined as spending 60% or more of their time on patient care activities.

Time Allocation												
Time Spent	Admin.		Supervisory		Patient Care		Education		Research		Other	
	Pri. Site	Sec. Site	Pri. Site	Sec. Site	Pri. Site	Sec. Site	Pri. Site	Sec. Site	Pri. Site	Sec. Site	Pri. Site	Sec. Site
All or Almost All (80-100%)	3%	3%	1%	2%	44%	59%	0%	4%	0%	0%	0%	0%
Most (60-79%)	4%	2%	2%	1%	20%	11%	0%	0%	0%	0%	0%	0%
About Half (40-59%)	8%	6%	4%	2%	12%	8%	0%	1%	0%	0%	0%	0%
Some (20-39%)	26%	15%	11%	6%	9%	5%	3%	2%	1%	1%	2%	1%
A Little (1-19%)	56%	66%	68%	67%	14%	12%	71%	65%	66%	66%	45%	45%
None (0%)	3%	8%	14%	22%	2%	4%	25%	28%	34%	33%	52%	53%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Patients Per Week				
# of Patients	Primary Location		Secondary Location	
	#	%	#	%
None	449	8%	174	12%
1 to 24	3,600	65%	1,164	80%
25 to 49	1,283	23%	110	8%
50 to 74	113	2%	10	1%
75 or More	66	1%	4	0%
Total	**5,511**	**100%**	**1,462**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

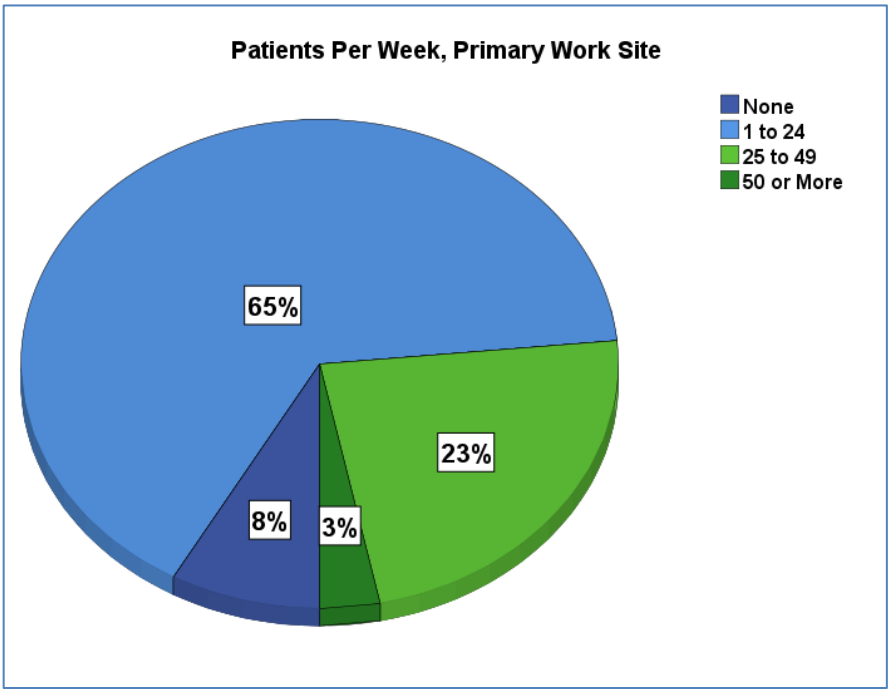
Patients Per Week

Primary Location: 1-24

Secondary Location: 1-24

Source: Va. Healthcare Workforce Data Center

Nearly two-thirds of all LCSWs treat between 1 and 24 patients per week at their primary work location. Among those LCSWs who also have a secondary work location, 80% treat between 1 and 24 patients per week.



Source: Va. Healthcare Workforce Data Center

At a Glance:
(Primary Locations)

Typical Patient Allocation

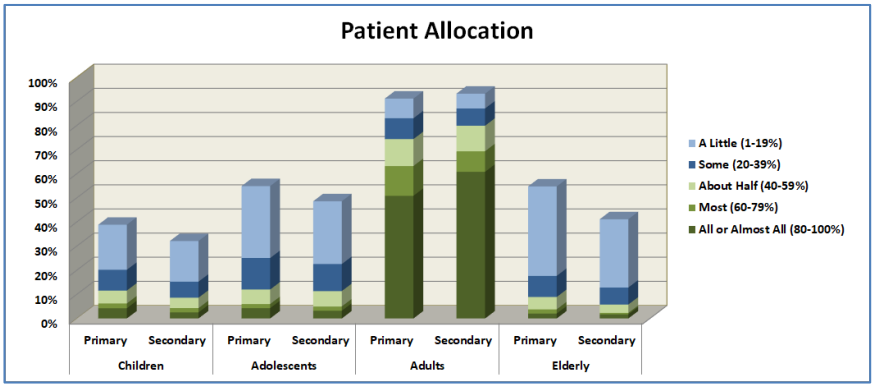
Children:	None
Adolescents:	1%-9%
Adults:	80%-89%
Elderly:	1%-9%

Roles

Children:	6%
Adolescents:	6%
Adults:	63%
Elderly:	4%

Source: Va. Healthcare Workforce Data Center

A Closer Look:



Source: Va. Healthcare Workforce Data Center

In general, between 80% and 90% of all patients seen by LCSWs at their primary work location are adults. In addition, 63% of LCSWs serve an adult patient care role, meaning that at least 60% of their patients are adults.

Patient Allocation								
Time Spent	Children		Adolescents		Adults		Elderly	
	Pri. Site	Sec. Site	Pri. Site	Sec. Site	Pri. Site	Sec. Site	Pri. Site	Sec. Site
All or Almost All (80-100%)	4%	3%	4%	3%	51%	61%	2%	2%
Most (60-79%)	2%	2%	2%	2%	12%	9%	2%	1%
About Half (40-59%)	5%	4%	6%	6%	11%	11%	5%	3%
Some (20-39%)	9%	7%	13%	11%	9%	7%	9%	7%
A Little (1-19%)	19%	17%	30%	26%	8%	6%	37%	28%
None (0%)	61%	68%	45%	51%	9%	7%	45%	59%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Telehealth Services		
	#	%
Providing Telehealth Services		
In Virginia	3,696	59%
Outside of Virginia	61	1%
Both	1,079	17%
Total Providing Telehealth Services	**4,836**	**77%**
Not Providing Telehealth Services		
Total Not Providing Telehealth Services	**1,458**	**23%**
Total		
Total	**6,295**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

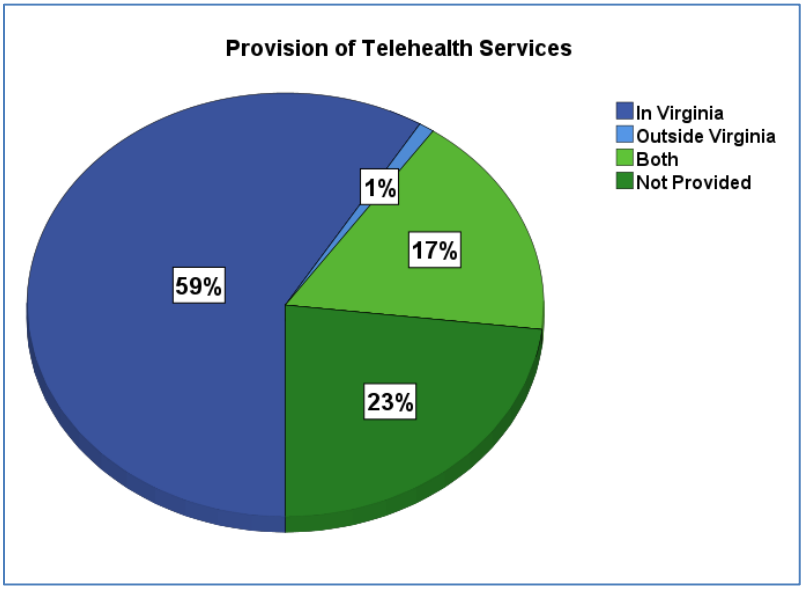
Telehealth Services

% Providing Telehealth: 77%

Telehealth Workload

Less than Half: 60%
More than Half: 20%
All: 20%

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

More than three-quarters of all LCSWs provide telehealth services, including 59% of LCSWs who provide telehealth services only in Virginia.

Two out of every five LCSWs work at a practice that provides more than half or all of their health care services via telehealth.

Telehealth Workload		
Percentage	**#**	**%**
Less than Half	3,322	60%
More than Half	1,079	20%
All	1,113	20%
Total	**5,514**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Interstate Compact
% in Compact: 2%

Compact Affiliation
Social Work Licensure: 81%
PSYPACT: 1%

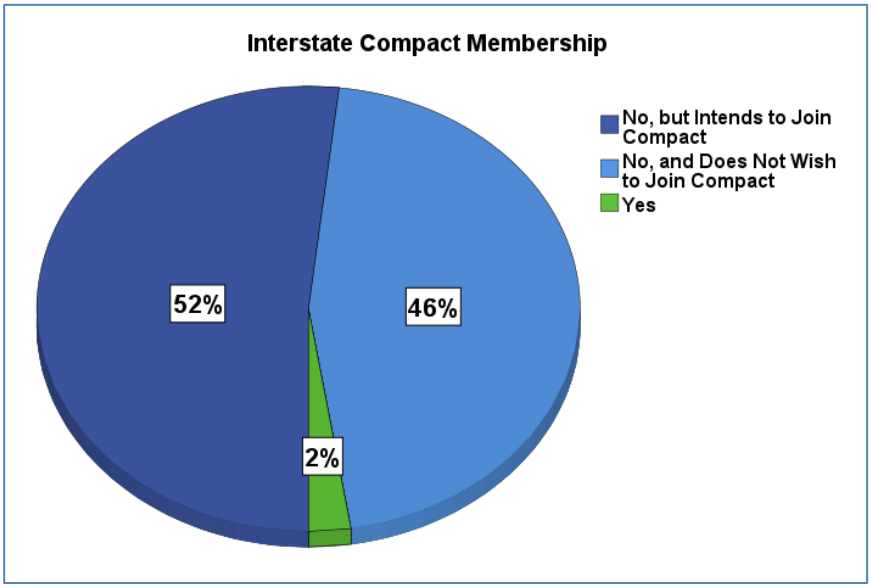
Source: Va. Healthcare Workforce Data Center

A Closer Look:

Interstate Compact		
	#	%
In Compact		
Total in Compact	**147**	**2%**
Not in Compact		
Intends to Join Compact	3,047	52%
Does Not Wish to Join Compact	2,687	46%
Total Not in Compact	**5,734**	**98%**
Total		
Total	**5,881**	**100%**

Source: Va. Healthcare Workforce Data Center

While 2% of LCSWs are currently a part of an interstate compact, 52% intend to join a compact in the future.



Source: Va. Healthcare Workforce Data Center

Compact Affiliation		
Affiliation	**#**	**%**
Social Work Licensure Compact	111	81%
Psychology Interjurisdictional Compact (PSYPACT)	1	1%
Counseling Compact	0	0%
Other	25	18%
Total	**137**	**100%**

Source: Va. Healthcare Workforce Data Center

More than four out of every five LCSWs currently in an interstate compact are affiliated with the Social Work Licensure Compact.

A Closer Look:

Retirement Expectations				
Expected Retirement Age	All LCSWs		LCSWs 50 and Over	
	#	%	#	%
Under Age 50	98	2%	-	-
50 to 54	132	3%	10	0%
55 to 59	418	8%	108	5%
60 to 64	1,040	20%	348	15%
65 to 69	1,636	31%	717	31%
70 to 74	891	17%	530	23%
75 to 79	381	7%	262	11%
80 or Over	158	3%	118	5%
I Do Not Intend to Retire	494	9%	255	11%
Total	5,249	100%	2,348	100%

Source: Va. Healthcare Workforce Data Center

At a Glance:

Retirement Expectations

All LCSWs

Under 65: 32%

Under 60: 12%

LCSWs 50 and Over

Under 65: 20%

Under 60: 5%

Time Until Retirement

Within 2 Years: 7%

Within 10 Years: 23%

Half the Workforce: By 2049

Source: Va. Healthcare Workforce Data Center

Among all LCSWs, 32% expect to retire before the age of 65. Among those LCSWs who are age 50 or over, 20% expect to retire by the age of 65.

Within the next two years, 12% of LCSWs expect to increase their patient care hours, and 8% expect to pursue additional educational opportunities.

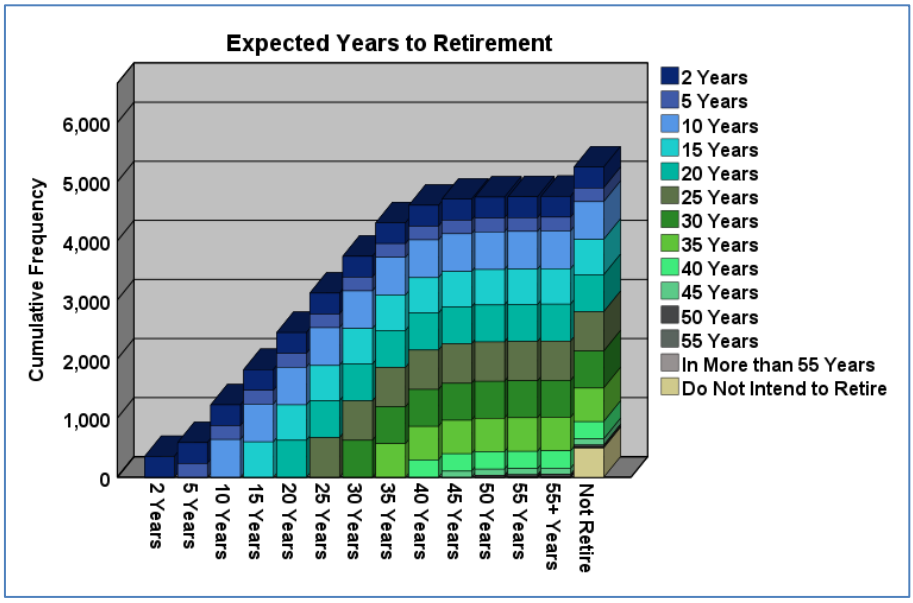
Future Plans		
Two-Year Plans:	#	%
Decrease Participation		
Leave Profession	106	1%
Leave Virginia	183	2%
Decrease Patient Care Hours	603	8%
Decrease Teaching Hours	31	0%
Increase Participation		
Increase Patient Care Hours	994	12%
Increase Teaching Hours	446	6%
Pursue Additional Education	660	8%
Return to the Workforce	59	1%

Source: Va. Healthcare Workforce Data Center

By comparing retirement expectation to age, we can estimate the maximum years to retirement for LCSWs. While 7% of LCSWs expect to retire in the next two years, 23% expect to retire in the next ten years. Half of the current workforce expect to retire by 2049.

Time to Retirement			
Expect to Retire Within. . .	#	%	Cumulative %
2 Years	352	7%	7%
5 Years	233	4%	11%
10 Years	639	12%	23%
15 Years	599	11%	35%
20 Years	625	12%	47%
25 Years	666	13%	59%
30 Years	625	12%	71%
35 Years	567	11%	82%
40 Years	295	6%	88%
45 Years	103	2%	90%
50 Years	35	1%	90%
55 Years	7	0%	90%
In More than 55 Years	8	0%	91%
Do Not Intend to Retire	494	9%	100%
Total	**5,249**	**100%**	

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

Using these estimates, retirement will begin to reach 10% of the current workforce starting in 2034. Retirement will peak at 13% of the current workforce around 2049 before declining to under 10% of the current workforce again around 2064.

At a Glance:

FTEs

Total: 6,384
FTEs/1,000 Residents[2]: 0.735
Average: 0.82

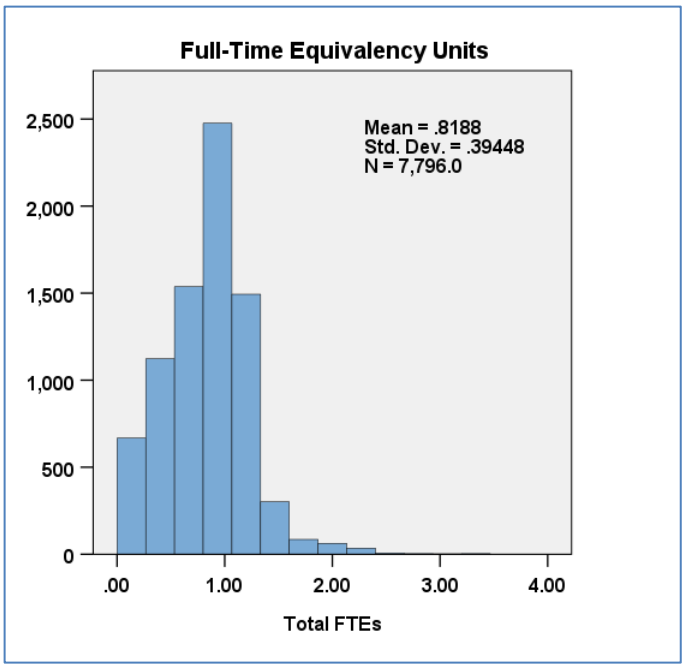
Age & Gender Effect

Age, *Partial Eta*^{2}: Medium
Gender, *Partial Eta*^{2}: Negligible

Partial Eta^2 *Explained:*
Partial Eta^2 is a statistical measure of effect size.

Source: Va. Healthcare Workforce Data Center

A Closer Look:

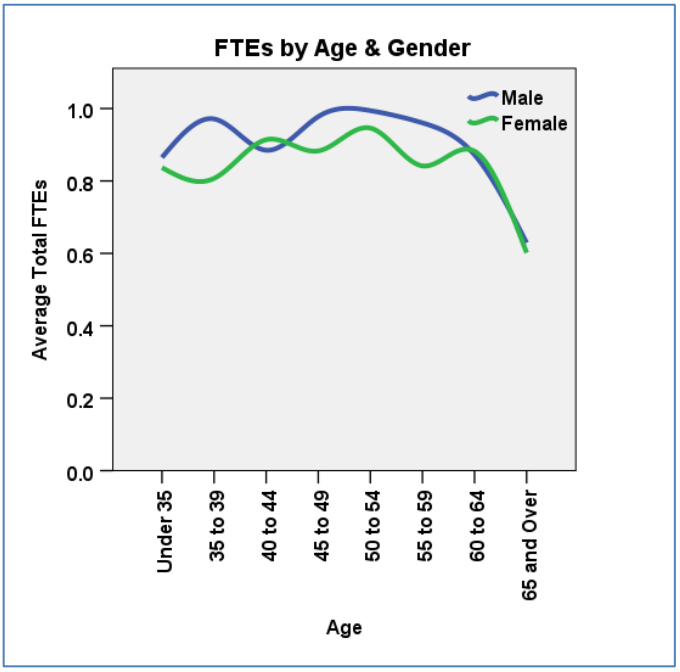


Source: Va. Healthcare Workforce Data Center

The typical (median) LCSW provided 0.88 FTEs over the past year, or approximately 35 hours per week for 50 weeks. Although FTEs appear to vary by age and gender, statistical tests did not verify that a difference exists.[3]

Full-Time Equivalency Units		
Age	**Average Age**	**Median Age**
Under 35	0.84	0.85
35 to 39	0.77	0.80
40 to 44	0.91	0.93
45 to 49	0.90	0.90
50 to 54	0.97	1.07
55 to 59	0.77	0.83
60 to 64	0.82	0.78
65 and Over	0.61	0.61
Gender		
Male	0.87	0.93
Female	0.84	0.89

Source: Va. Healthcare Workforce Data Center

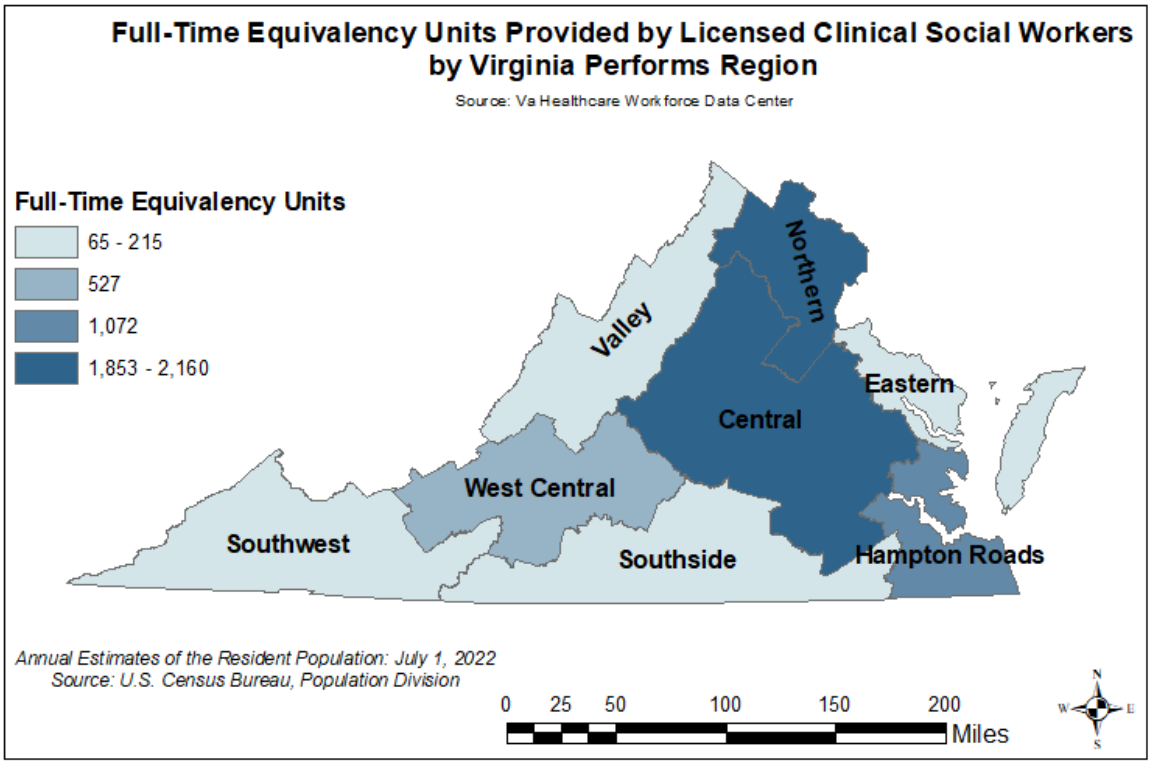


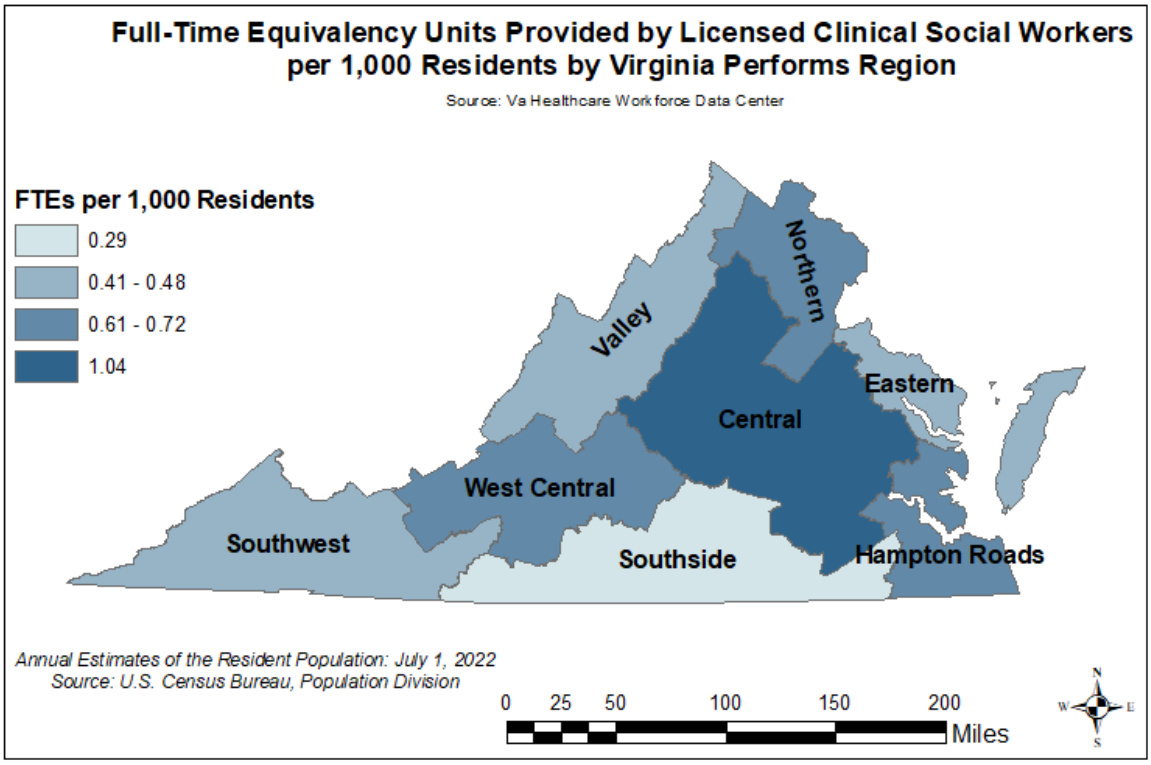
Source: Va. Healthcare Workforce Data Center

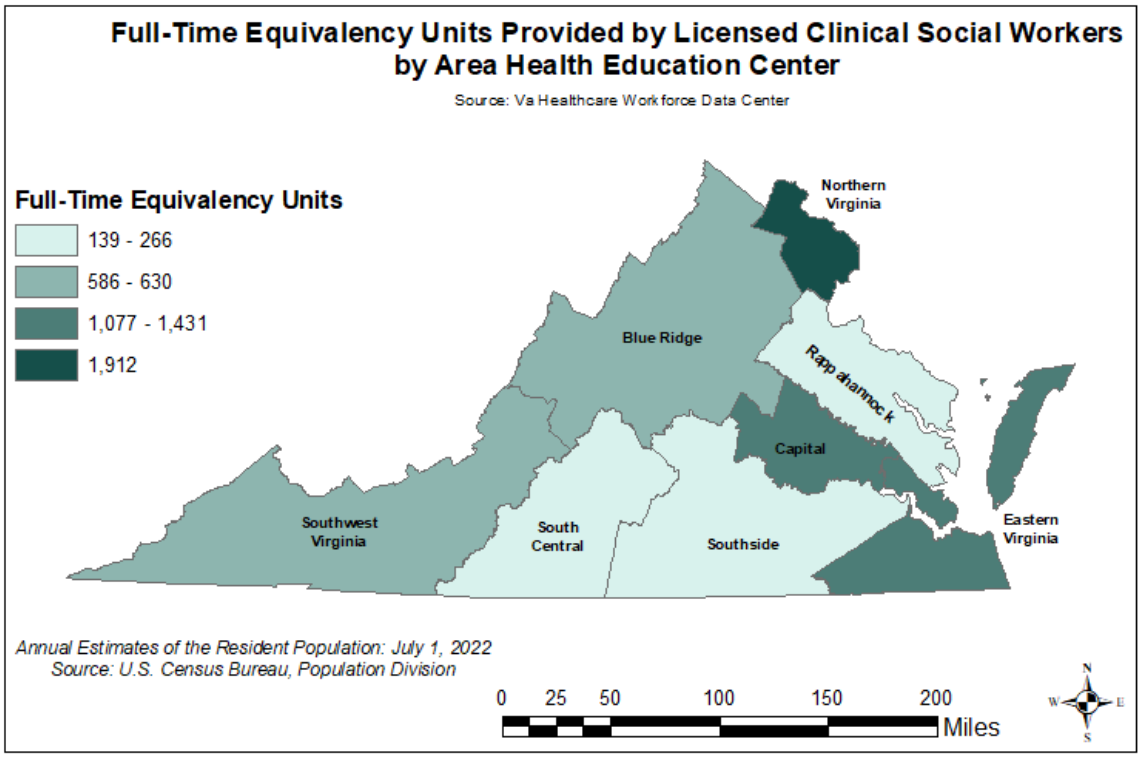
[2] Number of residents in 2022 was used as the denominator.
[3] Due to assumption violations in Mixed between-within ANOVA (Levene's Test was significant).

Maps

Virginia Performs Regions






Full-Time Equivalency Units Provided by Licensed Clinical Social Workers by Area Health Education Center
Source: Va Healthcare Workforce Data Center
Full-Time Equivalency Units
139 - 266
586 - 630
1,077 - 1,431
1,912
Northern Virginia
Blue Ridge
Rappahannock
Capital
Eastern Virginia
Southwest Virginia
South Central
Southside
Annual Estimates of the Resident Population: July 1, 2022
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
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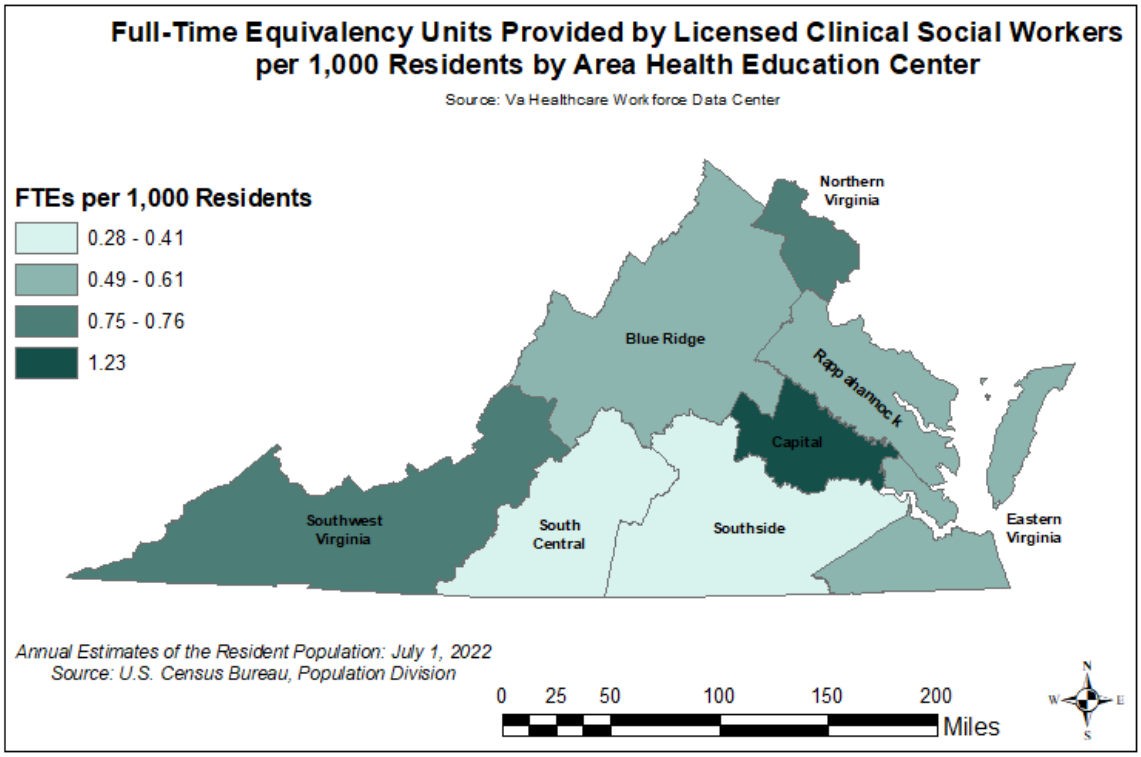
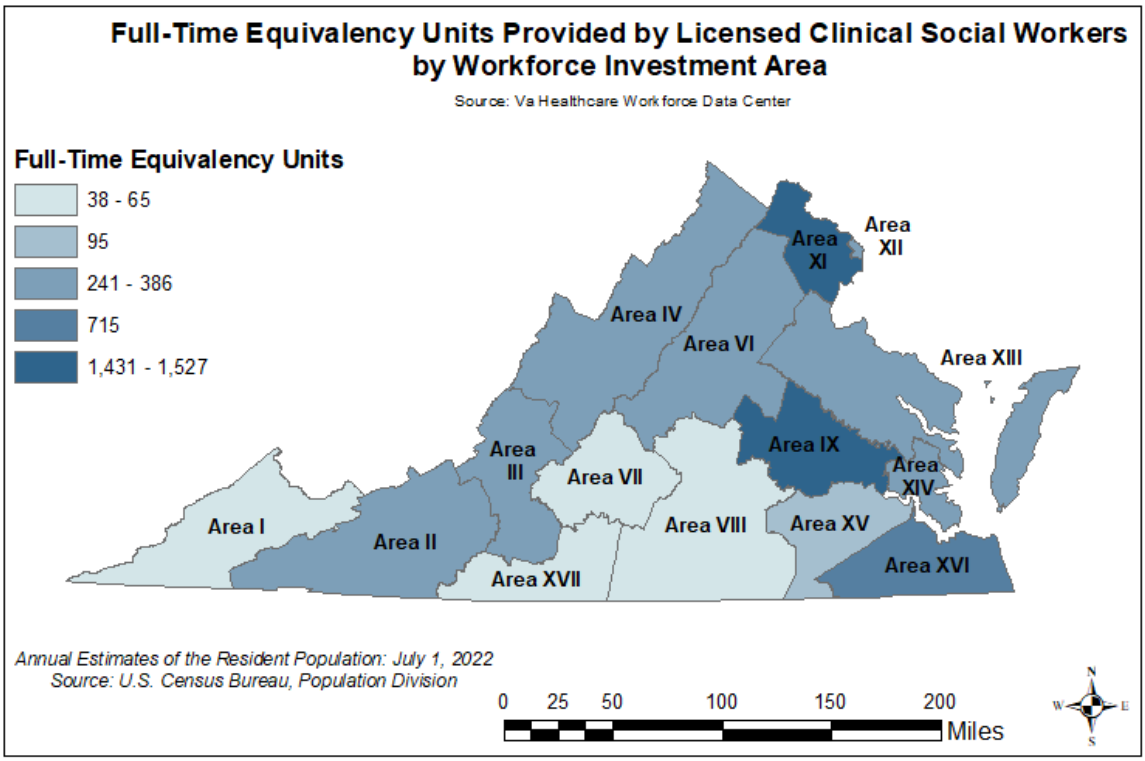
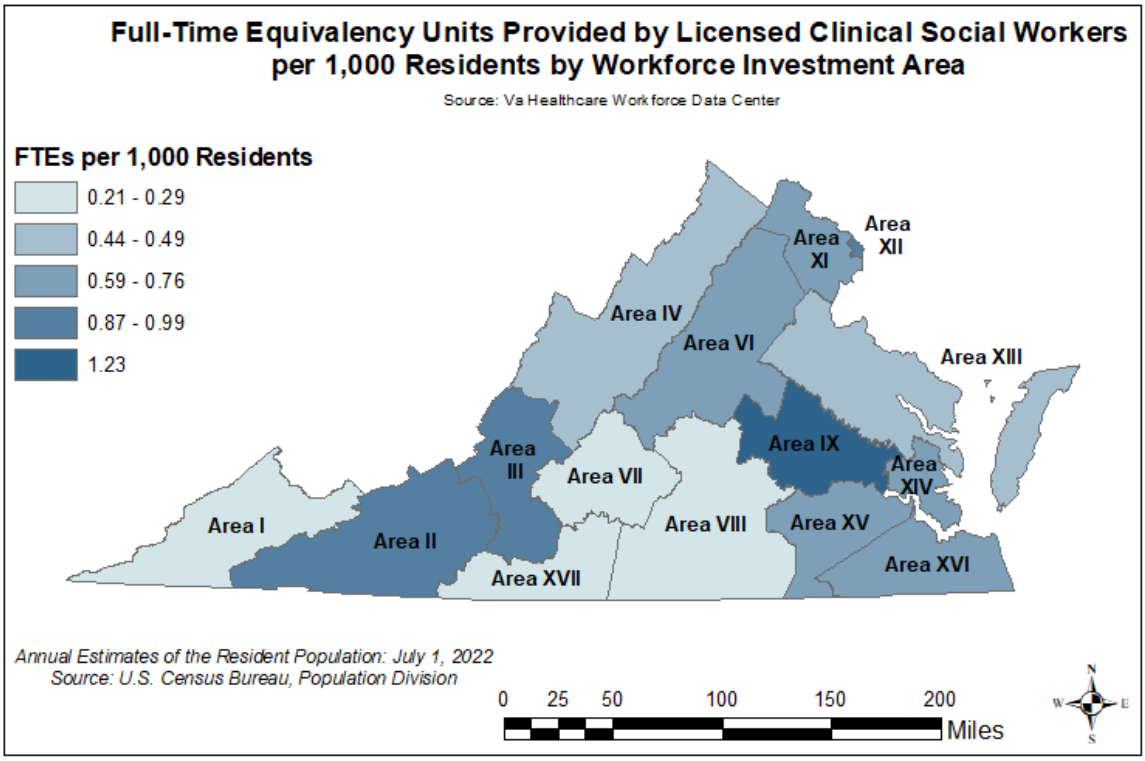
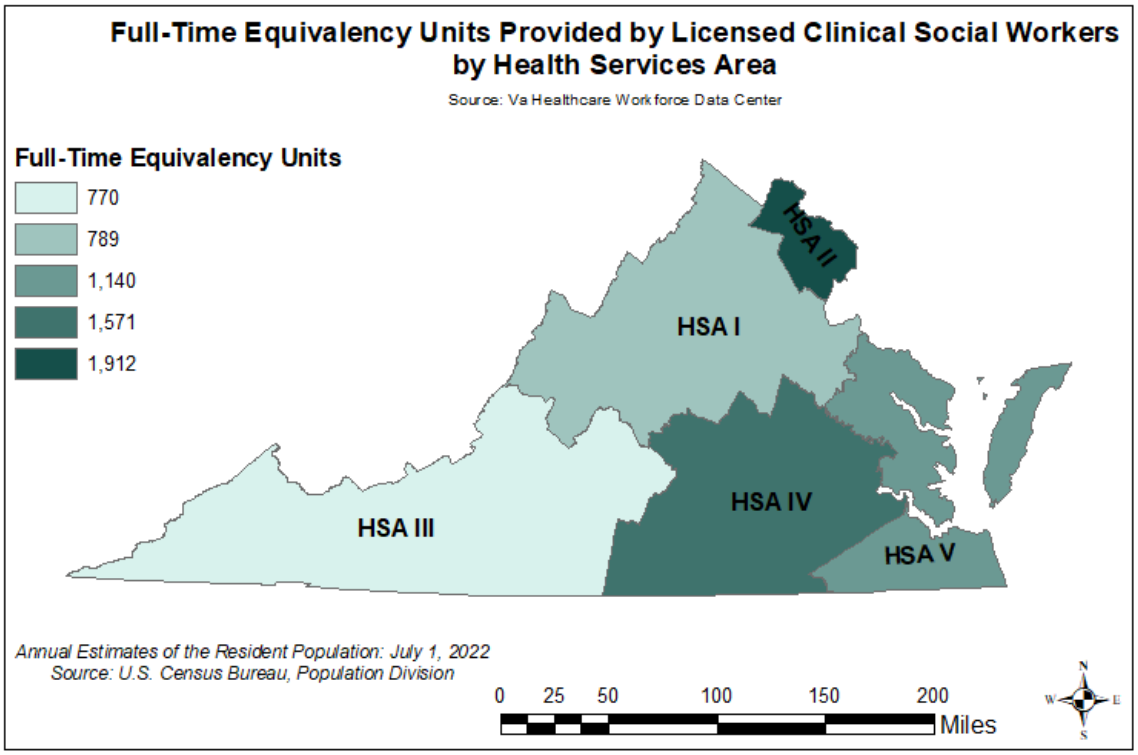
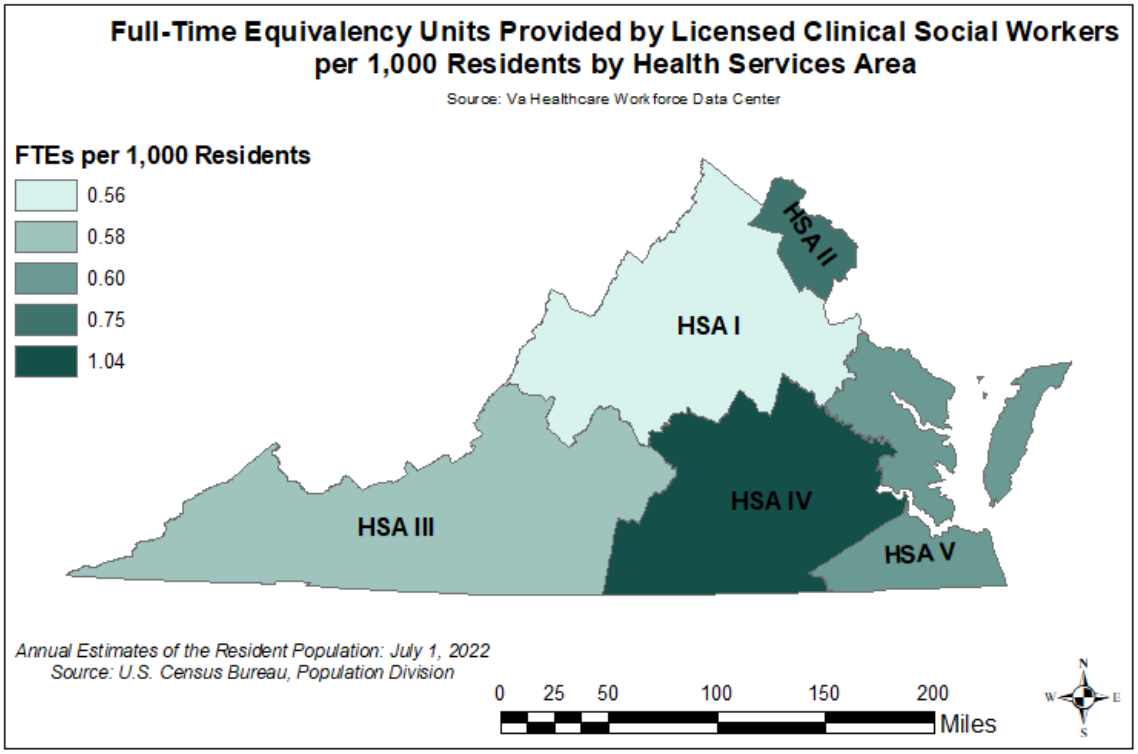
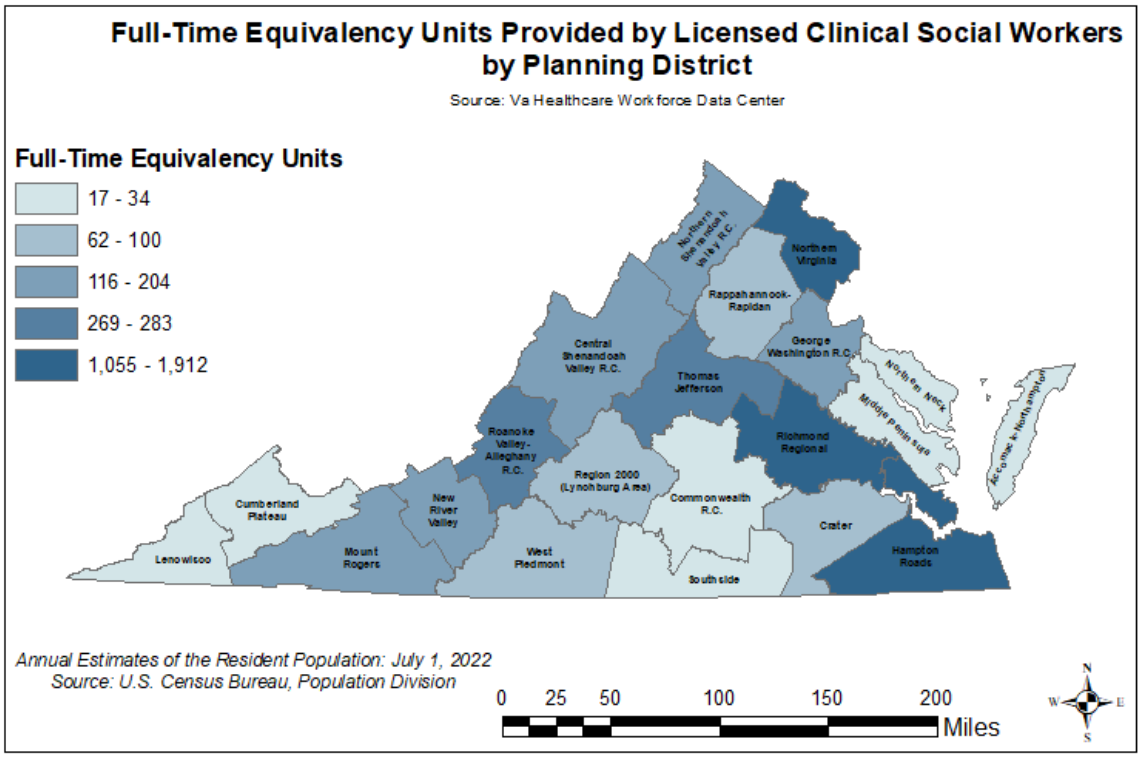

Full-Time Equivalency Units Provided by Licensed Clinical Social Workers per 1,000 Residents by Area Health Education Center
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
0.28 - 0.41
0.49 - 0.61
0.75 - 0.76
1.23
Northern Virginia
Blue Ridge
Rappahannock
Capital
Eastern Virginia
Southwest Virginia
South Central
Southside
Annual Estimates of the Resident Population: July 1, 2022
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S

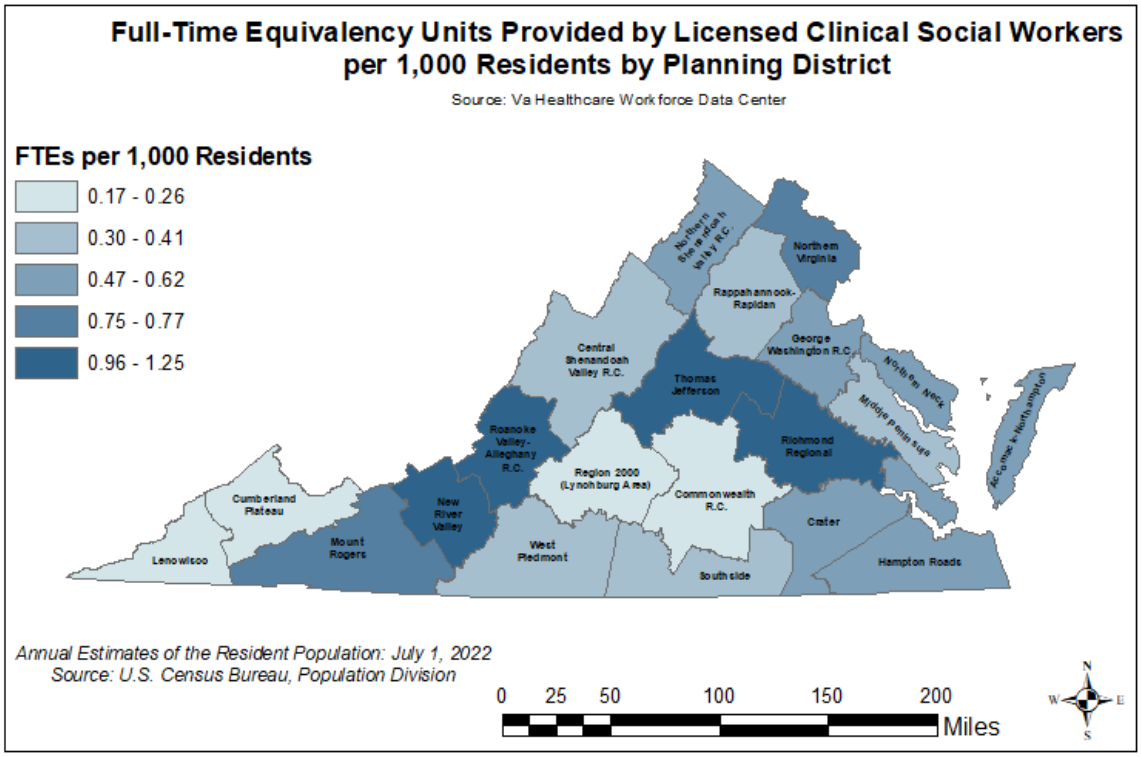

Full-Time Equivalency Units Provided by Licensed Clinical Social Workers by Workforce Investment Area
Source: Va Healthcare Workforce Data Center
Full-Time Equivalency Units
38 - 65
95
241 - 386
715
1,431 - 1,527
Area I
Area II
Area III
Area IV
Area VI
Area VII
Area VIII
Area IX
Area XI
Area XII
Area XIII
Area XIV
Area XV
Area XVI
Area XVII
Annual Estimates of the Resident Population: July 1, 2022
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S


Full-Time Equivalency Units Provided by Licensed Clinical Social Workers per 1,000 Residents by Workforce Investment Area
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
0.21 - 0.29
0.44 - 0.49
0.59 - 0.76
0.87 - 0.99
1.23
Area I
Area II
Area III
Area IV
Area VI
Area VII
Area VIII
Area IX
Area XI
Area XII
Area XIII
Area XIV
Area XV
Area XVI
Area XVII
Annual Estimates of the Resident Population: July 1, 2022
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S


Full-Time Equivalency Units Provided by Licensed Clinical Social Workers by Health Services Area
Source: Va Healthcare Workforce Data Center
Full-Time Equivalency Units
770
789
1,140
1,571
1,912
HSA II
HSA I
HSA III
HSA IV
HSA V
Annual Estimates of the Resident Population: July 1, 2022
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S


Full-Time Equivalency Units Provided by Licensed Clinical Social Workers per 1,000 Residents by Health Services Area
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
0.56
0.58
0.60
0.75
1.04
HSA II
HSA I
HSA III
HSA IV
HSA V
Annual Estimates of the Resident Population: July 1, 2022
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S


Full-Time Equivalency Units Provided by Licensed Clinical Social Workers by Planning District
Source: Va Healthcare Workforce Data Center
Full-Time Equivalency Units
17 - 34
62 - 100
116 - 204
269 - 283
1,055 - 1,912
Northern Shenandoah Valley R.C.
Northern Virginia
Rappahannock-Rapidan
George Washington R.C.
Central Shenandoah Valley R.C.
Thomas Jefferson
Northern Neck
Middle Peninsula
Accomack-Northampton
Roanoke Valley-Alleghany R.C.
Richmond Regional
Region 2000 (Lynchburg Area)
Commonwealth R.C.
Crater
New River Valley
Cumberland Plateau
Mount Rogers
West Piedmont
South side
Hampton Roads
Lenowisco
Annual Estimates of the Resident Population: July 1, 2022
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S


Full-Time Equivalency Units Provided by Licensed Clinical Social Workers per 1,000 Residents by Planning District
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
0.17 - 0.26
0.30 - 0.41
0.47 - 0.62
0.75 - 0.77
0.96 - 1.25
Northern Shenandoah Valley R.C.
Northern Virginia
Rappahannock-Rapidan
George Washington R.C.
Central Shenandoah Valley R.C.
Thomas Jefferson
Northern Neck
Middle Peninsula
Accomack-Northampton
Roanoke Valley-Alleghany R.C.
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Annual Estimates of the Resident Population: July 1, 2022
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S

Appendices

Appendix A: Weights

Rural Status	Location Weight			Total Weight	
	#	Rate	Weight	Min.	Max.
Metro, 1 Million+	5,918	89.90%	1.112	1.042	1.273
Metro, 250,000 to 1 Million	504	88.69%	1.128	1.056	1.290
Metro, 250,000 or Less	775	89.16%	1.122	1.051	1.283
Urban, Pop. 20,000+, Metro Adj.	50	82.00%	1.220	1.143	1.395
Urban, Pop. 20,000+, Non-Adj.	0	NA	NA	NA	NA
Urban, Pop. 2,500-19,999, Metro Adj.	200	84.50%	1.183	1.109	1.354
Urban, Pop. 2,500-19,999, Non-Adj.	100	94.00%	1.064	0.997	1.217
Rural, Metro Adj.	166	82.53%	1.212	1.135	1.386
Rural, Non-Adj.	35	77.14%	1.296	1.215	1.483
Virginia Border State/D.C.	2,076	79.96%	1.251	1.172	1.431
Other U.S. State	1,669	68.66%	1.456	1.365	1.666

Source: Va. Healthcare Workforce Data Center

Age	Age Weight			Total Weight	
	#	Rate	Weight	Min.	Max.
Under 35	1,536	74.02%	1.351	1.217	1.666
35 to 39	1,713	83.13%	1.203	1.084	1.484
40 to 44	1,621	84.27%	1.187	1.069	1.463
45 to 49	1,401	87.01%	1.149	1.035	1.417
50 to 54	1,422	87.48%	1.143	1.030	1.410
55 to 59	1,132	90.37%	1.107	0.997	1.365
60 to 64	984	87.60%	1.142	1.028	1.408
65 and Over	1,684	86.52%	1.156	1.041	1.425

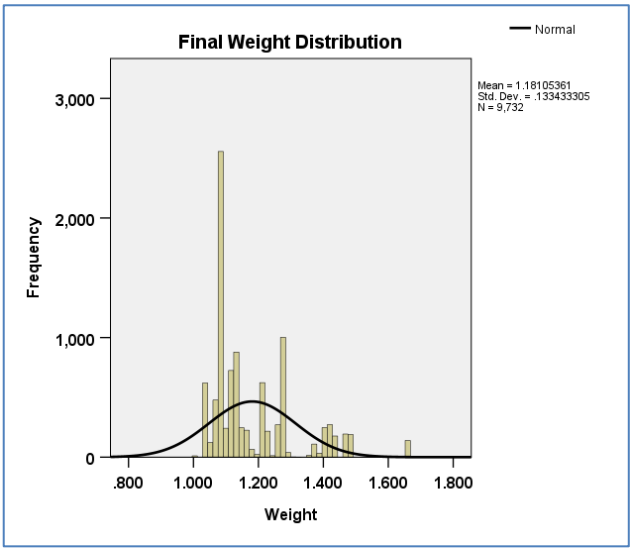
Source: Va. Healthcare Workforce Data Center

See the Methods section on the HWDC website for details on HWDC methods: https://www.dhp.virginia.gov/PublicResources/HealthcareWorkforceDataCenter/

Final weights are calculated by multiplying the two weights and the overall response rate:

Age Weight x Rural Weight x Response Rate = Final Weight.

Overall Response Rate: **0.846776**



Source: Va. Healthcare Workforce Data Center

DRAFT

Virginia's Licensed Master's Social Worker Survey: 2024

Healthcare Workforce Data Center

August 2024

Virginia Department of Health Professions
Healthcare Workforce Data Center
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, VA 23233
804-597-4213, 804-527-4434 (fax)
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Get a copy of this report from:
http://www.dhp.virginia.gov/PublicResources/HealthcareWorkforceDataCenter/ProfessionReports/

Nearly 1,000 Licensed Master's Social Workers voluntarily participated in this survey. *Without their efforts, the work of the center would not be possible. The Department of Health Professions, the Healthcare Workforce Data Center, and the Board of Social Work express our sincerest appreciation for their ongoing cooperation.*

Thank You!

Virginia Department of Health Professions

Arne E. Owens, MS
Director

James L. Jenkins, Jr., RN
Chief Deputy Director

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Ruth Ann Smulik
Forest

Executive Director

Jaime H. Hoyle, JD

Contents

The Licensed Master's Social Worker Survey At a Glance:

Licensees

Licensees:	1,531
Virginia's Workforce:	979
FTEs:	914

Survey Response Rate

All Licensees:	64%
Renewing Practitioners:	98%

Age

Median Age:	39
% Under 40:	52%
% 55 and Over:	15%

Work Location

Northern VA:	43%
Central VA:	24%
Hampton Roads:	17%

Supervision

Supervised:	60%
Supervisor w/ LCSW:	54%

Macro

Macro Concentration:	22%
Work at Agency:	69%
Pursuing LCSW:	57%

Micro

CSW Concentration:	67%
Work at Agency:	74%
Pursuing LCSW:	80%

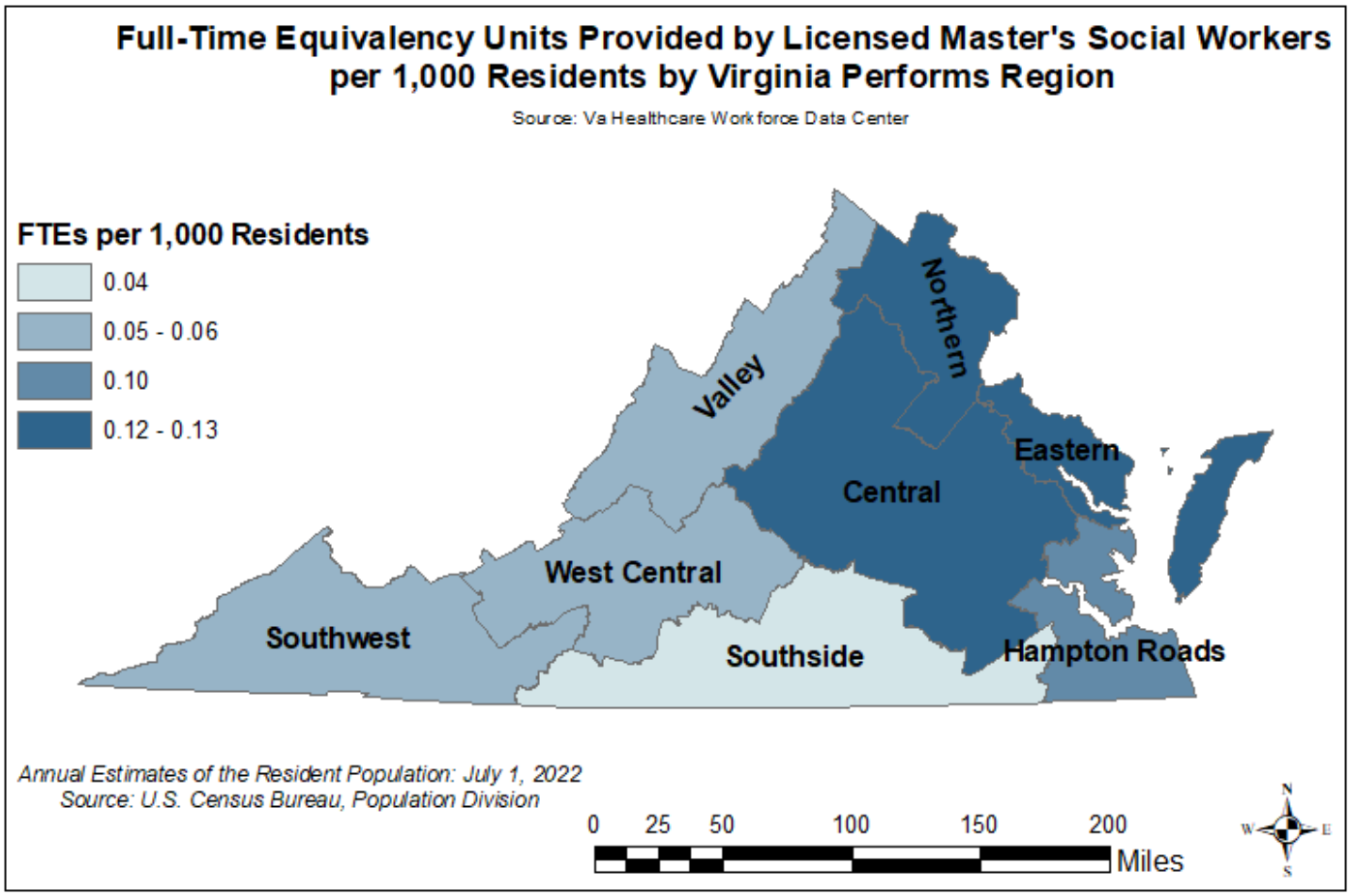
Job Turnover

New Location:	42%
Employed Over 2 Yrs.:	38%

Time Allocation

Clinical Work:	51%-60%
Administration:	11%-20%
Clinical Work Role:	41%

Source: Va. Healthcare Workforce Data Center



Results in Brief

This report contains the results of the 2024 Licensed Master's Social Worker (LMSW) Workforce Survey. Among all LMSWs, 987 voluntarily participated in this survey. The Virginia Department of Health Professions' Healthcare Workforce Data Center (HWDC) administers the survey during the license renewal process, which takes place every June for LMSWs. These survey respondents represent 64% of the 1,531 LMSWs licensed in the state and 98% of renewing practitioners.

The HWDC estimates that 979 LMSWs participated in Virginia's workforce during the survey period. For the purposes for this survey, the LSMW workforce is defined as those LMSWs who worked at least a portion of the year in the state, but it does not include LMSWs who live in the state and intend to work as an LMSW at some point in the future. Over the past year, Virginia's LMSW workforce provided 914 "full-time equivalency units," which the HWDC defines simply as working 2,000 hours per year.

The median age of the LMSW workforce is 39. Two out of every five LMSWs obtained a LMSW license because they believed it to be a prerequisite for licensure as a clinical social worker. Three out of every five LMSWs have a supervisor on site, and 54% of these supervisors are LCSWs. LMSWs spend approximately half of their time performing clinical work, and 41% of LMSWs fill a clinical work role, defined as spending at least 60% of their time in clinical work activities. Nearly two out of every five LMSWs have worked at their primary work location for more than two years.

More than one out of every five LMSWs pursued a Master's in Social Work with a macro concentration, and 69% of LMSWs with a macro concentration work at an agency. Among LMSWs with a macro concentration who work at an agency, 59% provide clinical social work services through their employment at that agency, 20% of which are exempt from licensing requirements. Among LMSWs with a macro concentration, 57% intend to eventually pursue licensure as a clinical social worker. One-third of LMSWs with a macro concentration are registered as a supervisee in social work.

Two-thirds of all LMSWs pursued a Master's in Social Work with a micro concentration, and 74% of LMSWs with a micro concentration work at an agency. Among LMSWs with a micro concentration who work at an agency, 85% provide clinical social work services through their employment at that agency, 8% of which are exempt from licensing requirements. Among LMSWs with a micro concentration, 80% intend to eventually pursue licensure as a clinical social worker. Nearly three out of every five LMSWs with a micro concentration are registered as a supervisee in social work.

Summary of Trends

In this section, all statistics for the current year are compared to the 2023 LMSW workforce. The number of licensed LMSWs in Virginia has increased by 18% (1,531 vs. 1,301). In addition, the size of Virginia's LMSW workforce has increased by 11% (979 vs. 879), and the number of FTEs provided by this workforce has increased by 10% (914 vs. 830). Virginia's renewing LMSWs are more likely to respond to this survey (98% vs. 93%).

LMSWs are slightly less likely to pursue a MSW because they believed that it was a prerequisite for licensure as a clinical social worker (40% vs. 41%). Likewise, LMSWs are slightly less likely to have a supervisor on site (60% vs. 61%).

The percentage of LMSWs who pursued a Master's in Social Work with a macro concentration has fallen (22% vs. 23%), and these LMSWs are less likely to work at an agency (69% vs. 73%). Furthermore, these LMSWs who work at an agency are less likely to provide clinical social work services (59% vs. 66%). These LMSWs are also more likely to provide assessment services (37% vs. 24%) than case management services (32% vs. 41%) at their agency.

While the percentage of LMSWs who pursued a Master's in Social Work with a micro concentration has not changed (67%), these LMSWs are slightly more likely to work at an agency (74% vs. 73%). Furthermore, these LMSWs who work at an agency are more likely to provide clinical social work services (85% vs. 82%). These LMSWs are more likely to provide treatment services (43% vs. 39%) than assessment services (21% vs. 25%) at their agency. LMSWs with a micro concentration are more likely to pursue licensure as a clinical social worker in the future (80% vs. 77%).

A Closer Look:

Licensees		
License Status	**#**	**%**
Renewing Practitioners	839	55%
New Licensees	394	26%
Non-Renewals	298	19%
All Licensees	**1,531**	**100%**

Source: Va. Healthcare Workforce Data Center

HWDC surveys tend to achieve very high response rates. Among all renewing LMSWs, 98% submitted a survey. These represent 64% of the 1,531 LMSWs who held a license at some point during the survey period.

Definitions

1. **The Survey Period:** The survey was conducted in June 2024.
2. **Target Population:** All LMSWs who held a Virginia license at some point between July 2023 and June 2024.
3. **Survey Population:** The survey was available to LMSWs who renewed their licenses online. It was not available to those who did not renew, including LMSWs newly licensed in 2024.

Response Rates			
Statistic	**Non Respondents**	**Respondents**	**Response Rate**
By Age			
Under 30	122	115	49%
30 to 34	102	185	65%
35 to 39	93	160	63%
40 to 44	65	164	72%
45 to 49	50	107	68%
50 to 54	43	97	69%
55 to 59	34	69	67%
60 and Over	35	90	72%
Total	**544**	**987**	**65%**
New Licenses			
Issued in Past Year	246	148	38%
Metro Status			
Non-Metro	23	43	65%
Metro	308	685	69%
Not in Virginia	213	259	55%

Source: Va. Healthcare Workforce Data Center

Response Rates	
Completed Surveys	**987**
Response Rate, All Licensees	**64%**
Response Rate, Renewals	**98%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Licensed LMSWs

Number:	1,531
New:	26%
Not Renewed:	19%

Response Rates

All Licensees:	64%
Renewing Practitioners:	98%

Source: Va. Healthcare Workforce Data Center

At a Glance:

Workforce

Virginia's LMSW Workforce:	979
FTEs:	914

Utilization Ratios

Licensees in VA Workforce:	64%
Licensees per FTE:	1.68
Workers per FTE:	1.07

Source: Va. Healthcare Workforce Data Center

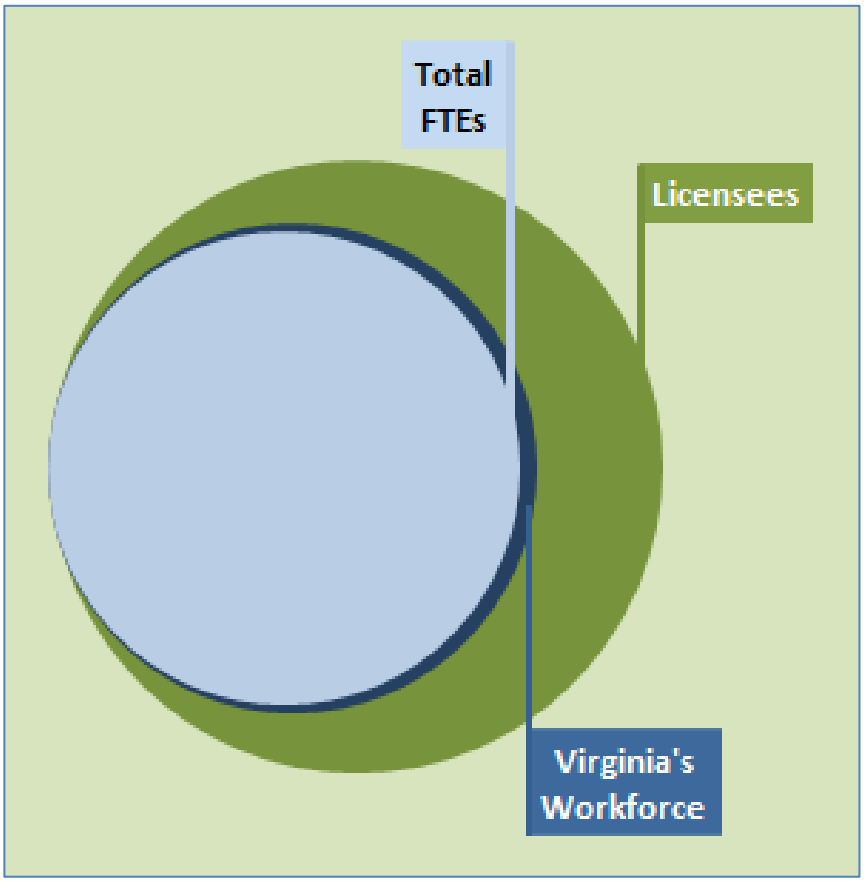
Definitions

1. **Virginia's Workforce:** A licensee with a primary or secondary work site in Virginia at any time in the past year. It does not include those who intend to return to Virginia's workforce at any point in the future.
2. **Full-Time Equivalency Unit (FTE):** The HWDC uses 2,000 (40 hours for 50 weeks) as its baseline measure for FTEs.
3. **Licensees in VA Workforce:** The proportion of licensees in Virginia's workforce.
4. **Licensees per FTE:** An indication of the number of licensees needed to create 1 FTE. Higher numbers indicate lower licensee participation.
5. **Workers per FTE:** An indication of the number of workers in Virginia's workforce needed to create 1 FTE. Higher numbers indicate lower utilization of available workers.

Virginia's LMSW Workforce	
Status	**#**
Virginia's Workforce	**979**
Total FTEs	**914**
Licensees	**1,531**

Source: Va. Healthcare Workforce Data Center

Weighting is used to estimate the figures in this report. Unless otherwise noted, figures refer to the Virginia Workforce only. For more information on the HWDC's methodology, visit: https://www.dhp.virginia.gov/PublicResources/HealthcareWorkforceDataCenter/



Source: Va. Healthcare Workforce Data Center

A Closer Look:

Age		
Age	**#**	**%**
Under 30	173	18%
30 to 34	184	19%
35 to 39	154	16%
40 to 44	132	13%
45 to 49	110	11%
50 to 54	80	8%
55 to 59	66	7%
60 and Over	80	8%
Total	**979**	**100%**

Source: Va. Healthcare Workforce Data Center

The median age of the LMSW workforce is 39. Among all LMSWs, 52% are under the age of 40, while 15% are age 55 or over.

At a Glance:

Age

Median Age:	39
% Under 40:	52%
% 55 or Over:	15%

Location

Metro:	95%
Urban:	3%
Rural:	2%

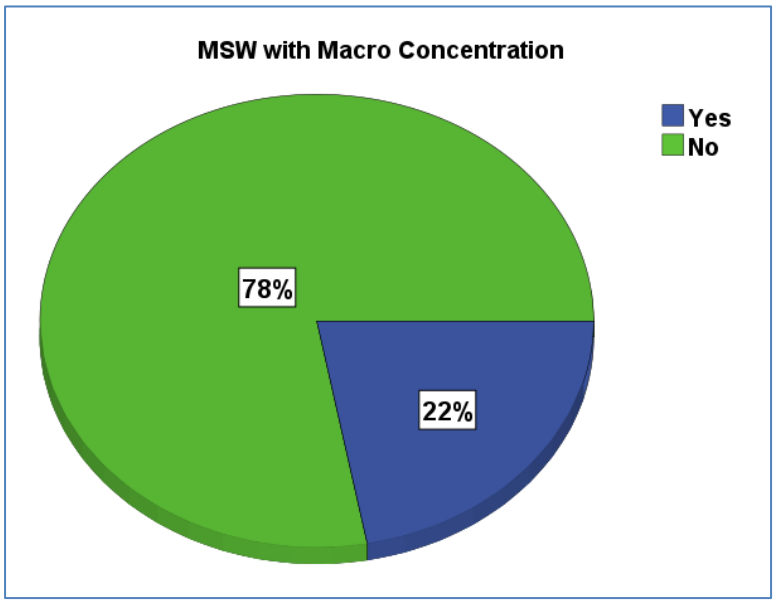
Source: Va. Healthcare Workforce Data Center

USDA Rural/Urban Continuum		
Area	**#**	**%**
Metro Counties		
Metro, 1 Million+	780	84%
Metro, 250,000 to 1 Million	37	4%
Metro, 250,000 or Less	72	8%
Non-Metro Counties		
Urban, Pop. 20,000+, Metro Adjacent	7	1%
Urban, Pop. 2,500-19,999, Metro Adjacent	8	1%
Urban, Pop. 2,500-19,999, Non-Adjacent	12	1%
Rural, Metro Adjacent	4	0%
Rural, Non-Adjacent	11	1%
Total	**931**	**100%**

Source: Va. Healthcare Workforce Data Center

Among all LMSWs who have a primary work location in Virginia, 95% work in a metro area. Another 2% of LMSWs have a primary work location in a rural area.

A Closer Look:



Source: Va. Healthcare Workforce Data Center

At a Glance:

Macro
% Concentration: 22%

Licensure
Future LCSW: 57%
Supervisee: 33%

Source: Va. Healthcare Workforce Data Center

Macro Concentration		
Response	**#**	**%**
Yes	213	22%
No	753	78%
Total	**966**	**100%**

Source: Va. Healthcare Workforce Data Center

More than one out of every five LMSWs pursued a MSW with a macro concentration.

Nearly three out of every five LMSWs with a macro concentration intend to eventually pursue licensure as a clinical social worker.

Intention to Pursue LCSW		
Response	**#**	**%**
Yes	119	57%
No	91	43%
Total	**210**	**100%**

Source: Va. Healthcare Workforce Data Center

Registered as a Supervisee		
Response	**#**	**%**
Yes	69	33%
No	140	67%
Total	**209**	**100%**

Source: Va. Healthcare Workforce Data Center

One-third of all LMSWs with a macro concentration are registered with the Board as a supervisee in Social Work.

Agency Employment for LMSWs with Macro Concentration

At a Glance:

Agency

Work at Agency:	69%
% CSW Services:	59%

Services

Assessment:	37%
Case Management:	32%
Treatment:	20%

Source: Va. Healthcare Workforce Data Center

Works at Agency		
Response	**#**	**%**
Yes	147	69%
No	66	31%
Total	**213**	**100%**

Source: Va. Healthcare Workforce Data Center

Nearly seven out of every ten LMSWs with a macro concentration work at an agency.

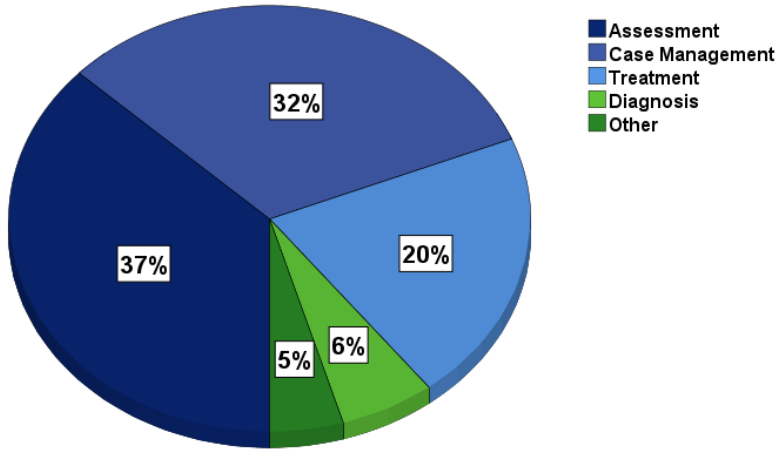
Provisioning of CSW Services		
Response	**#**	**%**
Yes	86	59%
No	60	41%
Total	**146**	**100%**

Source: Va. Healthcare Workforce Data Center

Clinical Services Offered		
Service	**#**	**%**
Assessment	31	37%
Case Management	27	32%
Treatment	17	20%
Diagnosis	5	6%
Other	4	5%
Total	**84**	**100%**

Source: Va. Healthcare Workforce Data Center

Clinical Services Offered at Agency for LMSWs with Macro Concentration



Source: Va. Healthcare Workforce Data Center

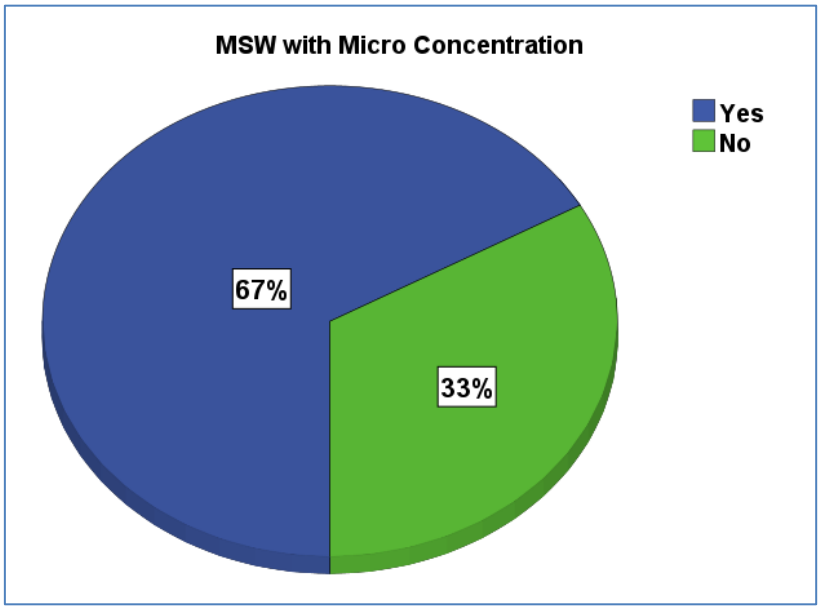
Nearly three out of every five LMSWs with a macro concentration who work at an agency provide clinical social work services through their employment at their agency.

One out of every five LMSWs with a macro concentration who perform clinical social work services are employed at an agency that is exempt from licensure.

Licensure Exemption		
Response	**#**	**%**
Yes	16	20%
No	65	80%
Total	**81**	**100%**

Source: Va. Healthcare Workforce Data Center

A Closer Look:



Source: Va. Healthcare Workforce Data Center

At a Glance:

Micro
% Concentration: 67%

Licensure
Future LCSW: 80%
Supervisee: 57%

Source: Va. Healthcare Workforce Data Center

Micro Concentration		
Response	**#**	**%**
Yes	648	67%
No	322	33%
Total	**970**	**100%**

Source: Va. Healthcare Workforce Data Center

Two-thirds of all LMSWs pursued a MSW with a micro concentration.

Four out of every five LMSWs with a micro concentration intend to eventually pursue licensure as a clinical social worker.

Intention to Pursue LCSW		
Response	**#**	**%**
Yes	488	80%
No	122	20%
Total	**610**	**100%**

Source: Va. Healthcare Workforce Data Center

Registered as a Supervisee		
Response	**#**	**%**
Yes	357	57%
No	267	43%
Total	**624**	**100%**

Source: Va. Healthcare Workforce Data Center

Nearly three out of every five LMSWs with a micro concentration are registered with the Board as a supervisee in Social Work.

Agency Employment for LMSWs with Micro Concentration

At a Glance:

Agency

Work at Agency:	74%
% CSW Services:	85%

Services

Treatment:	43%
Assessment:	21%
Case Management:	20%

Source: Va. Healthcare Workforce Data Center

Works at Agency		
Response	**#**	**%**
Yes	476	74%
No	165	26%
Total	**641**	**100%**

Source: Va. Healthcare Workforce Data Center

Nearly three out of every four LMSWs with a micro concentration are employed at an agency.

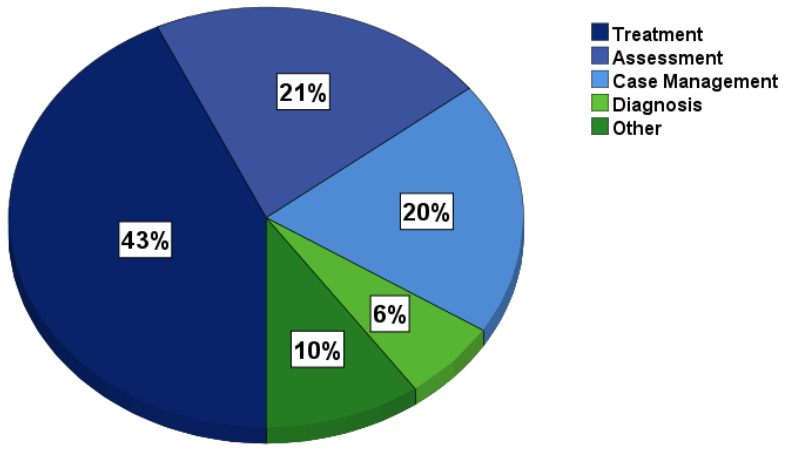
Provisioning of CSW Services		
Response	**#**	**%**
Yes	403	85%
No	71	15%
Total	**474**	**100%**

Source: Va. Healthcare Workforce Data Center

Clinical Services Offered		
Service	**#**	**%**
Treatment	171	43%
Assessment	85	21%
Case Management	78	20%
Diagnosis	24	6%
Other	39	10%
Total	**397**	**100%**

Source: Va. Healthcare Workforce Data Center

Clinical Services Offered at Agency for LMSWs with Micro Concentration



Source: Va. Healthcare Workforce Data Center

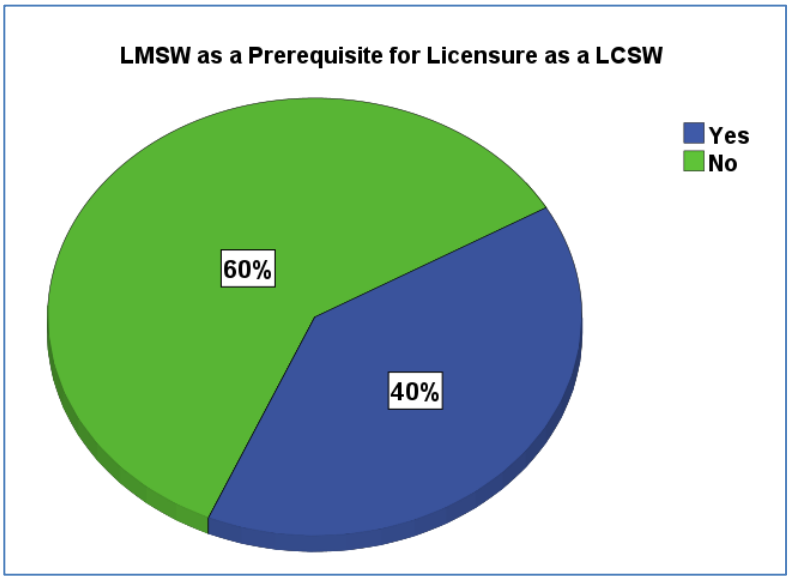
More than four out of every five LMSWs with a micro concentration who work at an agency provide clinical social work services through their employment at their agency.

Nearly one out of every ten LMSWs with a micro concentration who perform clinical social work services are employed at an agency that is exempt from licensure.

Licensure Exemption		
Response	**#**	**%**
Yes	31	8%
No	354	92%
Total	**385**	**100%**

Source: Va. Healthcare Workforce Data Center

A Closer Look:



Source: Va. Healthcare Workforce Data Center

At a Glance:

Prerequisite

Prerequisite for LCSW: 40%

Source: Va. Healthcare Workforce Data Center

LMSW as a Prerequisite for LCSW		
Response	**#**	**%**
Yes	381	40%
No	575	60%
Total	**956**	**100%**

Source: Va. Healthcare Workforce Data Center

Two out of every five LMSWs pursued a MSW because they believed that it was a prerequisite for licensure as a clinical social worker.

At a Glance:

Supervision

Supervisor on Site: 60%

Credential of Supervisor

LCSW: 54%
RN: 12%
LMSW: 9%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Supervisor on Site		
Response	**#**	**%**
Yes	544	60%
No	364	40%
Total	**908**	**100%**

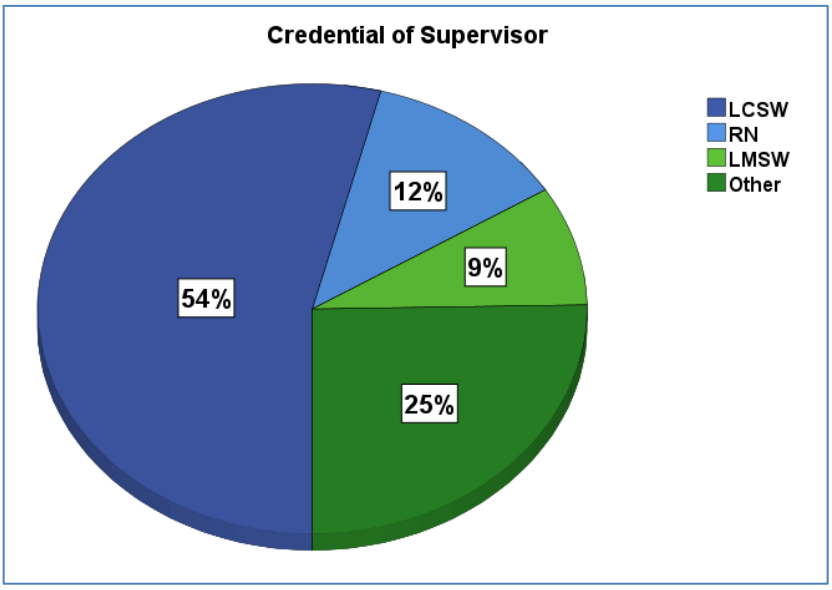
Source: Va. Healthcare Workforce Data Center

Three out of every five LMSWs have a supervisor on site at their place of employment.

More than half of all LMSWs have a supervisor with a LCSW. Another 12% of LMSWs have a supervisor with an RN.

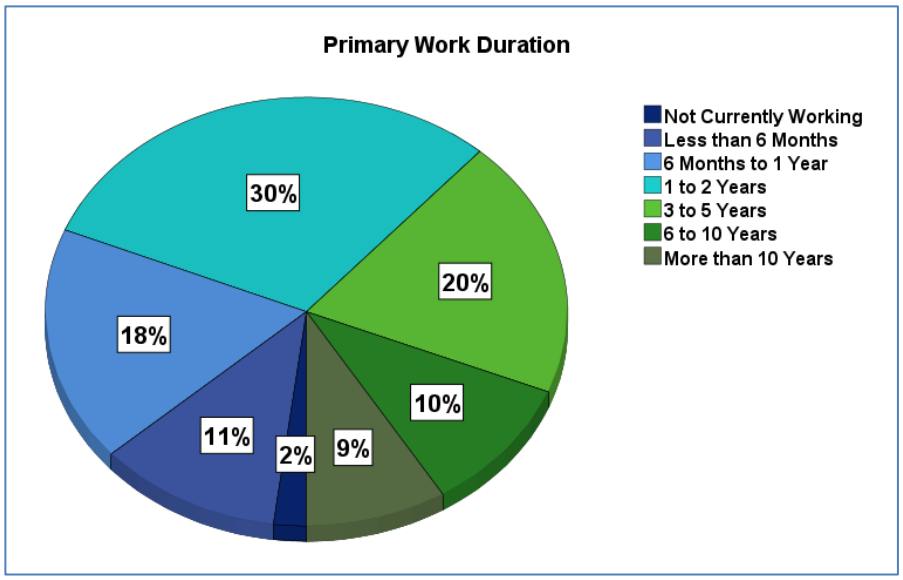
Credential of Supervisor		
Credential	**#**	**%**
LCSW	499	54%
RN	112	12%
LMSW	79	9%
LPC	29	3%
MD	11	1%
LCP	3	0%
Other	192	21%
Total	**925**	**100%**

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

A Closer Look:



Source: Va. Healthcare Workforce Data Center

At a Glance:

Turnover & Tenure

New Location:	42%
Over 2 Years:	38%
Over 2 Yrs., 2nd Location:	32%

Source: Va. Healthcare Workforce Data Center

Nearly two out of every five LMSWs have worked at their primary work location for more than two years.

Location Tenure				
Tenure	Primary		Secondary	
	#	%	#	%
Not Currently Working at This Location	19	2%	30	7%
Less than 6 Months	110	11%	56	14%
6 Months to 1 Year	171	18%	63	16%
1 to 2 Years	291	30%	126	31%
3 to 5 Years	188	20%	73	18%
6 to 10 Years	97	10%	33	8%
More than 10 Years	84	9%	21	5%
Subtotal	**961**	**100%**	**403**	**100%**
Did Not Have Location	0		563	
Item Missing	18		13	
Total	**979**		**979**	

Source: Va. Healthcare Workforce Data Center

At a Glance:

Concentration

Top Region:	43%
Top 3 Regions:	84%
Lowest Region:	1%

Locations

2 or More (Now*):	38%

Source: Va. Healthcare Workforce Data Center

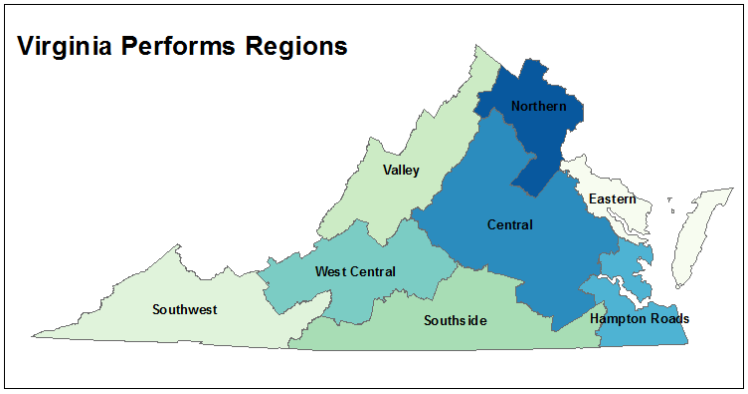
More than four out of every five LMSWs in the state work in Northern Virginia, Central Virginia, or Hampton Roads.

A Closer Look:

Regional Distribution of Work Locations

Virginia Performs Region	Primary Location		Secondary Location	
	#	%	#	%
Central	231	24%	67	17%
Eastern	13	1%	9	2%
Hampton Roads	162	17%	70	17%
Northern	416	43%	164	40%
Southside	12	1%	10	2%
Southwest	22	2%	9	2%
Valley	35	4%	13	3%
West Central	40	4%	21	5%
Virginia Border State/D.C.	13	1%	16	4%
Other U.S. State	18	2%	21	5%
Outside of the U.S.	0	0%	5	1%
Total	**962**	**100%**	**405**	**100%**
Item Missing	16		12	

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

Number of Work Locations

Locations	Work Locations Now*	
	#	%
0	30	3%
1	581	59%
2	330	34%
3	27	3%
4	8	1%
5	0	0%
6 or More	3	0%
Total	**979**	**100%**

*At the time of survey completion, June 2024.

Source: Va. Healthcare Workforce Data Center

Nearly two out of every five LMSWs currently have multiple work locations.

At a Glance:
(Primary Locations)

Typical Time Allocation

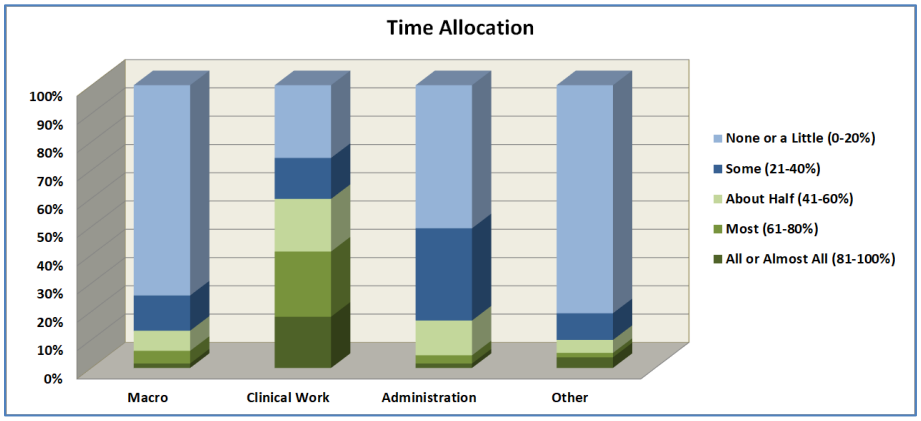
Macro:	0%-10%
Clinical Work:	51%-60%
Administration:	11%-20%
Other:	0%-10%

Roles

Macro:	6%
Clinical Work:	41%
Administration:	4%
Other:	5%

Source: Va. Healthcare Workforce Data Center

A Closer Look:



Source: Va. Healthcare Workforce Data Center

LMSWs spend approximately half of their time performing clinical work. In fact, 41% of all LMSWs fill a clinical work role, defined as spending more than 60% of their time on clinical work activities.

Time Allocation				
Time Spent	**Macro**	**Clinical Work**	**Admin.**	**Other**
All or Almost All (81-100%)	2%	18%	2%	4%
Most (61-80%)	4%	23%	3%	2%
About Half (41-60%)	7%	19%	12%	5%
Some (21-40%)	12%	15%	33%	9%
None or a Little (0-20%)	74%	26%	51%	81%

Source: Va. Healthcare Workforce Data Center

At a Glance:

FTEs

Total: 914

FTEs/1,000 Residents[1]: 0.105

Average: 0.93

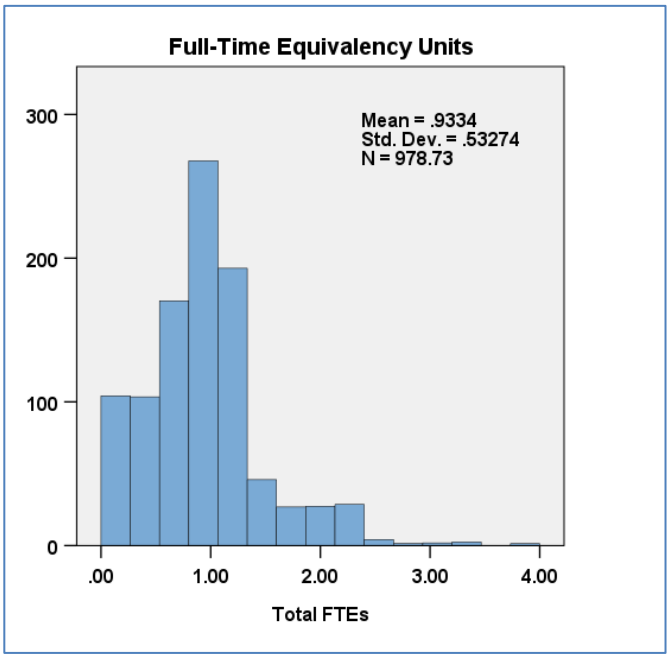
Age & Gender Effect

Age, *Partial Eta*^{2}: Small

Partial Eta^2 *Explained:*
Partial Eta^2 is a statistical measure of effect size.

Source: Va. Healthcare Workforce Data Center

A Closer Look:

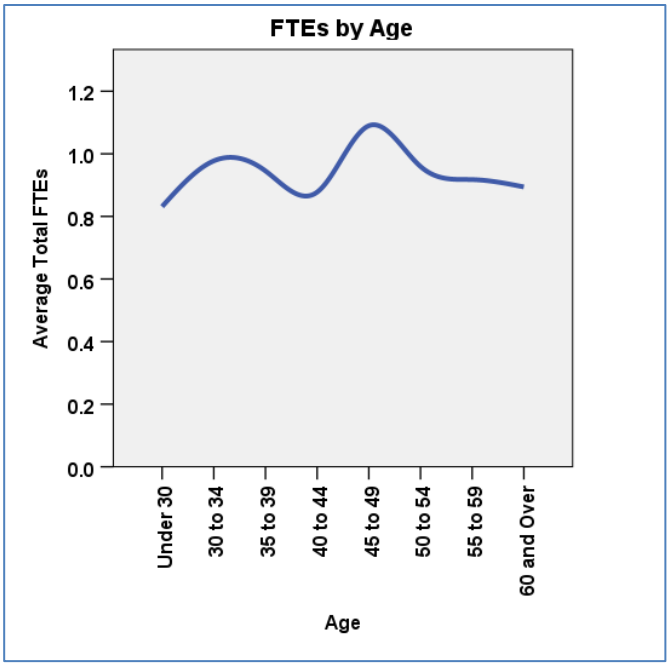


Source: Va. Healthcare Workforce Data Center

The typical (median) LMSW provided 0.96 FTEs over the past year, or approximately 38 hours per week for 50 weeks. Although FTEs appear to vary by age, statistical tests did not verify that a difference exists.[2]

Full-Time Equivalency Units		
Age	**Average**	**Median**
Age		
Under 30	0.83	0.78
30 to 34	0.98	1.00
35 to 39	0.95	0.98
40 to 44	0.88	0.93
45 to 49	1.09	1.05
50 to 54	0.96	1.03
55 to 59	0.92	1.01
60 and Over	0.89	0.99

Source: Va. Healthcare Workforce Data Center

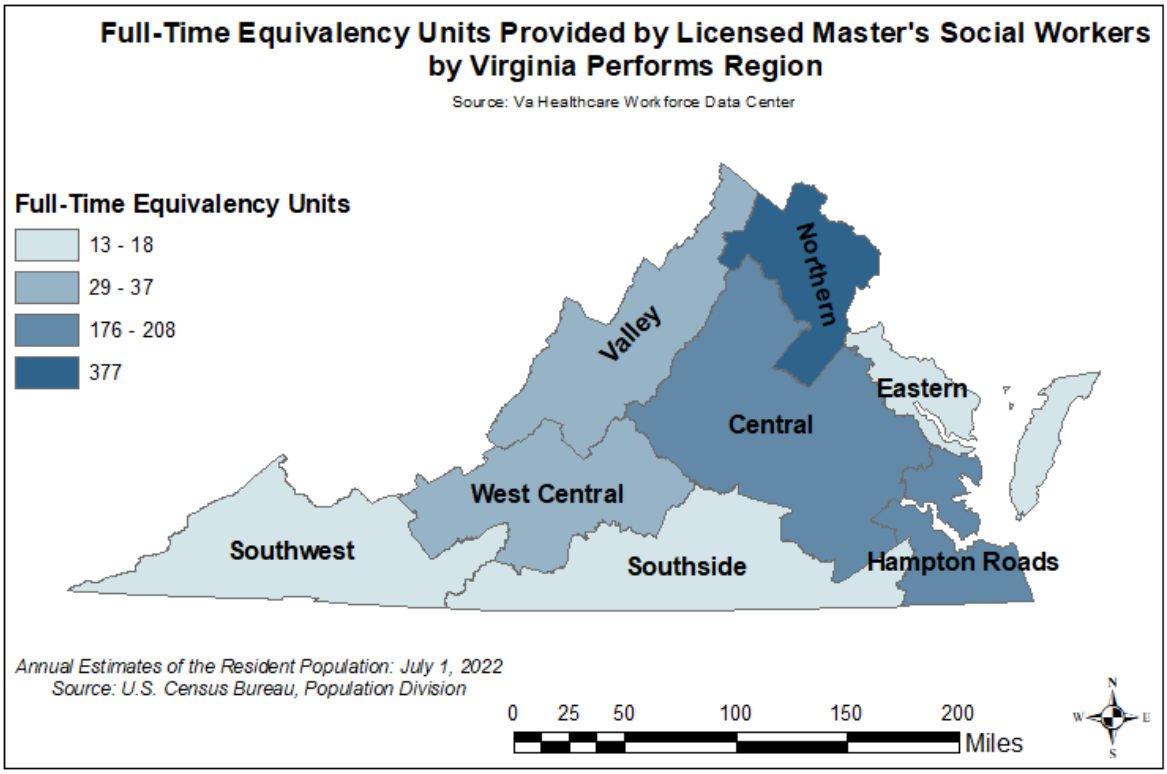


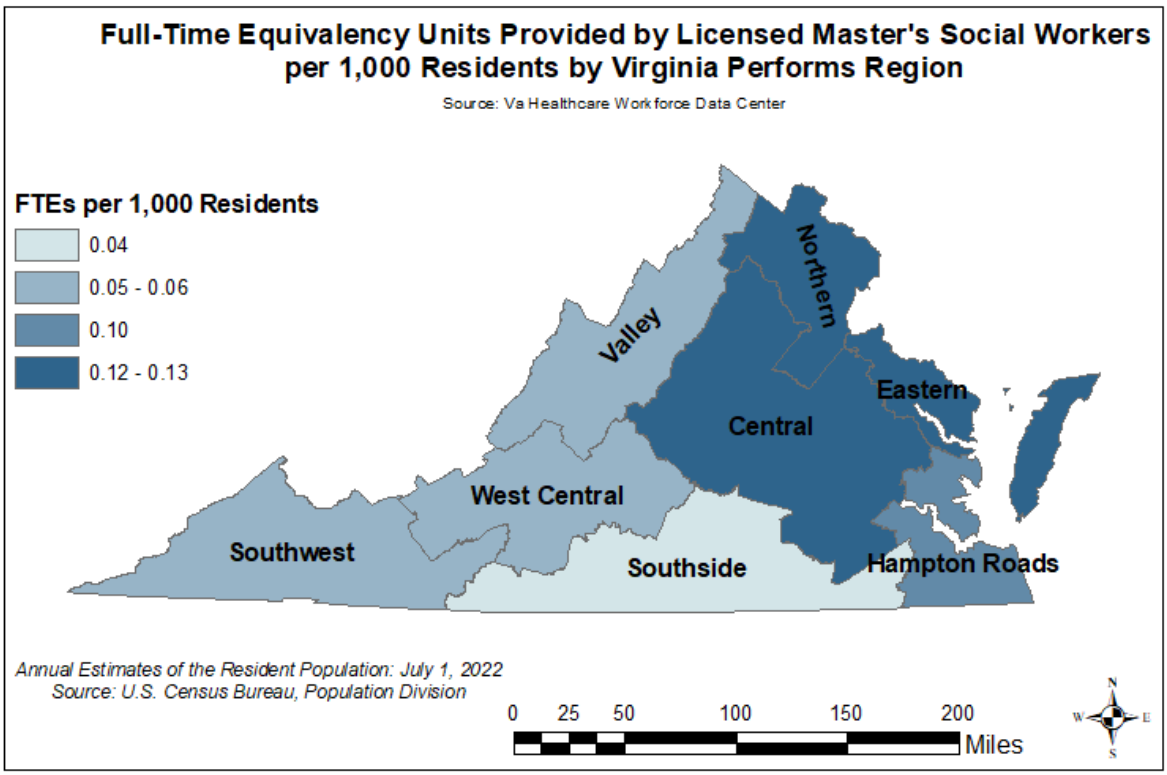
Source: Va. Healthcare Workforce Data Center

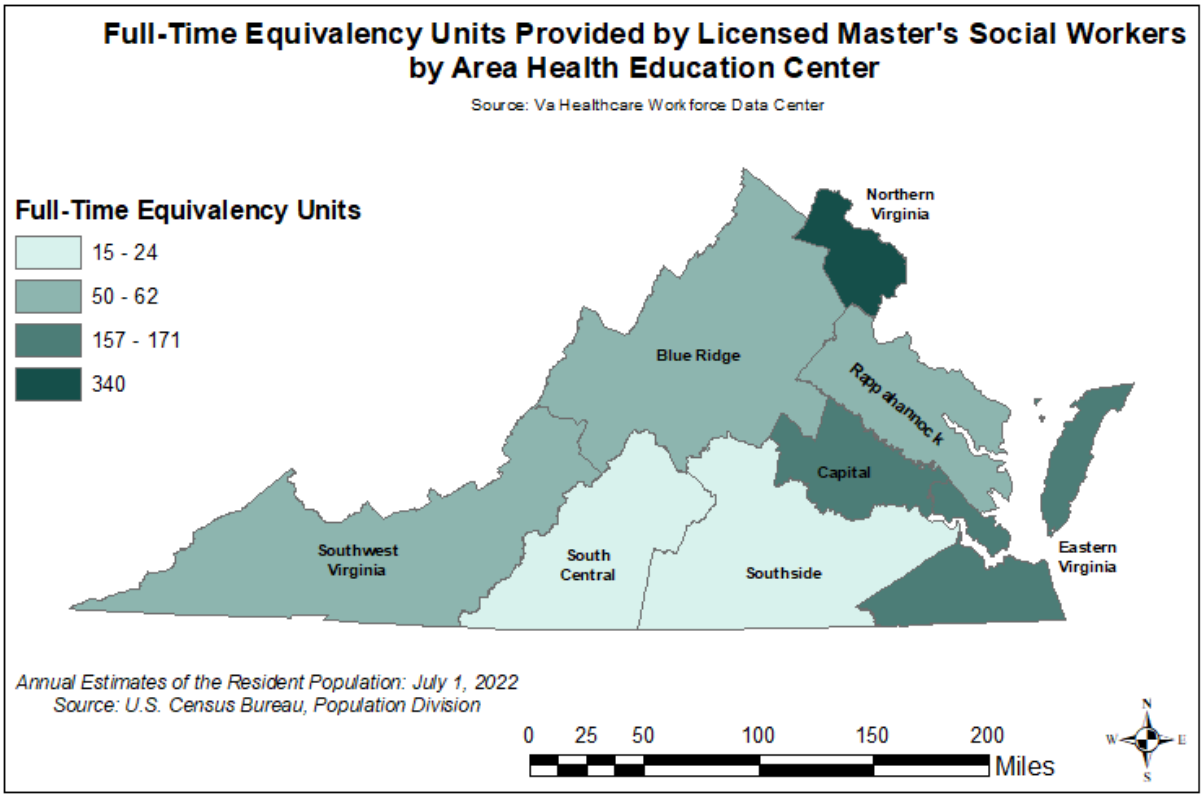
[1] Number of residents in 2022 was used as the denominator.
[2] Due to assumption violations in One-Way ANOVA.

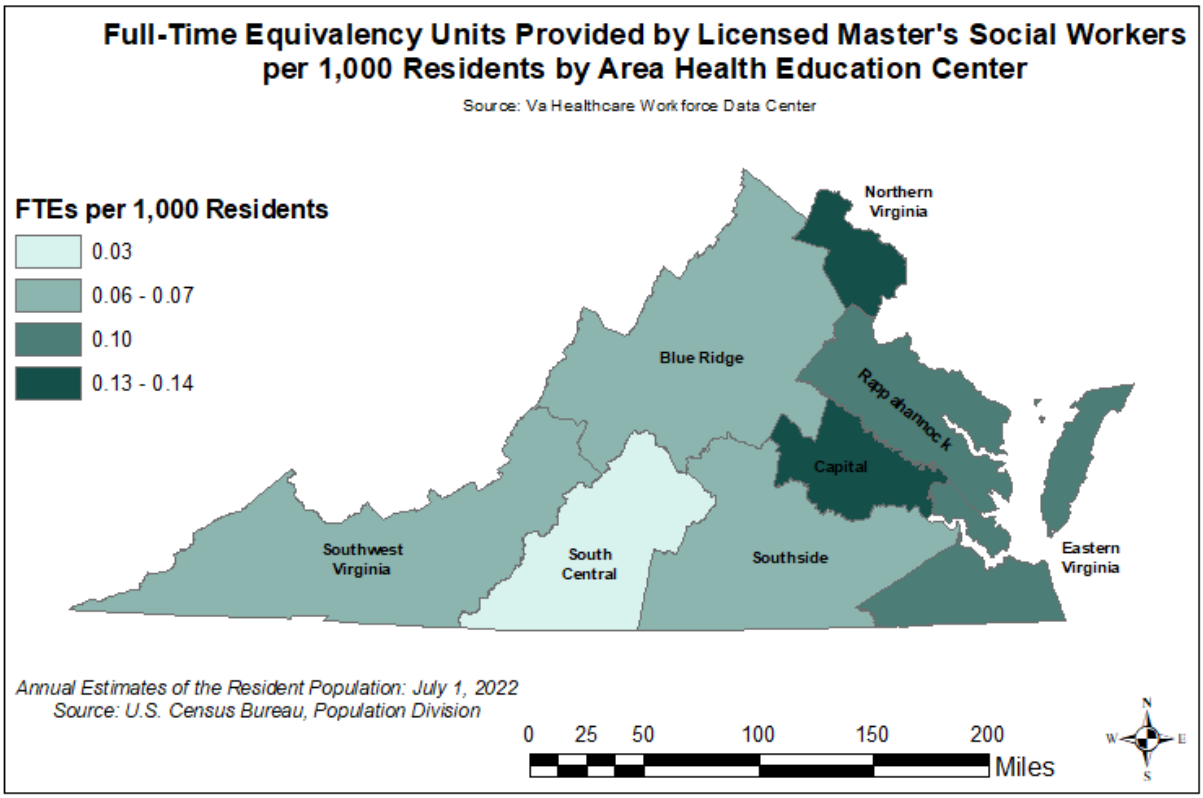
Maps

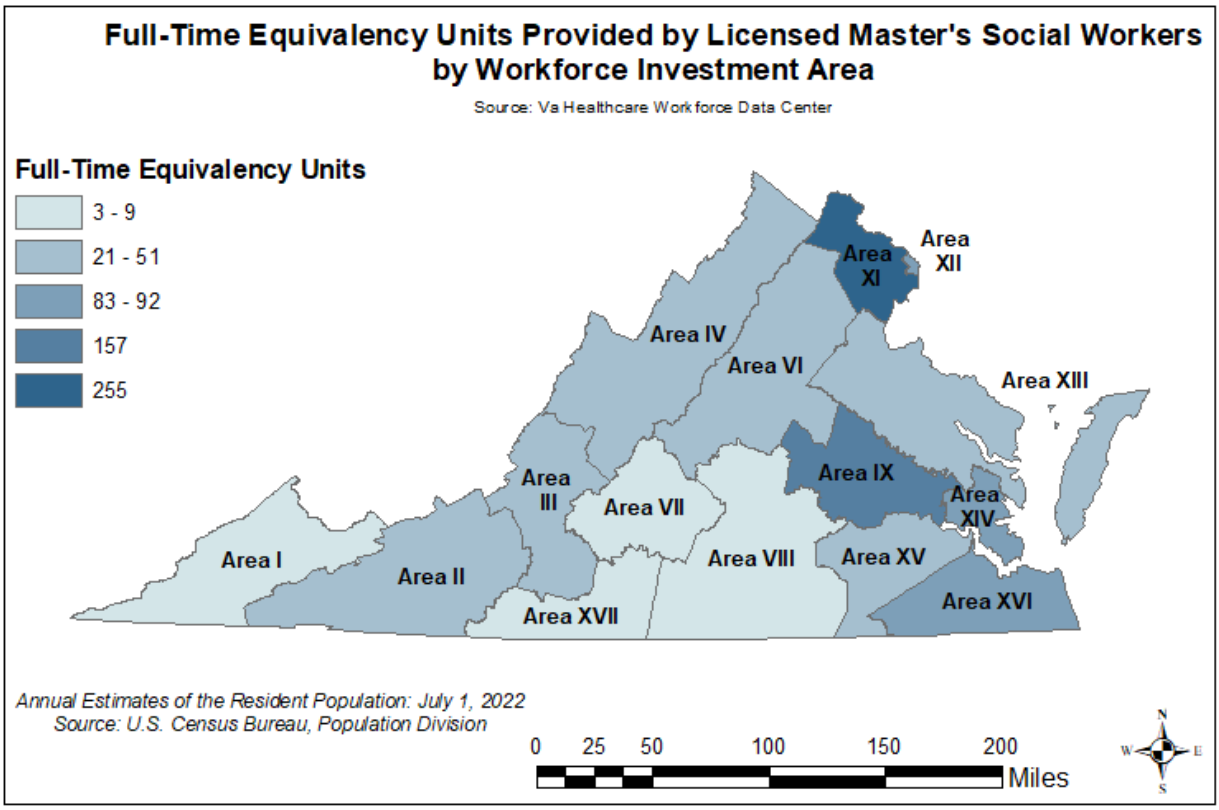
Virginia Performs Regions

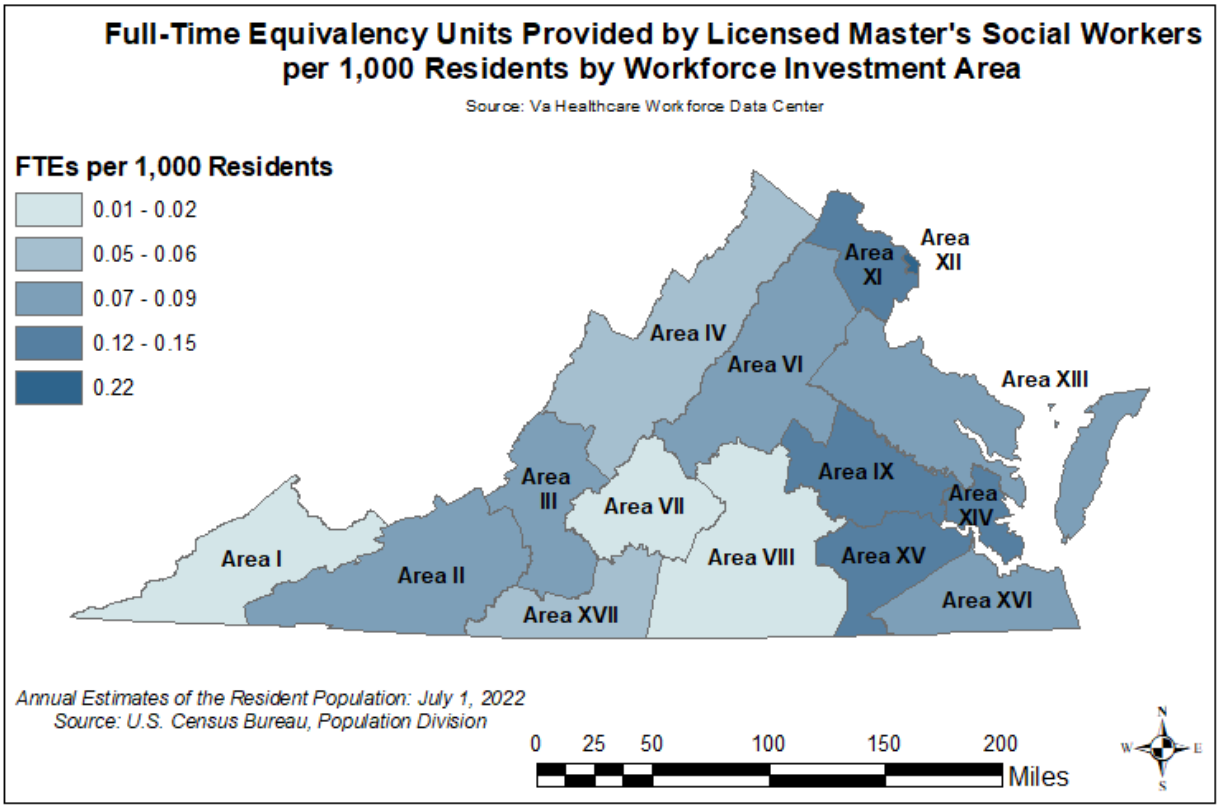


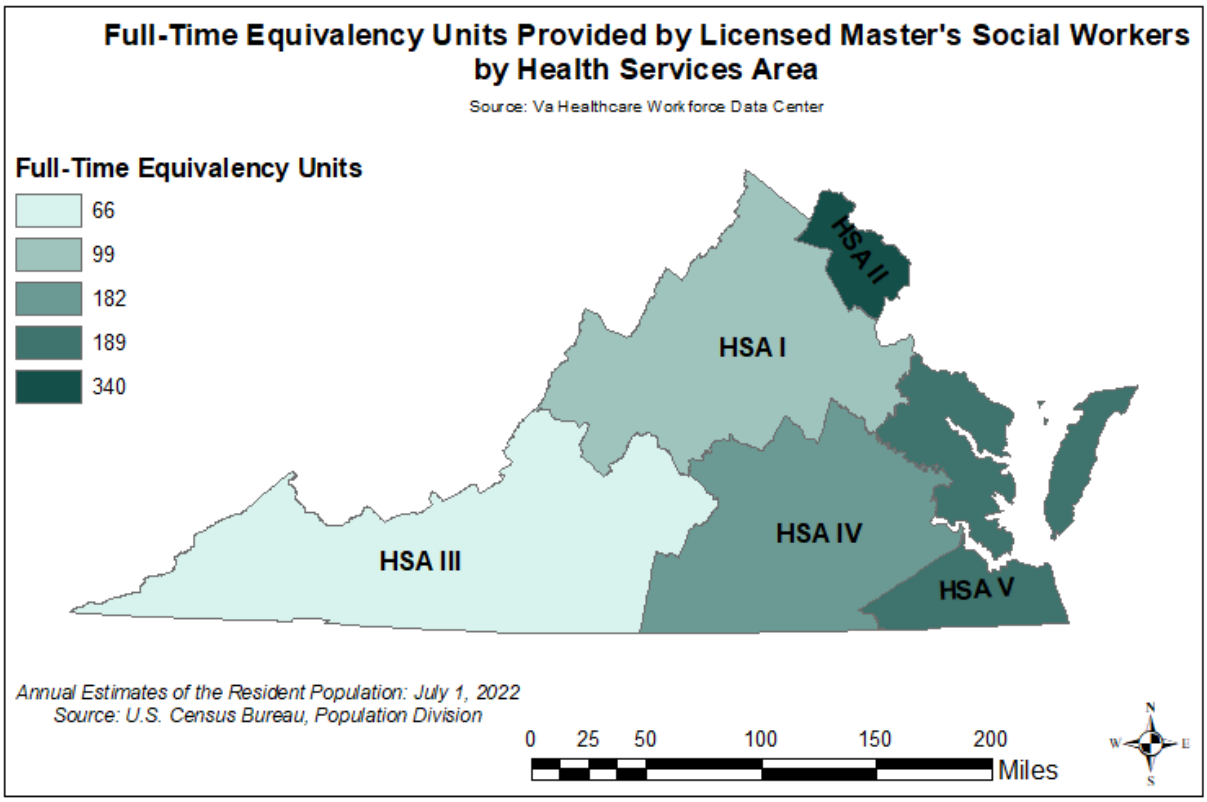


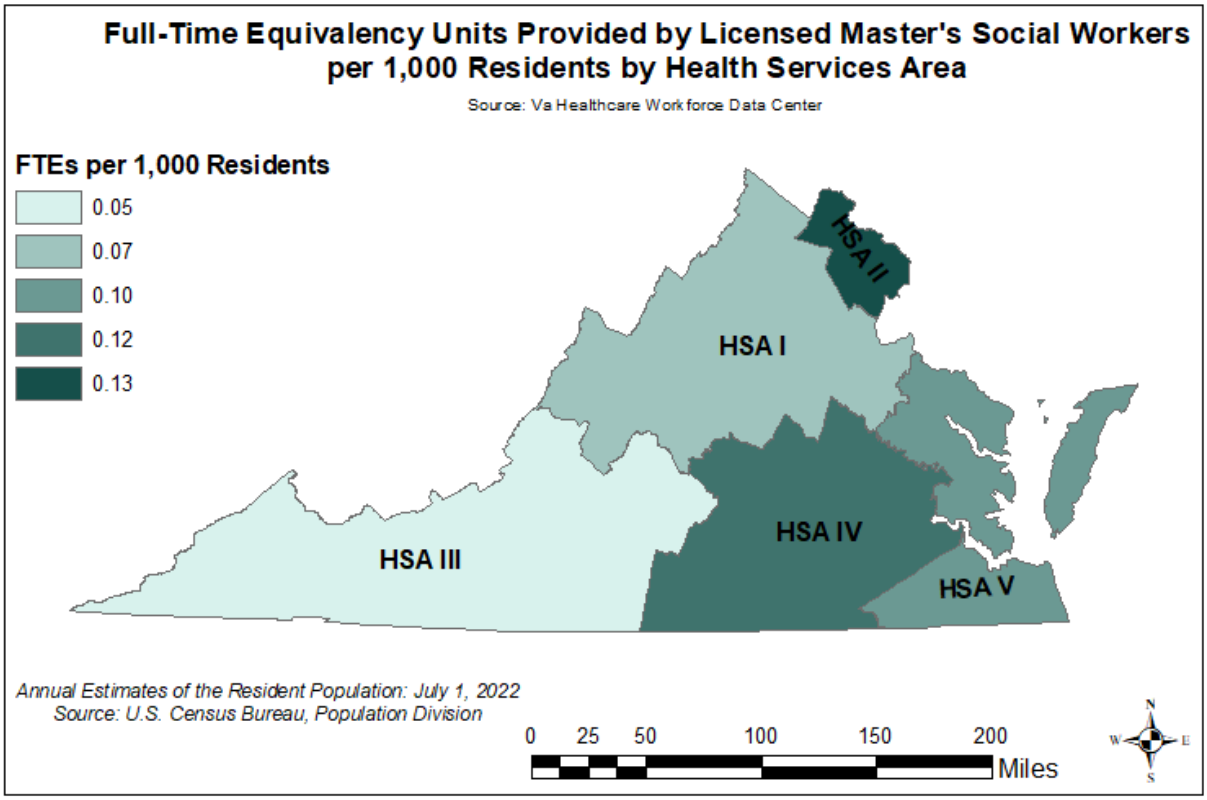

Full-Time Equivalency Units Provided by Licensed Master's Social Workers by Area Health Education Center
Source: Va Healthcare Workforce Data Center
Full-Time Equivalency Units
15 - 24
50 - 62
157 - 171
340
Northern Virginia
Blue Ridge
Rappahannock
Capital
Southwest Virginia
South Central
Southside
Eastern Virginia
Annual Estimates of the Resident Population: July 1, 2022
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S

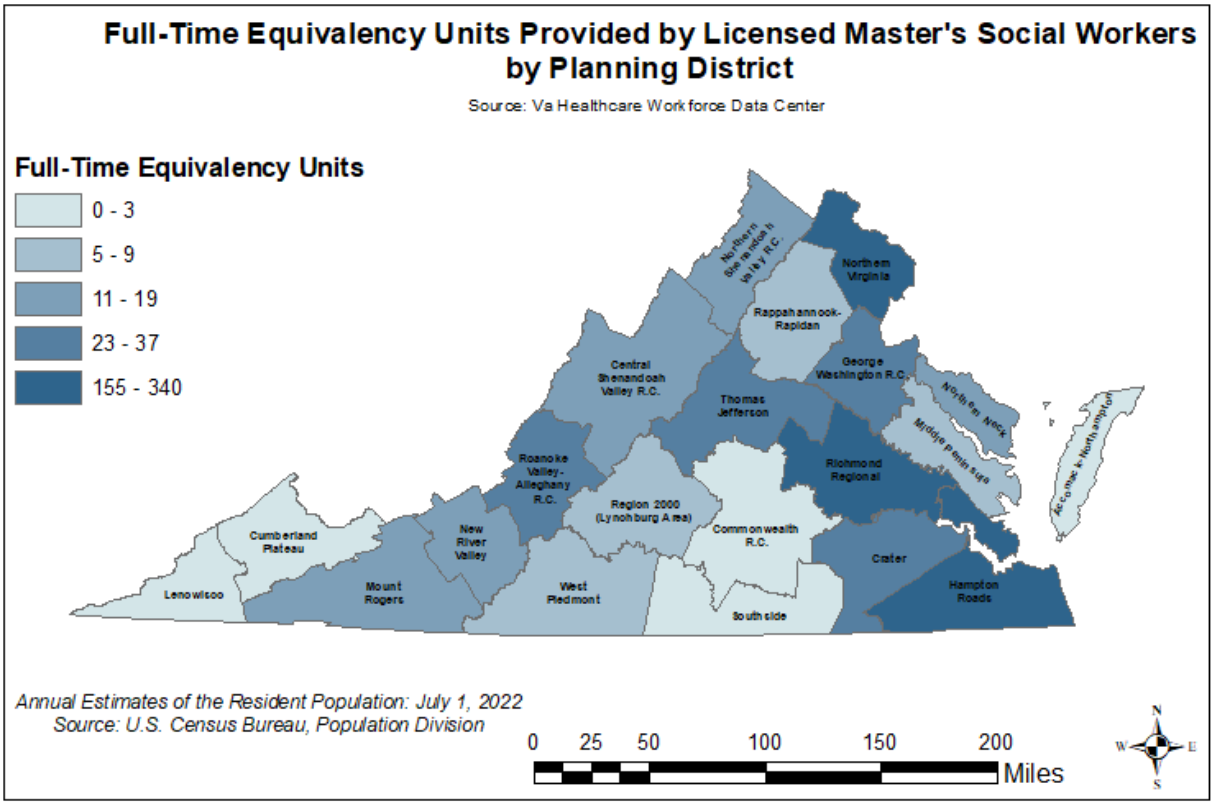

Full-Time Equivalency Units Provided by Licensed Master's Social Workers per 1,000 Residents by Area Health Education Center
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
0.03
0.06 - 0.07
0.10
0.13 - 0.14
Northern Virginia
Blue Ridge
Rappahannock
Capital
Southwest Virginia
South Central
Southside
Eastern Virginia
Annual Estimates of the Resident Population: July 1, 2022
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S

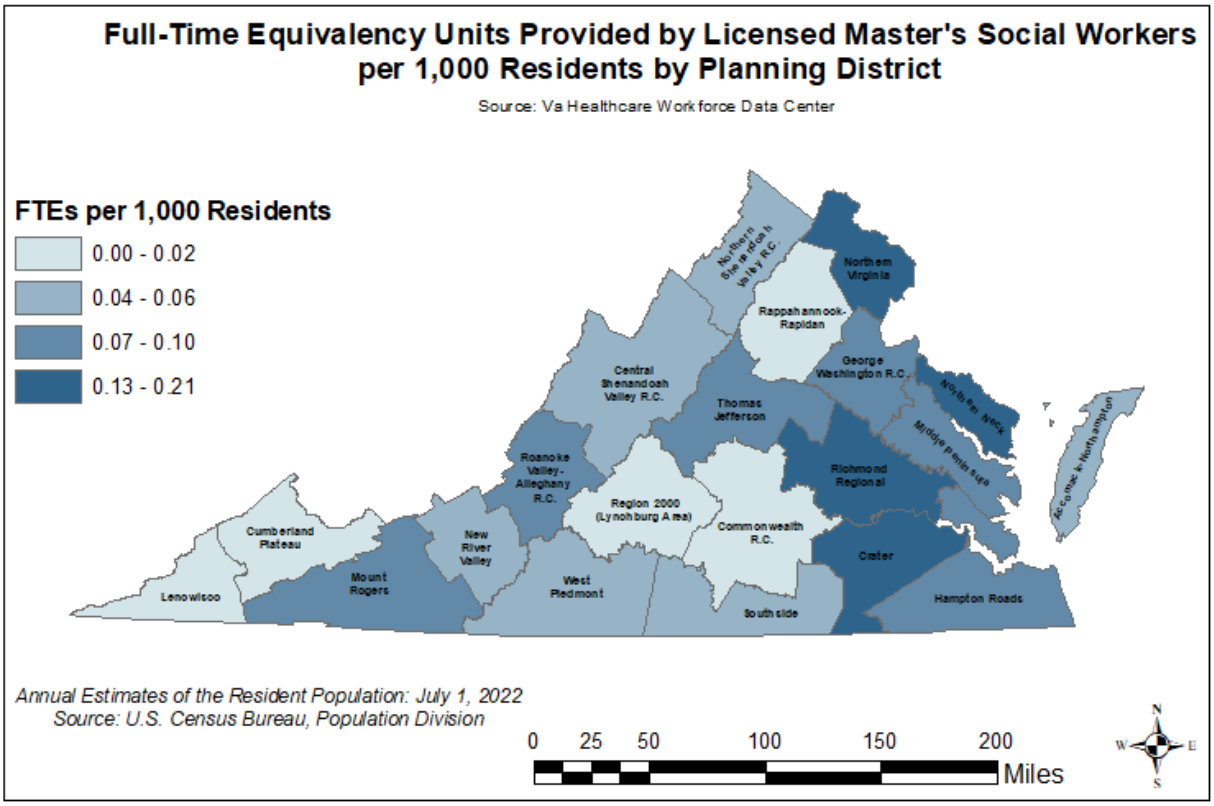

Full-Time Equivalency Units Provided by Licensed Master's Social Workers by Workforce Investment Area
Source: Va Healthcare Workforce Data Center
Full-Time Equivalency Units
3 - 9
21 - 51
83 - 92
157
255
Area I
Area II
Area III
Area IV
Area VI
Area VII
Area VIII
Area IX
Area XI
Area XII
Area XIII
Area XIV
Area XV
Area XVI
Area XVII
Annual Estimates of the Resident Population: July 1, 2022
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S


Full-Time Equivalency Units Provided by Licensed Master's Social Workers per 1,000 Residents by Workforce Investment Area
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
0.01 - 0.02
0.05 - 0.06
0.07 - 0.09
0.12 - 0.15
0.22
Area I
Area II
Area III
Area IV
Area VI
Area VII
Area VIII
Area IX
Area XI
Area XII
Area XIII
Area XIV
Area XV
Area XVI
Area XVII
Annual Estimates of the Resident Population: July 1, 2022
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S


Full-Time Equivalency Units Provided by Licensed Master's Social Workers by Health Services Area
Source: Va Healthcare Workforce Data Center
Full-Time Equivalency Units
66
99
182
189
340
HSA I
HSA II
HSA III
HSA IV
HSA V
Annual Estimates of the Resident Population: July 1, 2022
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S


Full-Time Equivalency Units Provided by Licensed Master's Social Workers per 1,000 Residents by Health Services Area
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
0.05
0.07
0.10
0.12
0.13
HSA I
HSA II
HSA III
HSA IV
HSA V
Annual Estimates of the Resident Population: July 1, 2022
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S


Full-Time Equivalency Units Provided by Licensed Master's Social Workers by Planning District
Source: Va Healthcare Workforce Data Center
Full-Time Equivalency Units
0 - 3
5 - 9
11 - 19
23 - 37
155 - 340
Northern Shenandoah Valley R.C.
Northern Virginia
Rappahannock-Rapidan
Central Shenandoah Valley R.C.
George Washington R.C.
Thomas Jefferson
Northern Neck
Middle Peninsula
Accomack-Northampton
Roanoke Valley-Alleghany R.C.
Richmond Regional
Region 2000 (Lynchburg Area)
Commonwealth R.C.
Crater
Hampton Roads
Cumberland Plateau
New River Valley
Mount Rogers
West Piedmont
South side
Lenowisco
Annual Estimates of the Resident Population: July 1, 2022
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S


Full-Time Equivalency Units Provided by Licensed Master's Social Workers per 1,000 Residents by Planning District
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
0.00 - 0.02
0.04 - 0.06
0.07 - 0.10
0.13 - 0.21
Northern Shenandoah Valley R.C.
Northern Virginia
Rappahannock-Rapidan
Central Shenandoah Valley R.C.
George Washington R.C.
Thomas Jefferson
Northern Neck
Middle Peninsula
Accomack-Northampton
Roanoke Valley-Alleghany R.C.
Richmond Regional
Region 2000 (Lynchburg Area)
Commonwealth R.C.
Crater
Hampton Roads
Cumberland Plateau
New River Valley
Mount Rogers
West Piedmont
South side
Lenowisco
Annual Estimates of the Resident Population: July 1, 2022
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles
N
W
E
S

Appendices

Appendix A: Weights

Rural Status	Location Weight			Total Weight	
	#	Rate	Weight	Min.	Max.
Metro, 1 Million+	875	69.26%	1.444	1.293	1.918
Metro, 250,000 to 1 Million	51	62.75%	1.594	1.427	2.117
Metro, 250,000 or Less	67	70.15%	1.426	1.276	1.894
Urban, Pop. 20,000+, Metro Adj.	6	50.00%	2.000	1.791	1.892
Urban, Pop. 20,000+, Non-Adj.	0	NA	NA	NA	NA
Urban, Pop. 2,500-19,999, Metro Adj.	24	58.33%	1.714	1.535	2.278
Urban, Pop. 2,500-19,999, Non-Adj.	8	87.50%	1.143	1.023	1.143
Rural, Metro Adj.	24	66.67%	1.500	1.343	1.993
Rural, Non-Adj.	4	75.00%	1.333	1.241	1.333
Virginia Border State/D.C.	249	56.22%	1.779	1.593	2.363
Other U.S. State	223	53.36%	1.874	1.678	2.490

Source: Va. Healthcare Workforce Data Center

Age	Age Weight			Total Weight	
	#	Rate	Weight	Min.	Max.
Under 30	237	48.52%	2.061	1.894	2.490
30 to 34	287	64.46%	1.551	1.143	1.874
35 to 39	253	63.24%	1.581	1.453	1.910
40 to 44	229	71.62%	1.396	1.029	1.687
45 to 49	157	68.15%	1.467	1.081	1.892
50 to 54	140	69.29%	1.443	1.063	1.861
55 to 59	103	66.99%	1.493	1.100	1.803
60 and Over	125	72.00%	1.389	1.023	1.791

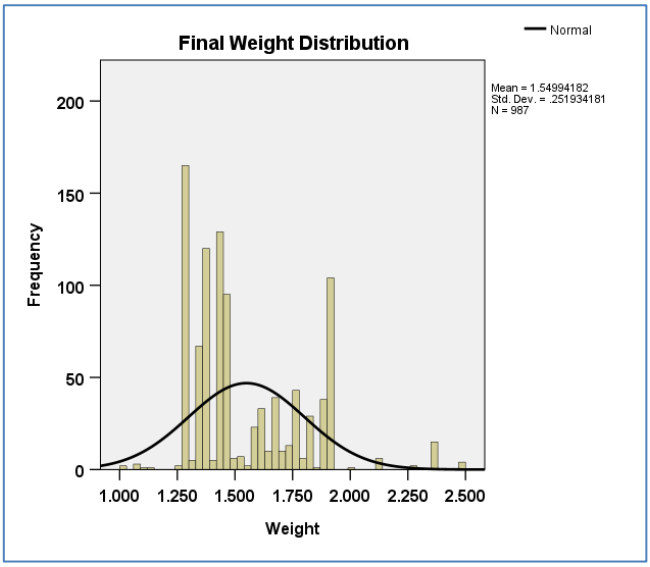
Source: Va. Healthcare Workforce Data Center

See the Methods section on the HWDC website for details on HWDC methods: https://www.dhp.virginia.gov/PublicResources/HealthcareWorkforceDataCenter/

Final weights are calculated by multiplying the two weights and the overall response rate:

Age Weight x Rural Weight x Response Rate = Final Weight.

Overall Response Rate: **0.644677**



Source: Va. Healthcare Workforce Data Center

Board of Social Work
Current Regulatory Actions
As of September 12, 2024

In the Governor's office

None

In the Secretary's office

VAC	Stage	Subject Matter	Submitted from agency	Time in current location	Notes
18VAC140-30	Proposed	Initial regulations for licensure of music therapists	1/19/2022	853 days	Implements licensure of music therapists pursuant to directive by the General Assembly
18VAC140-20	Proposed	Amendments resulting from 2022 periodic review	12/19/2022	83 days	Amendments from 2022 periodic review excluding the section 37 changes that were filed in a separate action

At the Department of Planning and Budget

None

At the Office of the Attorney General

None.

Agenda Item: Adoption of Proposed Regulations to Accept APA Approved Trainings as CE

Included in your agenda package:

- Proposed regulatory amendments to 18VAC140-20-105
- TownHall comments on NOIRA stage

Staff Note: There were eight comments provided. Six comments were in support of the action and two were unclear in their position.

Action needed:

- Motion to adopt proposed regulations of 18VAC140-20-105 as presented

Project 7915 - NOIRA

Board of Social Work

Acceptance of APA approved trainings as CE providers

Chapter 20

Regulations Governing the Practice of Social Work

18VAC140-20-105. Continued competency requirements for renewal of an active license.

A. Licensed clinical social workers shall be required to have completed a minimum of 30 contact hours of continuing education. LBSWs and LMSWs shall be required to have completed a minimum of 15 contact hours of continuing education prior to licensure renewal in even years. Courses or activities shall be directly related to the practice of social work or another behavioral health field. A minimum of six of those hours for licensed clinical social workers and a minimum of three of those hours for licensed social workers must pertain to ethics or the standards of practice for the behavioral health professions or to laws governing the practice of social work in Virginia. Up to two continuing education hours required for renewal may be satisfied through delivery of social work services, without compensation, to low-income individuals receiving health services through a local health department or a free clinic organized in whole or primarily for the delivery of those services, as verified by the department or clinic. Three hours of volunteer service is required for one hour of continuing education credit.

1. The board may grant an extension for good cause of up to one year for the completion of continuing education requirements upon written request from the licensee prior to the renewal date. Such extension shall not relieve the licensee of the continuing education requirement.

2. The board may grant an exemption for all or part of the continuing education requirements due to circumstances beyond the control of the licensee such as temporary disability, mandatory military service, or officially declared disasters upon written request from the licensee prior to the renewal date.

B. Hours may be obtained from a combination of board-approved activities in the following two categories:

1. Category I. Formally Organized Learning Activities. A minimum of 20 hours for licensed clinical social workers or 10 hours for licensed social workers shall be documented in this category, which shall include one or more of the following:

a. Regionally accredited university or college academic courses in a behavioral health discipline. A maximum of 15 hours will be accepted for each academic course.

b. Continuing education programs offered by universities or colleges accredited by the Council on Social Work Education.

c. Workshops, seminars, conferences, or courses in the behavioral health field offered by federal, state or local social service agencies, public school systems, or licensed health facilities and licensed hospitals.

d. Workshops, seminars, conferences, or courses in the behavioral health field offered by an individual or organization that has been certified or approved by one of the following:

(1) The Child Welfare League of America and its state and local affiliates.

(2) The National Association of Social Workers and its state and local affiliates.

(3) The National Association of Black Social Workers and its state and local affiliates.

(4) The Family Service Association of America and its state and local affiliates.

(5) The Clinical Social Work Association and its state and local affiliates.

(6) ~~The Association of Social Work Boards.~~ The American Psychological Association.

(7) ~~Any state social work board.~~The Association of Social Work Boards.

(8) Any state social work board.

2. Category II. Individual Professional Activities. A maximum of 10 of the required 30 hours for licensed clinical social workers or a maximum of five of the required 15 hours for licensed social workers may be earned in this category, which shall include one or more of the following:

a. Participation in an Association of Social Work Boards item writing workshop. (Activity will count for a maximum of two hours.)

b. Publication of a professional social work-related book or initial preparation or presentation of a

social work-related course. (Activity will count for a maximum of 10 hours.)

c. Publication of a professional social work-related article or chapter of a book, or initial preparation or presentation of a social work-related in-service training, seminar, or workshop. (Activity will count for a maximum of five hours.)

d. Provision of a continuing education program sponsored or approved by an organization listed under Category I. (Activity will count for a maximum of two hours and will only be accepted one time for any specific program.)

e. Field instruction of graduate students in a Council on Social Work Education-accredited school. (Activity will count for a maximum of two hours.)

f. Serving as an officer or committee member of one of the national professional social work associations listed under subdivision B 1 d of this section or as a member of a state social work licensing board. (Activity will count for a maximum of two hours.)

g. Attendance at formal staffings at federal, state, or local social service agencies, public school systems, or licensed health facilities and licensed hospitals. (Activity will count for a maximum of five hours.)

h. Individual or group study including listening to audio tapes, viewing video tapes, or reading professional books or articles. (Activity will count for a maximum of five hours.)

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Agency **Department of Health Professions**

Board **Board of Social Work**

Chapter **Regulations Governing the Practice of Social Work [18 VAC 140 - 20]**

Action	**Acceptance of APA approved trainings as CE providers**
Stage	**NOIRA**
Comment Period	Ended on 7/17/2024

8 comments

All good comments for this forum **Show Only Flagged**

Back to List of Comments

Commenter: Anonymous 7/12/24 10:37 pm

Support and expand

I support this petition and would actually expand it so that continuing education programs offered by ANY mental health organization holding status as a continuing education provider are accepted as continuing education hours. There is no logical reason why a social worker who attends continuing education programs offered by competing but allied organizations (APA, ACA, NBCC, AMA) should not receive credit for the training.

CommentID: **227204**

Commenter: Anonymous 7/13/24 11:08 am

Support petition and expand options

I support this petition and strongly recommend expanding the ability for social workers to receive CE credit for attending continuing education programs offered by other licensed mental health providers and organizations. This would include mental health presentations and trainings awarded CE's through APA, ACA, NBCC, AMA, and universities.

CommentID: **227205**

Commenter: Anonymous 7/13/24 6:39 pm

Support petition AND expand options

I support this petition and strongly recommend expanding the ability for social workers to receive CE credit for attending continuing education programs offered by other licensed mental health providers and organizations. This would include mental health presentations and trainings awarding CE's through APA, ACA, NBCC, AMA, and universities.

CommentID: **227206**

Commenter: anonymous 7/14/24 10:43 am

Support

I highly support this recommendation and feel that the more on the same page mental health professionals can be the better for everyone.

CommentID: **227207**

Commenter: Melissa Shore, Shore Up Wellness 7/14/24 9:29 pm

APA CE approval

As an LCSW who works many hours a week to help people heal their lives and recover from traumatic events, I need the support of my Board to allow CE's that are acceptable to other Boards with equally high standards to be allowed by our Board of Social Work. Please don't make the lives of those of us who sacrifice a lot in our work any more complicated or difficult than they already are or we will be facing a higher level of burn-out than already exists among social workers. Thank you for your consideration! Melissa Shore

CommentID: **227208**

Commenter: MIchelle Sirch PhD, LPC 7/15/24 10:17 am

I strongly support this petition

As a provider of mental health services since 1983 I feel it is imperative that there are unified ways for all licensed professionals to gain educational experiences across disciplines as we all serve the same clients and support one another in doing so.

CommentID: **227210**

Commenter: Anonymous 7/15/24 1:45 pm

Petition Support

I strongly support the addition of APA as an approved continuing education provider.

CommentID: **227211**

Commenter: Anonymous 7/17/24 9:56 am

I support approval of APA CEUs

I support approval of APA CEUs

CommentID: **227213**

Agenda Item: Provide definition of "generalist social work"

Included in your agenda packet is:

- Copy of proposed regulations approved by the Board in December 2022 with suggested definition included.

Staff Note: OAG has provided guidance that the Board needs to determine "generalist social work" to use in these amended regulations. This issue came before the Board at the June 2024 meeting, at which time the Board determined the matter should be discussed by the Regulatory Committee. The Board decided at its November 2023 meeting to remove this section from the original periodic review amendments and create a NOIRA to address this concern. The Board does not have a Regulatory Committee currently and the action is up for proposed stage action, so the issue is before the Board again and needs to be decided.

Action Needed:

- Motion to amend proposed regulations with a definition of generalist social work as determined by the Board.

Project 7250 - Proposed

Board of Social Work

Amendments resulting from 2022 periodic review

Chapter 20

Regulations Governing the Practice of Social Work

18VAC140-20-10. Definitions.

A. The following words and terms when used in this chapter shall have the meanings ascribed to them in § 54.1-3700 of the Code of Virginia:

Baccalaureate social worker

Board

Casework

Casework management and supportive services

Clinical social worker

Master's social worker

Practice of social work

Social worker

B. The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"Accredited school of social work" means a school of social work accredited by the Council on Social Work Education.

"Active practice" means post-licensure practice at the level of licensure for which an applicant is seeking licensure in Virginia and shall include at least 360 hours of practice in a 12-month period.

"Ancillary services" means activities such as ~~case management,~~ recordkeeping, referral, ~~and~~ coordination of services, intervention into situations on a client's behalf with the objectives of meeting the client's needs, and participation in required staff meetings.

"Clinical course of study" means graduate course work that includes specialized advanced courses in human behavior and the social environment, social justice and policy, psychopathology, and diversity issues; research; clinical practice with individuals, families, and groups; and a clinical practicum that focuses on diagnostic, prevention, and treatment services.

"Clinical social work services" include the application of social work principles and methods in performing assessments and diagnoses based on a recognized manual of mental and emotional disorders or recognized system of problem definition, preventive and early intervention services, and treatment services, including psychosocial interventions, psychotherapy, and counseling for mental disorders, substance abuse, marriage and family dysfunction, and problems caused by social and psychological stress or health impairment.

~~"Conversion therapy" means any practice or treatment as defined in § 54.1-2409.5 A of the Code of Virginia.~~

"Exempt practice" is that which meets the conditions of exemption from the requirements of licensure as defined in § 54.1-3701 of the Code of Virginia.

"Face-to-face " means the physical presence of the individuals involved in the supervisory relationship during either individual or group supervision or in the delivery of clinical social work services by a supervisee and may include the use of technology that provides real-time, interactive contact among the individuals involved.

“Generalist social work” means non-clinical practice at the case management level which involves engaging, assessing, intervening, evaluating, supporting, educating, and organizing with and on behalf of individuals, families, and collections of people. Work may include community development, organizational development, and evaluation to ensure that services are useful, effective, and ethical.

"LBSW" means a licensed baccalaureate social worker.

"LCSW" means a licensed clinical social worker.

"LMSW" means a licensed master's social worker.

~~"Nonexempt practice" means that which does not meet the conditions of exemption from the requirements of licensure as defined in § 54.1-3701 of the Code of Virginia.~~

"NPDB" means the U.S. Department of Health and Human Services National Practitioner Data Bank.

"Supervisee" means an individual who has submitted a supervisory contract and has received board approval to provide clinical services in social work under supervision.

"Supervision" means a professional relationship between a supervisor and supervisee in which the supervisor directs, monitors and evaluates the supervisee's social work practice while promoting development of the supervisee's knowledge, skills and abilities to provide social work services in an ethical and competent manner.

“Supervisory contract” means an agreement that outlines the expectations and responsibilities of the supervisor and supervisee in accordance with regulations of the board.

18VAC140-20-37. Licensure; general.

~~LBSWs and LMSWs may practice in exempt practice settings under appropriate supervision. In accordance with § 54.1-3700 of the Code of Virginia, an LBSW shall engage in the practice of~~

~~social work under the supervision of a master's social worker. Only licensed clinical social workers may practice at the autonomous level.~~

A. In accordance with § 54.1-3700 of the Code of Virginia, an LBSW shall engage in the practice of social work under the supervision of an LMSW or LCSW.

B. LBSWs and LMSWs may practice in exempt practice settings under appropriate supervision.

C. LBSWs and LMSWs may practice generalist social work.

D. Only LCSWs may practice at the autonomous level.

Agenda Item: Adoption of NOIRA for Social Work Compact

Included in your agenda package:

- Chapter 690 of the 2024 Acts of Assembly

Action needed:

- Motion to issue a Notice of Intended Regulatory Action to amend regulations for entry into the Social Work Licensure Compact

CHAPTER 690

An Act to amend the Code of Virginia by adding in Chapter 37 of Title 54.1 an article numbered 3, consisting of a section numbered 54.1-3709.4, relating to Social Work Licensure Compact.

[H 326]

Approved April 8, 2024

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Chapter 37 of Title 54.1 an article numbered 3, consisting of a section numbered 54.1-3709.4, as follows:

Article 3.

Social Work Licensure Compact.

§ 54.1-3709.4. Social Work Licensure Compact.

The General Assembly hereby enacts, and the Commonwealth of Virginia hereby enters into, the Social Work Licensure Compact with any and all states legally joining therein according to its terms, in the form substantially as follows:

SOCIAL WORK LICENSURE COMPACT.

Section 1.

Purpose.

The purpose of this Compact is to facilitate interstate practice of Regulated Social Workers by improving public access to competent Social Work Services. The Compact preserves the regulatory authority of States to protect public health and safety through the current system of State licensure.

This Compact is designed to achieve the following objectives:

1. Increase public access to Social Work Services;

2. Reduce overly burdensome and duplicative requirements associated with holding multiple licenses;

3. Enhance the Member States' ability to protect the public's health and safety;

4. Encourage the cooperation of Member States in regulating multistate practice;

5. Promote mobility and address workforce shortages by eliminating the necessity for licenses in multiple States by providing for the mutual recognition of other Member State licenses;

6. Support military families;

7. Facilitate the exchange of licensure and disciplinary information among Member States;

8. Authorize all Member States to hold a Regulated Social Worker accountable for abiding by a Member State's laws, regulations, and applicable professional standards in the Member State in which the client is located at the time care is rendered; and

9. Allow for the use of telehealth to facilitate increased access to regulated Social Work Services.

Section 2.

Definitions.

As used in this Compact, and except as otherwise provided, the following definitions shall apply:

"Active Military Member" means any individual with full-time duty status in the active armed forces of the United States including members of the National Guard and Reserve.

"Adverse Action" means any administrative, civil, equitable, or criminal action permitted by a State's laws which is imposed by a Licensing Authority or other authority against a Regulated Social Worker, including actions against an individual's license or Multistate Authorization to Practice such as revocation, suspension, probation, monitoring of the Licensee, limitation on the Licensee's practice, or any other Encumbrance on licensure affecting a Regulated Social Worker's authorization to practice, including issuance of a cease and desist action.

"Alternative Program" means a non-disciplinary monitoring or practice remediation process approved by a Licensing Authority to address practitioners with an Impairment.

"Charter Member States" means Member States who have enacted legislation to adopt this Compact where such legislation predates the effective date of this Compact as described in Section 14.

"Compact Commission" or "Commission" means the government agency whose membership consists of all States that have enacted this Compact, which is known as the Social Work Licensure Compact Commission, as described in Section 10, and which shall operate as an instrumentality of the Member States.

"Current Significant Investigative Information" means:

1. Investigative information that a Licensing Authority, after a preliminary inquiry that includes notification and an opportunity for the Regulated Social Worker to respond has reason to believe is not groundless and, if proved true, would indicate more than a minor infraction as may be defined by the Commission; or

2. Investigative information that indicates that the Regulated Social Worker represents an immediate

threat to public health and safety, as may be defined by the Commission, regardless of whether the Regulated Social Worker has been notified and has had an opportunity to respond.

"Data System" means a repository of information about Licensees, including, continuing education, examination, licensure, Current Significant Investigative Information, Disqualifying Event, Multistate License(s), and Adverse Action information or other information as required by the Commission.

"Domicile" means the jurisdiction in which the Licensee resides and intends to remain indefinitely.

"Disqualifying Event" means any Adverse Action or incident which results in an Encumbrance that disqualifies or makes the Licensee ineligible to either obtain, retain, or renew a Multistate License.

"Encumbrance" means a revocation or suspension of, or any limitation on, the full and unrestricted practice of Social Work licensed and regulated by a Licensing Authority.

"Executive Committee" means a group of delegates elected or appointed to act on behalf of, and within the powers granted to them by, the Compact and Commission.

"Home State" means the Member State that is the Licensee's primary Domicile.

"Impairment" means a condition(s) that may impair a practitioner's ability to engage in full and unrestricted practice as a Regulated Social Worker without some type of intervention and may include alcohol and drug dependence, mental health impairment, and neurological or physical impairments.

"Licensee(s)" means an individual who currently holds a license from a State to practice as a Regulated Social Worker.

"Licensing Authority" means the board or agency of a Member State or equivalent that is responsible for the licensing and regulation of Regulated Social Workers.

"Member State" means a state, commonwealth, district, or territory of the United States of America that has enacted this Compact.

"Multistate Authorization to Practice" means a legally authorized privilege to practice, which is equivalent to a license, associated with a Multistate License permitting the practice of Social Work in a Remote State.

"Multistate License" means a license to practice as a Regulated Social Worker issued by a Home State Licensing Authority that authorizes the Regulated Social Worker to practice in all Member States under Multistate Authorization to Practice.

"Qualifying National Exam" means a national licensing examination approved by the Commission.

"Regulated Social Worker" means any clinical, master's or bachelor's Social Worker licensed by a Member State regardless of the title used by that Member State.

"Remote State" means a Member State other than the Licensee's Home State.

"Rule(s)" or "Rule(s) of the Commission" means a regulation or regulations duly promulgated by the Commission, as authorized by the Compact, that has the force of law.

"Single State License" means a Social Work license issued by any State that authorizes practice only within the issuing State and does not include Multistate Authorization to Practice in any Member State.

"Social Work" or "Social Work Services" means the application of social work theory, knowledge, methods, ethics, and the professional use of self to restore or enhance social, psychosocial, or biopsychosocial functioning of individuals, couples, families, groups, organizations, and communities through the care and services provided by a Regulated Social Worker as set forth in the Member State's statutes and regulations in the State where the services are being provided.

"State" means any state, commonwealth, district, or territory of the United States of America that regulates the practice of Social Work.

"Unencumbered License" means a license that authorizes a Regulated Social Worker to engage in the full and unrestricted practice of Social Work.

Section 3.

State Participation in the Compact.

A. To be eligible to participate in the Compact, a potential Member State must currently meet all of the following criteria:

1. License and regulate the practice of Social Work at either the clinical, master's, or bachelor's category.

2. Require applicants for licensure to graduate from a program that is:

a. Operated by a college or university recognized by the Licensing Authority;

b. Accredited, or in candidacy by an institution that subsequently becomes accredited, by an accrediting agency recognized by either:

(1) The Council for Higher Education Accreditation, or its successor; or

(2) The United States Department of Education; and

c. Corresponds to the licensure sought as outlined in Section 4.

3. Require applicants for clinical licensure to complete a period of supervised practice.

4. Have a mechanism in place for receiving, investigating, and adjudicating complaints about Licensees.

B. To maintain membership in the Compact a Member State shall:

1. Require that applicants for a Multistate License pass a Qualifying National Exam for the corresponding category of Multistate License sought as outlined in Section 4;

2. Participate fully in the Commission's Data System, including using the Commission's unique identifier as defined in Rules;

3. Notify the Commission, in compliance with the terms of the Compact and Rules, of any Adverse Action or the availability of Current Significant Investigative Information regarding a Licensee;

4. Implement procedures for considering the criminal history records of applicants for a Multistate License. Such procedures shall include the submission of fingerprints or other biometric-based information by applicants for the purpose of obtaining an applicant's criminal history record information from the Federal Bureau of Investigation and the agency responsible for retaining that State's criminal records;

5. Comply with the Rules of the Commission;

6. Require an applicant to obtain or retain a license in the Home State and meet the Home State's qualifications for licensure or renewal of licensure, as well as all other applicable Home State laws;

7. Authorize a Licensee holding a Multistate License in any Member State to practice in accordance with the terms of the Compact and Rules of the Commission; and

8. Designate a delegate to participate in the Commission meetings.

C. A Member State meeting the requirements of Sections 3 A and 3 B of this Compact shall designate the categories of Social Work licensure that are eligible for issuance of a Multistate License for applicants in such Member State. To the extent that any Member State does not meet the requirements for participation in the Compact at any particular category of Social Work licensure, such Member State may choose, but is not obligated to, issue a Multistate License to applicants that otherwise meet the requirements of Section 4 for issuance of a Multistate License in such category or categories of licensure.

D. The Home State may charge a fee for granting the Multistate License.

Section 4.

Social Worker Participation in the Compact.

A. To be eligible for a Multistate License under the terms and provisions of the Compact, an applicant, regardless of category must:

1. Hold or be eligible for an active, Unencumbered License in the Home State.

2. Pay any applicable fees, including any State fee, for the Multistate License.

3. Submit, in connection with an application for a Multistate License, fingerprints or other biometric data for the purpose of obtaining criminal history record information from the Federal Bureau of Investigation and the agency responsible for retaining that State's criminal records.

4. Notify the Home State of any Adverse Action, Encumbrance, or restriction on any professional license taken by any Member State or non-Member State within 30 days from the date the action is taken.

5. Meet any continuing competence requirements established by the Home State.

6. Abide by the laws, regulations, and applicable standards in the Member State where the client is located at the time care is rendered.

B. An applicant for a clinical-category Multistate License must meet all of the following requirements:

1. Fulfill a competency requirement, which shall be satisfied by either:

a. Passage of a clinical-category Qualifying National Exam; or

b. Licensure of the applicant in their Home State at the clinical category, beginning prior to such time as a Qualifying National Exam was required by the Home State and accompanied by a period of continuous Social Work licensure thereafter, all of which may be further governed by the Rules of the Commission; or

c. The substantial equivalency of the foregoing competency requirements which the Commission may determine by Rule.

2. Attain at least a master's degree in Social Work from a program that is:

a. Operated by a college or university recognized by the Licensing Authority; and

b. Accredited, or in candidacy that subsequently becomes accredited, by an accrediting agency recognized by either:

(1) The Council for Higher Education Accreditation or its successor; or

(2) The United States Department of Education.

3. Fulfill a practice requirement, which shall be satisfied by demonstrating completion of either:

a. A period of postgraduate supervised clinical practice equal to a minimum of three thousand hours; or

b. A minimum of two years of full-time postgraduate supervised clinical practice; or

c. The substantial equivalency of the foregoing practice requirements which the Commission may determine by Rule.

C. An applicant for a master's-category Multistate License must meet all of the following requirements:

1. Fulfill a competency requirement, which shall be satisfied by either:

a. Passage of a masters-category Qualifying National Exam;

b. Licensure of the applicant in their Home State at the master's category, beginning prior to such time as a Qualifying National Exam was required by the Home State at the master's category and accompanied by a continuous period of Social Work licensure thereafter, all of which may be further governed by the Rules of the Commission; or

c. The substantial equivalency of the foregoing competency requirements which the Commission may determine by Rule.

2. Attain at least a master's degree in Social Work from a program that is:

a. Operated by a college or university recognized by the Licensing Authority; and

b. Accredited, or in candidacy that subsequently becomes accredited, by an accrediting agency recognized by either:

(1) The Council for Higher Education Accreditation or its successor; or

(2) The United States Department of Education.

D. An applicant for a bachelor's-category Multistate License must meet all of the following requirements:

1. Fulfill a competency requirement, which shall be satisfied by either:

a. Passage of a bachelor's-category Qualifying National Exam;

b. Licensure of the applicant in their Home State at the bachelor's category, beginning prior to such time as a Qualifying National Exam was required by the Home State and accompanied by a period of continuous Social Work licensure thereafter, all of which may be further governed by the Rules of the Commission; or

c. The substantial equivalency of the foregoing competency requirements which the Commission may determine by Rule.

2. Attain at least a bachelor's degree in Social Work from a program that is:

a. Operated by a college or university recognized by the Licensing Authority; and

b. Accredited, or in candidacy that subsequently becomes accredited, by an accrediting agency recognized by either:

(1) The Council for Higher Education Accreditation or its successor; or

(2) The United States Department of Education.

E. The Multistate License for a Regulated Social Worker is subject to the renewal requirements of the Home State. The Regulated Social Worker must maintain compliance with the requirements of Section 4 A to be eligible to renew a Multistate License.

F. The Regulated Social Worker's services in a Remote State are subject to that Member State's regulatory authority. A Remote State may, in accordance with due process and that Member State's laws, remove a Regulated Social Worker's Multistate Authorization to Practice in the Remote State for a specific period of time, impose fines, and take any other necessary actions to protect the health and safety of its citizens.

G. If a Multistate License is encumbered, the Regulated Social Worker's Multistate Authorization to Practice shall be deactivated in all Remote States until the Multistate License is no longer encumbered.

H. If a Multistate Authorization to Practice is encumbered in a Remote State, the regulated Social Worker's Multistate Authorization to Practice may be deactivated in that State until the Multistate Authorization to Practice is no longer encumbered.

Section 5.

Issuance of a Multistate License.

A. Upon receipt of an application for Multistate License, the Home State Licensing Authority shall determine the applicant's eligibility for a Multistate License in accordance with Section 4 of this Compact.

B. If such applicant is eligible pursuant to Section 4 of this Compact, the Home State Licensing Authority shall issue a Multistate License that authorizes the applicant or Regulated Social Worker to practice in all Member States under a Multistate Authorization to Practice.

C. Upon issuance of a Multistate License, the Home State Licensing Authority shall designate whether the Regulated Social Worker holds a Multistate License in the Bachelor's, Masters, or Clinical category of Social Work.

D. A Multistate License issued by a Home State to a resident in that State shall be recognized by all Compact Member States as authorizing Social Work Practice under a Multistate Authorization to Practice corresponding to each category of licensure regulated in each Member State.

Section 6.

Authority of Interstate Compact Commission and Member State Licensing Authorities.

A. Nothing in this Compact, nor any Rule of the Commission, shall be construed to limit, restrict, or in any way reduce the ability of a Member State to enact and enforce laws, regulations, or other rules related to the practice of Social Work in that State, where those laws, regulations, or other rules are not inconsistent with the provisions of this Compact.

B. Nothing in this Compact shall affect the requirements established by a Member State for the issuance of a Single State License.

C. Nothing in this Compact, nor any Rule of the Commission, shall be construed to limit, restrict, or

in any way reduce the ability of a Member State to take Adverse Action against a Licensee's Single State License to practice Social Work in that State.

D. Nothing in this Compact, nor any Rule of the Commission, shall be construed to limit, restrict, or in any way reduce the ability of a Remote State to take Adverse Action against a Licensee's Multistate Authorization to Practice in that State.

E. Nothing in this Compact, nor any Rule of the Commission, shall be construed to limit, restrict, or in any way reduce the ability of a Licensee's Home State to take Adverse Action against a Licensee's Multistate License based upon information provided by a Remote State.

Section 7.

Reissuance of a Multistate License by a New Home State.

A. A Licensee can hold a Multistate License, issued by their Home State, in only one Member State at any given time.

B. If a Licensee changes their Home State by moving between two Member States:

1. The Licensee shall immediately apply for the reissuance of their Multistate License in their new Home State. The Licensee shall pay all applicable fees and notify the prior Home State in accordance with the Rules of the Commission.

2. Upon receipt of an application to reissue a Multistate License, the new Home State shall verify that the Multistate License is active, unencumbered, and eligible for reissuance under the terms of the Compact and the Rules of the Commission. The Multistate License issued by the prior Home State will be deactivated and all Member States notified in accordance with the applicable Rules adopted by the Commission.

3. Prior to the reissuance of the Multistate License, the new Home State shall conduct procedures for considering the criminal history records of the Licensee. Such procedures shall include the submission of fingerprints or other biometric-based information by applicants for the purpose of obtaining an applicant's criminal history record information from the Federal Bureau of Investigation and the agency responsible for retaining that State's criminal records.

4. If required for initial licensure, the new Home State may require completion of jurisprudence requirements in the new Home State.

5. Notwithstanding any other provision of this Compact, if a Licensee does not meet the requirements set forth in this Compact for the reissuance of a Multistate License by the new Home State, then the Licensee shall be subject to the new Home State requirements for the issuance of a Single State License in that State.

C. If a Licensee changes their primary State of residence by moving from a Member State to a non-Member State, or from a non-Member State to a Member State, then the Licensee shall be subject to the State requirements for the issuance of a Single State License in the new Home State.

D. Nothing in this Compact shall interfere with a Licensee's ability to hold a Single State License in multiple States; however, for the purposes of this Compact, a Licensee shall have only one Home State, and only one Multistate License.

E. Nothing in this Compact shall interfere with the requirements established by a Member State for the issuance of a Single State License.

Section 8.

Military Families.

An Active Military Member or their spouse shall designate a Home State where the individual has a Multistate License. The individual may retain their Home State designation during the period the service member is on active duty.

Section 9.

Adverse Actions.

A. In addition to the other powers conferred by State law, a Remote State shall have the authority, in accordance with existing State due process law, to:

1. Take Adverse Action against a Regulated Social Worker's Multistate Authorization to Practice only within that Member State, and issue subpoenas for both hearings and investigations that require the attendance and testimony of witnesses as well as the production of evidence. Subpoenas issued by a Licensing Authority in a Member State for the attendance and testimony of witnesses or the production of evidence from another Member State shall be enforced in the latter State by any court of competent jurisdiction, according to the practice and procedure of that court applicable to subpoenas issued in proceedings pending before it. The issuing Licensing Authority shall pay any witness fees, travel expenses, mileage, and other fees required by the service statutes of the State in which the witnesses or evidence are located.

2. Only the Home State shall have the power to take Adverse Action against a Regulated Social Worker's Multistate License.

B. For purposes of taking Adverse Action, the Home State shall give the same priority and effect to reported conduct received from a Member State as it would if the conduct had occurred within the Home State. In so doing, the Home State shall apply its own State laws to determine appropriate action.

C. The Home State shall complete any pending investigations of a Regulated Social Worker who

changes their Home State during the course of the investigations. The Home State shall also have the authority to take appropriate action(s) and shall promptly report the conclusions of the investigations to the administrator of the Data System. The administrator of the Data System shall promptly notify the new Home State of any Adverse Actions.

D. A Member State, if otherwise permitted by State law, may recover from the affected Regulated Social Worker the costs of investigations and dispositions of cases resulting from any Adverse Action taken against that Regulated Social Worker.

E. A Member State may take Adverse Action based on the factual findings of another Member State, provided that the Member State follows its own procedures for taking the Adverse Action.

F. Joint Investigations:

1. In addition to the authority granted to a Member State by its respective Social Work practice act or other applicable State law, any Member State may participate with other Member States in joint investigations of Licensees.

2. Member States shall share any investigative, litigation, or compliance materials in furtherance of any joint or individual investigation initiated under the Compact.

G. If Adverse Action is taken by the Home State against the Multistate License of a Regulated Social Worker, the Regulated Social Worker's Multistate Authorization to Practice in all other Member States shall be deactivated until all Encumbrances have been removed from the Multistate License. All Home State disciplinary orders that impose Adverse Action against the license of a Regulated Social Worker shall include a statement that the Regulated Social Worker's Multistate Authorization to Practice is deactivated in all Member States until all conditions of the decision, order, or agreement are satisfied.

H. If a Member State takes Adverse Action, it shall promptly notify the administrator of the Data System. The administrator of the Data System shall promptly notify the Home State and all other Member States of any Adverse Actions by Remote States.

I. Nothing in this Compact shall override a Member State's decision that participation in an Alternative Program may be used in lieu of Adverse Action.

J. Nothing in this Compact shall authorize a Member State to demand the issuance of subpoenas for attendance and testimony of witnesses or the production of evidence from another Member State for lawful actions within that Member State.

K. Nothing in this Compact shall authorize a Member State to impose discipline against a Regulated Social Worker who holds a Multistate Authorization to Practice for lawful actions within another Member State.

Section 10.

Establishment of Social Work Licensure Compact Commission.

A. The Compact Member States hereby create and establish a joint government agency whose membership consists of all Member States that have enacted the compact known as the Social Work Licensure Compact Commission. The Commission is an instrumentality of the Compact States acting jointly and not an instrumentality of any one State. The Commission shall come into existence on or after the effective date of the Compact as set forth in Section 14.

B. Membership, Voting, and Meetings:

1. Each Member State shall have and be limited to one (1) delegate selected by that Member State's State Licensing Authority.

2. The delegate shall be either:

a. A current member of the State Licensing Authority at the time of appointment, who is a Regulated Social Worker or public member of the State Licensing Authority; or

b. An administrator of the State Licensing Authority or their designee.

3. The Commission shall by Rule or bylaw establish a term of office for delegates and may by Rule or bylaw establish term limits.

4. The Commission may recommend removal or suspension of any delegate from office.

5. A Member State's State Licensing Authority shall fill any vacancy of its delegate occurring on the Commission within 60 days of the vacancy.

6. Each delegate shall be entitled to one vote on all matters before the Commission requiring a vote by Commission delegates.

7. A delegate shall vote in person or by such other means as provided in the bylaws. The bylaws may provide for delegates to meet by telecommunication, videoconference, or other means of communication.

8. The Commission shall meet at least once during each calendar year. Additional meetings may be held as set forth in the bylaws. The Commission may meet by telecommunication, video conference, or other similar electronic means.

C. The Commission shall have the following powers:

1. Establish the fiscal year of the Commission;

2. Establish code of conduct and conflict of interest policies;

3. Establish and amend Rules and bylaws;

4. Maintain its financial records in accordance with the bylaws;

5. Meet and take such actions as are consistent with the provisions of this Compact, the Commission's Rules, and the bylaws;

6. Initiate and conclude legal proceedings or actions in the name of the Commission, provided that the standing of any State Licensing Board to sue or be sued under applicable law shall not be affected;

7. Maintain and certify records and information provided to a Member State as the authenticated business records of the Commission, and designate an agent to do so on the Commission's behalf;

8. Purchase and maintain insurance and bonds;

9. Borrow, accept, or contract for services of personnel, including, but not limited to, employees of a Member State;

10. Conduct an annual financial review;

11. Hire employees, elect or appoint officers, fix compensation, define duties, grant such individuals appropriate authority to carry out the purposes of the Compact, and establish the Commission's personnel policies and programs relating to conflicts of interest, qualifications of personnel, and other related personnel matters;

12. Assess and collect fees;

13. Accept any and all appropriate gifts, donations, grants of money, other sources of revenue, equipment, supplies, materials, and services, and receive, utilize, and dispose of the same; provided that at all times the Commission shall avoid any appearance of impropriety or conflict of interest;

14. Lease, purchase, retain, own, hold, improve, or use any property, real, personal, or mixed, or any undivided interest therein;

15. Sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property real, personal, or mixed;

16. Establish a budget and make expenditures;

17. Borrow money;

18. Appoint committees, including standing committees, composed of members, State regulators, State legislators or their representatives, and consumer representatives, and such other interested persons as may be designated in this Compact and the bylaws;

19. Provide and receive information from, and cooperate with, law enforcement agencies;

20. Establish and elect an Executive Committee, including a chair and a vice chair;

21. Determine whether a State's adopted language is materially different from the model compact language such that the State would not qualify for participation in the Compact; and

22. Perform such other functions as may be necessary or appropriate to achieve the purposes of this Compact.

D. The Executive Committee:

1. The Executive Committee shall have the power to act on behalf of the Commission according to the terms of this Compact. The powers, duties, and responsibilities of the Executive Committee shall include:

a. Oversee the day-to-day activities of the administration of the compact including enforcement and compliance with the provisions of the compact, its Rules and bylaws, and other such duties as deemed necessary;

b. Recommend to the Commission changes to the Rules or bylaws, changes to this Compact legislation, fees charged to Compact Member States, fees charged to Licensees, and other fees;

c. Ensure Compact administration services are appropriately provided, including by contract;

d. Prepare and recommend the budget;

e. Maintain financial records on behalf of the Commission;

f. Monitor Compact compliance of Member States and provide compliance reports to the Commission;

g. Establish additional committees as necessary;

h. Exercise the powers and duties of the Commission during the interim between Commission meetings, except for adopting or amending Rules, adopting or amending bylaws, and exercising any other powers and duties expressly reserved to the Commission by Rule or bylaw; and

i. Other duties as provided in the Rules or bylaws of the Commission.

2. The Executive Committee shall be composed of up to eleven (11) members:

a. The chair and vice chair of the Commission shall be voting members of the Executive Committee; and

b. The Commission shall elect five voting members from the current membership of the Commission.

c. Up to four (4) ex-officio, nonvoting members from four (4) recognized national Social Work organizations.

d. The ex-officio members will be selected by their respective organizations.

3. The Commission may remove any member of the Executive Committee as provided in the Commission's bylaws.

4. The Executive Committee shall meet at least annually.

a. Executive Committee meetings shall be open to the public, except that the Executive Committee may meet in a closed, non-public meeting as provided in subsection F 2 below.

b. The Executive Committee shall give seven (7) days' notice of its meetings, posted on its website and as determined to provide notice to persons with an interest in the business of the Commission.

c. The Executive Committee may hold a special meeting in accordance with subsection F.1.b. below.

E. The Commission shall adopt and provide to the Member States an annual report.

F. Meetings of the Commission:

1. All meetings shall be open to the public, except that the Commission may meet in a closed, non-public meeting as provided in subsection F 2 below.

a. Public notice for all meetings of the full Commission of meetings shall be given in the same manner as required under the Rulemaking provisions in Section 12, except that the Commission may hold a special meeting as provided in subsection F 1 b below.

b. The Commission may hold a special meeting when it must meet to conduct emergency business by giving 48 hours' notice to all commissioners, on the Commission's website, and other means as provided in the Commission's Rules. The Commission's legal counsel shall certify that the Commission's need to meet qualifies as an emergency.

2. The Commission or the Executive Committee or other committees of the Commission may convene in a closed, non-public meeting for the Commission or Executive Committee or other committees of the Commission to receive legal advice or to discuss:

a. Non-compliance of a Member State with its obligations under the Compact;

b. The employment, compensation, discipline, or other matters, practices, or procedures related to specific employees;

c. Current or threatened discipline of a Licensee by the Commission or by a Member State's Licensing Authority;

d. Current, threatened, or reasonably anticipated litigation;

e. Negotiation of contracts for the purchase, lease, or sale of goods, services, or real estate;

f. Accusing any person of a crime or formally censuring any person;

g. Trade secrets or commercial or financial information that is privileged or confidential;

h. Information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;

i. Investigative records compiled for law enforcement purposes;

j. Information related to any investigative reports prepared by or on behalf of or for use of the Commission or other committee charged with responsibility of investigation or determination of compliance issues pursuant to the Compact;

k. Matters specifically exempted from disclosure by federal or Member State law; or

l. Other matters as promulgated by the Commission by Rule.

3. If a meeting, or portion of a meeting, is closed, the presiding officer shall state that the meeting will be closed and reference each relevant exempting provision, and such reference shall be recorded in the minutes.

4. The Commission shall keep minutes that fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, and the reasons therefor, including a description of the views expressed. All documents considered in connection with an action shall be identified in such minutes. All minutes and documents of a closed meeting shall remain under seal, subject to release only by a majority vote of the Commission or order of a court of competent jurisdiction.

G. Financing of the Commission:

1. The Commission shall pay, or provide for the payment of, the reasonable expenses of its establishment, organization, and ongoing activities.

2. The Commission may accept any and all appropriate revenue sources as provided in subsection C 13.

3. The Commission may levy on and collect an annual assessment from each Member State and impose fees on Licensees of Member States to whom it grants a Multistate License to cover the cost of the operations and activities of the Commission and its staff, which must be in a total amount sufficient to cover its annual budget as approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount for Member States shall be allocated based upon a formula that the Commission shall promulgate by Rule.

4. The Commission shall not incur obligations of any kind prior to securing the funds adequate to meet the same; nor shall the Commission pledge the credit of any of the Member States, except by and with the authority of the Member State.

5. The Commission shall keep accurate accounts of all receipts and disbursements. The receipts and disbursements of the Commission shall be subject to the financial review and accounting procedures established under its bylaws. However, all receipts and disbursements of funds handled by the Commission shall be subject to an annual financial review by a certified or licensed public accountant, and the report of the financial review shall be included in and become part of the annual report of the Commission.

H. Qualified Immunity, Defense, and Indemnification:

1. The members, officers, executive director, employees, and representatives of the Commission shall be immune from suit and liability, both personally and in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error, or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities; provided that nothing in this paragraph shall be construed to protect any such person from suit or liability for any damage, loss, injury, or liability caused by the intentional or willful or wanton misconduct of that person. The procurement of insurance of any type by the Commission shall not in any way compromise or limit the immunity granted hereunder.

2. The Commission shall defend any member, officer, executive director, employee, and representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of Commission employment, duties, or responsibilities, or as determined by the Commission that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities; provided that nothing herein shall be construed to prohibit that person from retaining their own counsel at their own expense; and provided further, that the actual or alleged act, error, or omission did not result from that person's intentional or willful or wanton misconduct.

3. The Commission shall indemnify and hold harmless any member, officer, executive director, employee, and representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error, or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from the intentional or willful or wanton misconduct of that person.

4. Nothing herein shall be construed as a limitation on the liability of any Licensee for professional malpractice or misconduct, which shall be governed solely by any other applicable State laws.

5. Nothing in this Compact shall be interpreted to waive or otherwise abrogate a Member State's state action immunity or state action affirmative defense with respect to antitrust claims under the Sherman Act, Clayton Act, or any other State or federal antitrust or anticompetitive law or regulation.

6. Nothing in this Compact shall be construed to be a waiver of sovereign immunity by the Member States or by the Commission.

Section 11.
Data System.

A. The Commission shall provide for the development, maintenance, operation, and utilization of a coordinated Data System.

B. The Commission shall assign each applicant for a Multistate License a unique identifier, as determined by the Rules of the Commission.

C. Notwithstanding any other provision of State law to the contrary, a Member State shall submit a uniform data set to the Data System on all individuals to whom this Compact is applicable as required by the Rules of the Commission, including:

1. Identifying information;

2. Licensure data;

3. Adverse Actions against a license and information related thereto;

4. Non-confidential information related to Alternative Program participation, the beginning and ending dates of such participation, and other information related to such participation not made confidential under Member State law;

5. Any denial of application for licensure, and the reason(s) for such denial;

6. The presence of Current Significant Investigative Information; and

7. Other information that may facilitate the administration of this Compact or the protection of the public, as determined by the Rules of the Commission.

D. The records and information provided to a Member State pursuant to this Compact or through the Data System, when certified by the Commission or an agent thereof, shall constitute the authenticated business records of the Commission, and shall be entitled to any associated hearsay exception in any relevant judicial, quasi-judicial or administrative proceedings in a Member State.

E. Current Significant Investigative Information pertaining to a Licensee in any Member State will only be available to other Member States.

It is the responsibility of the Member States to report any Adverse Action against a Licensee and to monitor the database to determine whether Adverse Action has been taken against a Licensee. Adverse Action information pertaining to a Licensee in any Member State will be available to any other Member State.

F. Member States contributing information to the Data System may designate information that may not be shared with the public without the express permission of the contributing State. Any information submitted to the Data System that is subsequently expunged pursuant to federal law or the laws of the Member State contributing the information shall be removed from the Data System.

Section 12.
Rulemaking.

A. The Commission shall promulgate reasonable Rules in order to effectively and efficiently implement and administer the purposes and provisions of the Compact. A Rule shall be invalid and have no force or effect only if a court of competent jurisdiction holds that the Rule is invalid because the Commission exercised its rulemaking authority in a manner that is beyond the scope and purposes of the Compact, or the powers granted hereunder, or based upon another applicable standard of review.

B. The Rules of the Commission shall have the force of law in each Member State, provided however that where the Rules of the Commission conflict with the laws of the Member State that establish the Member State's laws, regulations, and applicable standards that govern the practice of Social Work as held by a court of competent jurisdiction, the Rules of the Commission shall be ineffective in that State to the extent of the conflict.

C. The Commission shall exercise its Rulemaking powers pursuant to the criteria set forth in this Section and the Rules adopted thereunder. Rules shall become binding on the day following adoption or the date specified in the rule or amendment, whichever is later.

D. If a majority of the legislatures of the Member States rejects a Rule or portion of a Rule, by enactment of a statute or resolution in the same manner used to adopt the Compact within four (4) years of the date of adoption of the Rule, then such Rule shall have no further force and effect in any Member State.

E. Rules shall be adopted at a regular or special meeting of the Commission.

F. Prior to adoption of a proposed Rule, the Commission shall hold a public hearing and allow persons to provide oral and written comments, data, facts, opinions, and arguments.

G. Prior to adoption of a proposed Rule by the Commission, and at least thirty (30) days in advance of the meeting at which the Commission will hold a public hearing on the proposed Rule, the Commission shall provide a Notice of Proposed Rulemaking:

1. On the website of the Commission or other publicly accessible platform;

2. To persons who have requested notice of the Commission's notices of proposed rulemaking; and

3. In such other way(s) as the Commission may by Rule specify.

H. The Notice of Proposed Rulemaking shall include:

1. The time, date, and location of the public hearing at which the Commission will hear public comments on the proposed Rule and, if different, the time, date, and location of the meeting where the Commission will consider and vote on the proposed Rule;

2. If the hearing is held via telecommunication, video conference, or other electronic means, the Commission shall include the mechanism for access to the hearing in the Notice of Proposed Rulemaking;

3. The text of the proposed Rule and the reason therefor;

4. A request for comments on the proposed Rule from any interested person; and

5. The manner in which interested persons may submit written comments.

I. All hearings will be recorded. A copy of the recording and all written comments and documents received by the Commission in response to the proposed Rule shall be available to the public.

J. Nothing in this Section shall be construed as requiring a separate hearing on each Rule. Rules may be grouped for the convenience of the Commission at hearings required by this Section.

K. The Commission shall, by majority vote of all members, take final action on the proposed Rule based on the Rulemaking record and the full text of the Rule.

1. The Commission may adopt changes to the proposed Rule provided the changes do not enlarge the original purpose of the proposed Rule.

2. The Commission shall provide an explanation of the reasons for substantive changes made to the proposed Rule as well as reasons for substantive changes not made that were recommended by commenters.

3. The Commission shall determine a reasonable effective date for the Rule. Except for an emergency as provided in Section 12 L, the effective date of the Rule shall be no sooner than 30 days after issuing the notice that it adopted or amended the Rule.

L. Upon determination that an emergency exists, the Commission may consider and adopt an emergency Rule with 48 hours' notice, with opportunity to comment, provided that the usual Rulemaking procedures provided in the Compact and in this Section shall be retroactively applied to the Rule as soon as reasonably possible, in no event later than ninety (90) days after the effective date of the Rule. For the purposes of this provision, an emergency Rule is one that must be adopted immediately in order to:

1. Meet an imminent threat to public health, safety, or welfare;

2. Prevent a loss of Commission or Member State funds;

3. Meet a deadline for the promulgation of a Rule that is established by federal law or rule; or

4. Protect public health and safety.

M. The Commission or an authorized committee of the Commission may direct revisions to a previously adopted Rule for purposes of correcting typographical errors, errors in format, errors in

consistency, or grammatical errors. Public notice of any revisions shall be posted on the website of the Commission. The revision shall be subject to challenge by any person for a period of thirty (30) days after posting. The revision may be challenged only on grounds that the revision results in a material change to a Rule. A challenge shall be made in writing and delivered to the Commission prior to the end of the notice period. If no challenge is made, the revision will take effect without further action. If the revision is challenged, the revision may not take effect without the approval of the Commission.

N. No Member State's rulemaking requirements shall apply under this compact.

Section 13.

Oversight, Dispute Resolution, and Enforcement.

A. Oversight:

1. The executive and judicial branches of State government in each Member State shall enforce this Compact and take all actions necessary and appropriate to implement the Compact.

2. Except as otherwise provided in this Compact, venue is proper and judicial proceedings by or against the Commission shall be brought solely and exclusively in a court of competent jurisdiction where the principal office of the Commission is located. The Commission may waive venue and jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute resolution proceedings. Nothing herein shall affect or limit the selection or propriety of venue in any action against a Licensee for professional malpractice, misconduct, or any such similar matter.

3. The Commission shall be entitled to receive service of process in any proceeding regarding the enforcement or interpretation of the Compact and shall have standing to intervene in such a proceeding for all purposes. Failure to provide the Commission service of process shall render a judgment or order void as to the Commission, this Compact, or promulgated Rules.

B. Default, Technical Assistance, and Termination:

1. If the Commission determines that a Member State has defaulted in the performance of its obligations or responsibilities under this Compact or the promulgated Rules, the Commission shall provide written notice to the defaulting State. The notice of default shall describe the default, the proposed means of curing the default, and any other action that the Commission may take, and shall offer training and specific technical assistance regarding the default.

2. The Commission shall provide a copy of the notice of default to the other Member States.

C. If a State in default fails to cure the default, the defaulting State may be terminated from the Compact upon an affirmative vote of a majority of the delegates of the Member States, and all rights, privileges, and benefits conferred on that State by this Compact may be terminated on the effective date of termination. A cure of the default does not relieve the offending State of obligations or liabilities incurred during the period of default.

D. Termination of membership in the Compact shall be imposed only after all other means of securing compliance have been exhausted. Notice of intent to suspend or terminate shall be given by the Commission to the governor, the majority and minority leaders of the defaulting State's legislature, the defaulting State's State Licensing Authority and each of the Member States' State Licensing Authority.

E. A State that has been terminated is responsible for all assessments, obligations, and liabilities incurred through the effective date of termination, including obligations that extend beyond the effective date of termination.

F. Upon the termination of a State's membership from this Compact, that State shall immediately provide notice to all Licensees within that State of such termination. The terminated State shall continue to recognize all licenses granted pursuant to this Compact for a minimum of six (6) months after the date of said notice of termination.

G. The Commission shall not bear any costs related to a State that is found to be in default or that has been terminated from the Compact, unless agreed upon in writing between the Commission and the defaulting State.

H. The defaulting State may appeal the action of the Commission by petitioning the U.S. District Court for the District of Columbia or the federal district where the Commission has its principal offices. The prevailing party shall be awarded all costs of such litigation, including reasonable attorney fees.

I. Dispute Resolution:

1. Upon request by a Member State, the Commission shall attempt to resolve disputes related to the Compact that arise among Member States and between Member and non-Member States.

2. The Commission shall promulgate a Rule providing for both mediation and binding dispute resolution for disputes as appropriate.

J. Enforcement:

1. By majority vote as provided by Rule, the Commission may initiate legal action against a Member State in default in the United States District Court for the District of Columbia or the federal district where the Commission has its principal offices to enforce compliance with the provisions of the Compact and its promulgated Rules. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing party shall be awarded all costs of such litigation, including reasonable attorney fees. The remedies herein shall not be the exclusive remedies of the Commission. The Commission may pursue any other remedies available under federal or the

defaulting Member State's law.

2. A Member State may initiate legal action against the Commission in the U.S. District Court for the District of Columbia or the federal district where the Commission has its principal offices to enforce compliance with the provisions of the Compact and its promulgated Rules. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing party shall be awarded all costs of such litigation, including reasonable attorney fees.

3. No person other than a Member State shall enforce this compact against the Commission.

Section 14.

Effective Date, Withdrawal, and Amendment.

A. The Compact shall come into effect on the date on which the Compact statute is enacted into law in the seventh Member State.

1. On or after the effective date of the Compact, the Commission shall convene and review the enactment of each of the first seven Member States ("Charter Member States") to determine if the statute enacted by each such Charter Member State is materially different than the model Compact statute.

a. A Charter Member State whose enactment is found to be materially different from the model Compact statute shall be entitled to the default process set forth in Section 13.

b. If any Member State is later found to be in default, or is terminated or withdraws from the Compact, the Commission shall remain in existence and the Compact shall remain in effect even if the number of Member States should be less than seven.

2. Member States enacting the Compact subsequent to the seven initial Charter Member States shall be subject to the process set forth in Section 10 C 21 to determine if their enactments are materially different from the model Compact statute and whether they qualify for participation in the Compact.

3. All actions taken for the benefit of the Commission or in furtherance of the purposes of the administration of the Compact prior to the effective date of the Compact or the Commission coming into existence shall be considered to be actions of the Commission unless specifically repudiated by the Commission.

4. Any State that joins the Compact subsequent to the Commission's initial adoption of the Rules and bylaws shall be subject to the Rules and bylaws as they exist on the date on which the Compact becomes law in that State. Any Rule that has been previously adopted by the Commission shall have the full force and effect of law on the day the Compact becomes law in that State.

B. Any Member State may withdraw from this Compact by enacting a statute repealing the same.

1. A Member State's withdrawal shall not take effect until 180 days after enactment of the repealing statute.

2. Withdrawal shall not affect the continuing requirement of the withdrawing State's Licensing Authority to comply with the investigative and Adverse Action reporting requirements of this Compact prior to the effective date of withdrawal.

3. Upon the enactment of a statute withdrawing from this compact, a State shall immediately provide notice of such withdrawal to all Licensees within that State. Notwithstanding any subsequent statutory enactment to the contrary, such withdrawing State shall continue to recognize all licenses granted pursuant to this compact for a minimum of 180 days after the date of such notice of withdrawal.

C. Nothing contained in this Compact shall be construed to invalidate or prevent any licensure agreement or other cooperative arrangement between a Member State and a non-Member State that does not conflict with the provisions of this Compact.

D. This Compact may be amended by the Member States. No amendment to this Compact shall become effective and binding upon any Member State until it is enacted into the laws of all Member States.

Section 15.

Construction and Severability.

A. This Compact and the Commission's rulemaking authority shall be liberally construed so as to effectuate the purposes, and the implementation and administration of the Compact. Provisions of the Compact expressly authorizing or requiring the promulgation of Rules shall not be construed to limit the Commission's rulemaking authority solely for those purposes.

B. The provisions of this Compact shall be severable and if any phrase, clause, sentence, or provision of this Compact is held by a court of competent jurisdiction to be contrary to the constitution of any Member State, a State seeking participation in the Compact, or of the United States, or the applicability thereof to any government, agency, person, or circumstance is held to be unconstitutional by a court of competent jurisdiction, the validity of the remainder of this Compact and the applicability thereof to any other government, agency, person, or circumstance shall not be affected thereby.

C. Notwithstanding subsection B of this Section, the Commission may deny a State's participation in the Compact or, in accordance with the requirements of Section 13.B, terminate a Member State's participation in the Compact, if it determines that a constitutional requirement of a Member State is a material departure from the Compact. Otherwise, if this Compact shall be held to be contrary to the constitution of any Member State, the Compact shall remain in full force and effect as to the remaining

Member States and in full force and effect as to the Member State affected as to all severable matters.

Section 16.

Consistent Effect and Conflict with Other State Laws.

A. A Licensee providing services in a Remote State under a Multistate Authorization to Practice shall adhere to the laws and regulations, including laws, regulations, and applicable standards, of the Remote State where the client is located at the time care is rendered.

B. Nothing herein shall prevent or inhibit the enforcement of any other law of a Member State that is not inconsistent with the Compact.

C. Any laws, statutes, regulations, or other legal requirements in a Member State in conflict with the Compact are superseded to the extent of the conflict.

D. All permissible agreements between the Commission and the Member States are binding in accordance with their terms.

2. That applicants for a Multistate License shall pay for the cost of fingerprinting required by the Social Work Licensure Compact, as entered into by this act.

Inaugural Meeting

September 17th, 2024

Facilitated by the Council of State Governments

Social Work Licensure Compact Commission
Inaugural Meeting Agenda
September 17th, 2024: 10am ET – 5pm ET
Zoom: https://csg-org.zoom.us/meeting/register/tZYvdeqtrzkrHt1_qNWwyfVCqaRb0BVxxdAn

I. Welcome and Introductions of Interim Staff

II. Call to Order:
    Roll Call
    Commission Delegate Introductions
    Overview of Agenda
    Adoption of Agenda

III. Legislative Update/Legal Opinion on Legislative Deviations

IV. Review Commission Governance Structure

V. Discussion of Compact Commission By-Laws

VI. Discussion of Rule on Rulemaking

VII. Discussion of Leadership Nominations

Lunch 12:00p

VIII. Discussion of Data System

IX. Discussion of Commission Finances and Staff Hiring

X. Discussion of Future Rules for Consideration

XI. Ex Officio Organization Selection

XII. Questions from Delegates/Public Comment from Non-Delegate Attendees

XIII. Review Transition Plan and Next Steps

Adjourn 5:00pm

Social Work Compact Legislative Update

2023 SW Compact Legislative Enactments

State	*Bill Number*	*Date Enacted*
1. Missouri	SB 70	July 6th, 2023

2024 DDH Compact Legislative Enactments

2. South Dakota	HB 1015	February 5th, 2024
3. Utah	HB 44	March 14th, 2024
4. Washington	HB 1939	March 19th, 2024
5. Kentucky	HB 56	April 5th, 2024
6. Kansas	HB 2484	April 12th, 2024
7. Virginia	HB 326	April 8th, 2024
8. Nebraska	LB 932	April 15th, 2024
9. Vermont	H 543	April 23rd, 2024
10. Maine	LD 2140	April 26th, 2024
11. Georgia	SB 195	May 2nd, 2024
12. Iowa	HF 2512	May 3rd, 2024
13. Alabama	SB 208	May 5th, 2024
14. Ohio	SB 90	Mayb 10th, 2024
15. Connecticut	HB 5197	May 21st, 2024
16. Minnesota	HF 5247	May 24th, 2024
17. Tennessee	SB 2134	May 28th, 2024
18. Colorado	HB 24-1002	June 3rd, 2024
19. Arizona	SB 1036	June 21st, 2024
20. Louisiana	HB 888	June 25th, 2024
21. Rhode Island	HB 7350	June 25th , 2024
22. New Hampshire	HB 1190	July 7th, 2024

Compact Legislation Pending

State	***Bill Number***	***Status***
New Jersey	S2688/A2813	Passed Assembly. Waiting on Senate Commerce Committee vote.
Pennsylvania	HB 1841	Introduced and assigned to House Professional Licensure committee.

Social Work Licensure Compact Section 10-C-21

C. The Commission shall have the following powers:

21. Determine whether a State's adopted language is materially different from the Model Compact language such that the State would not qualify for participation in the Compact;

Social Work Licensure Compact Section 14-A-1

1. *On or after the effective date of the Compact, the Commission shall convene and review the enactment of each of the first seven Member States ("Charter Member States") to determine if the statute enacted by each such Charter Member State is materially different than the model Compact statute.*
    a. *A Charter Member State whose enactment is found to be materially different from the model Compact statute shall be entitled to the default process set forth in Section 13.*
    b. *If any Member State is later found to be in default, or is terminated or withdraws from the Compact, the Commission shall remain in existence and the Compact shall remain in effect even if the number of Member States should be less than seven.*

SOCIAL WORK LICENSURE COMPACT

SECTION 1: PURPOSE

The purpose of this Compact is to facilitate interstate practice of Regulated Social Workers by improving public access to competent Social Work Services. The Compact preserves the regulatory authority of States to protect public health and safety through the current system of State licensure.

This Compact is designed to achieve the following objectives:

A. Increase public access to Social Work Services;

B. Reduce overly burdensome and duplicative requirements associated with holding multiple licenses;

C. Enhance the Member States' ability to protect the public's health and safety;

D. Encourage the cooperation of Member States in regulating multistate practice;

E. Promote mobility and address workforce shortages by eliminating the necessity for licenses in multiple States by providing for the mutual recognition of other Member State licenses;

F. Support military families;

G. Facilitate the exchange of licensure and disciplinary information among Member States;

H. Authorize all Member States to hold a Regulated Social Worker accountable for abiding by a Member State's laws, regulations, and applicable professional standards in the Member State in which the client is located at the time care is rendered; and

I. Allow for the use of telehealth to facilitate increased access to regulated Social Work Services.

SECTION 2. DEFINITIONS

As used in this Compact, and except as otherwise provided, the following definitions shall apply:

A. **"Active Military Member"** means any individual with full-time duty status in the active armed forces of the United States including members of the National Guard and Reserve.

B. **"Adverse Action"** means any administrative, civil, equitable or criminal action permitted by a State's laws which is imposed by a Licensing Authority or other authority against a Regulated Social Worker, including actions against an individual's license or Multistate Authorization to Practice such as revocation,

suspension, probation, monitoring of the Licensee, limitation on the Licensee's practice, or any other Encumbrance on licensure affecting a Regulated Social Worker's authorization to practice, including issuance of a cease and desist action.

C. **"Alternative Program"** means a non-disciplinary monitoring or practice remediation process approved by a Licensing Authority to address practitioners with an Impairment.

D. **"Charter Member States"** - Member States who have enacted legislation to adopt this Compact where such legislation predates the effective date of this Compact as described in Section 14.

E. **"Compact Commission" or "Commission"** means the government agency whose membership consists of all States that have enacted this Compact, which is known as the Social Work Licensure Compact Commission, as described in Section 10, and which shall operate as an instrumentality of the Member States.

F. **"Current Significant Investigative Information"** means:

1. Investigative information that a Licensing Authority, after a preliminary inquiry that includes notification and an opportunity for the Regulated Social Worker to respond has reason to believe is not groundless and, if proved true, would indicate more than a minor infraction as may be defined by the Commission; or

2. Investigative information that indicates that the Regulated Social Worker represents an immediate threat to public health and safety, as may be defined by the Commission, regardless of whether the Regulated Social Worker has been notified and has had an opportunity to respond.

G. **"Data System"** means a repository of information about Licensees, including, continuing education, examination, licensure, Current Significant Investigative Information, Disqualifying Event, Multistate License(s) and Adverse Action information or other information as required by the Commission.

H. **"Disqualifying Event"** means any Adverse Action or incident which results in an Encumbrance that disqualifies or makes the Licensee ineligible to either obtain, retain or renew a Multistate License.

I. **"Domicile"** means the jurisdiction in which the Licensee resides and intends to remain indefinitely.

J. **"Encumbrance"** means a revocation or suspension of, or any limitation on, the full and unrestricted practice of Social Work licensed and regulated by a Licensing Authority.

K. **"Executive Committee"** means a group of delegates elected or appointed to act on behalf of, and within the powers granted to them by, the compact and Commission.

L. **"Home State"** means the Member State that is the Licensee's primary Domicile.

M. **"Impairment"** means a condition(s) that may impair a practitioner's ability to engage in full and unrestricted practice as a Regulated Social Worker without some type of intervention and may include alcohol and drug dependence, mental health impairment, and neurological or physical impairments.

N. **"Licensee(s)"** means an individual who currently holds a license from a State to practice as a Regulated Social Worker.

O. **"Licensing Authority"** means the board or agency of a Member State, or equivalent, that is responsible for the licensing and regulation of Regulated Social Workers.

P. **"Member State"** means a state, commonwealth, district, or territory of the United States of America that has enacted this Compact.

Q. **"Multistate Authorization to Practice"** means a legally authorized privilege to practice, which is equivalent to a license, associated with a Multistate License permitting the practice of Social Work in a Remote State.

R. **"Multistate License"** means a license to practice as a Regulated Social Worker issued by a Home State Licensing Authority that authorizes the Regulated Social Worker to practice in all Member States under Multistate Authorization to Practice.

S. **"Qualifying National Exam"** means a national licensing examination approved by the Commission.

T. **"Regulated Social Worker"** means any clinical, master's or bachelor's Social Worker licensed by a Member State regardless of the title used by that Member State.

U. **"Remote State"** means a Member State other than the Licensee's Home State.

V. **"Rule(s)" or "Rule(s) of the Commission"** means a regulation or regulations duly promulgated by the Commission, as authorized by the Compact, that has the force of law.

W. **"Single State License"** means a Social Work license issued by any State that authorizes practice only within the issuing State and does not include Multistate Authorization to Practice in any Member State.

X. **"Social Work" or "Social Work Services"** means the application of social work theory, knowledge, methods, ethics, and the professional use of self to restore or enhance social, psychosocial, or biopsychosocial functioning of individuals,

couples, families, groups, organizations, and communities through the care and services provided by a Regulated Social Worker as set forth in the Member State's statutes and regulations in the State where the services are being provided.

Y. **"State"** means any state, commonwealth, district, or territory of the United States of America that regulates the practice of Social Work.

Z. "**Unencumbered License"** means a license that authorizes a Regulated Social Worker to engage in the full and unrestricted practice of Social Work.

SECTION 3. STATE PARTICIPATION IN THE COMPACT

A. To be eligible to participate in the compact, a potential Member State must currently meet all of the following criteria:

1. License and regulate the practice of Social Work at either the clinical, master's, or bachelor's category.

2. Require applicants for licensure to graduate from a program that is:

   a. Operated by a college or university recognized by the Licensing Authority;

   b. Accredited, or in candidacy by an institution that subsequently becomes accredited, by an accrediting agency recognized by either:

      i. the Council for Higher Education Accreditation, or its successor; or

      ii. the United States Department of Education; and

   c. Corresponds to the licensure sought as outlined in Section 4.

3. Require applicants for clinical licensure to complete a period of supervised practice.

4. Have a mechanism in place for receiving, investigating, and adjudicating complaints about Licensees.

B. To maintain membership in the Compact a Member State shall:

1. Require that applicants for a Multistate License pass a Qualifying National Exam for the corresponding category of Multistate License sought as outlined in Section 4.

2. Participate fully in the Commission's Data System, including using the Commission's unique identifier as defined in Rules;

3. Notify the Commission, in compliance with the terms of the Compact and Rules, of any Adverse Action or the availability of Current Significant Investigative Information regarding a Licensee;

4. Implement procedures for considering the criminal history records of applicants for a Multistate License. Such procedures shall include the submission of fingerprints or other biometric-based information by applicants for the purpose of obtaining an applicant's criminal history record information from the Federal Bureau of Investigation and the agency responsible for retaining that State's criminal records.

5. Comply with the Rules of the Commission;

6. Require an applicant to obtain or retain a license in the Home State and meet the Home State's qualifications for licensure or renewal of licensure, as well as all other applicable Home State laws;

7. Authorize a Licensee holding a Multistate License in any Member State to practice in accordance with the terms of the Compact and Rules of the Commission; and

8. Designate a delegate to participate in the Commission meetings.

C. A Member State meeting the requirements of Section 3.A. and 3.B of this Compact shall designate the categories of Social Work licensure that are eligible for issuance of a Multistate License for applicants in such Member State. To the extent that any Member State does not meet the requirements for participation in the Compact at any particular category of Social Work licensure, such Member State may choose, but is not obligated to, issue a Multistate License to applicants that otherwise meet the requirements of Section 4 for issuance of a Multistate License in such category or categories of licensure.

D. The Home State may charge a fee for granting the Multistate License.

SECTION 4. SOCIAL WORKER PARTICIPATION IN THE COMPACT

A. To be eligible for a Multistate License under the terms and provisions of the Compact, an applicant, regardless of category must:

1. Hold or be eligible for an active, Unencumbered License in the Home State;

2. Pay any applicable fees, including any State fee, for the Multistate License;

3. Submit, in connection with an application for a Multistate License, fingerprints or other biometric data for the purpose of obtaining criminal history record information from the Federal Bureau of Investigation and the agency responsible for retaining that State's criminal records.

4. Notify the Home State of any Adverse Action, Encumbrance, or restriction on any professional license taken by any Member State or non-Member State within 30 days from the date the action is taken.

5. Meet any continuing competence requirements established by the Home State;

6. Abide by the laws, regulations, and applicable standards in the Member State where the client is located at the time care is rendered.

B. An applicant for a clinical-category Multistate License must meet all of the following requirements:

1. Fulfill a competency requirement, which shall be satisfied by either:

d. Passage of a clinical-category Qualifying National Exam; or

e. Licensure of the applicant in their Home State at the clinical category, beginning prior to such time as a Qualifying National Exam was required by the Home State and accompanied by a period of continuous Social Work licensure thereafter, all of which may be further governed by the Rules of the Commission; or

f. The substantial equivalency of the foregoing competency requirements which the Commission may determine by Rule.

2. Attain at least a master's degree in Social Work from a program that is:

a. Operated by a college or university recognized by the Licensing Authority; and

b. Accredited, or in candidacy that subsequently becomes accredited, by an accrediting agency recognized by either:

i. the Council for Higher Education Accreditation or its successor; or

ii. the United States Department of Education.

3. Fulfill a practice requirement, which shall be satisfied by demonstrating completion of either:

a. A period of postgraduate supervised clinical practice equal to a minimum of three thousand hours; or

b. A minimum of two years of full-time postgraduate supervised clinical practice; or

c. The substantial equivalency of the foregoing practice requirements which the Commission may determine by Rule.

C. An applicant for a master's-category Multistate License must meet all of the following requirements:

1. Fulfill a competency requirement, which shall be satisfied by either:

a. Passage of a masters-category Qualifying National Exam;

b. Licensure of the applicant in their Home State at the master's category, beginning prior to such time as a Qualifying National Exam was required by the Home State at the master's category and accompanied by a continuous period of Social Work licensure thereafter, all of which may be further governed by the Rules of the Commission; or

c. The substantial equivalency of the foregoing competency requirements which the Commission may determine by Rule.

2. Attain at least a master's degree in Social Work from a program that is:

a. Operated by a college or university recognized by the Licensing Authority; and

b. Accredited, or in candidacy that subsequently becomes accredited, by an accrediting agency recognized by either:

i. the Council for Higher Education Accreditation or its successor; or

ii. the United States Department of Education.

D. An applicant for a bachelor's-category Multistate License must meet all of the following requirements:

1. Fulfill a competency requirement, which shall be satisfied by either:

a. Passage of a bachelor's-category Qualifying National Exam;

b. Licensure of the applicant in their Home State at the bachelor's category, beginning prior to such time as a Qualifying National Exam was required by the Home State and accompanied by a period of continuous Social Work licensure thereafter, all of which may be further governed by the Rules of the Commission; or

c. The substantial equivalency of the foregoing competency requirements which the Commission may determine by Rule.

2. Attain at least a bachelor's degree in Social Work from a program that is:

a. Operated by a college or university recognized by the Licensing Authority; and

b. Accredited, or in candidacy that subsequently becomes accredited, by an accrediting agency recognized by either:

i. the Council for Higher Education Accreditation or its successor; or

ii. the United States Department of Education.

E. The Multistate License for a Regulated Social Worker is subject to the renewal requirements of the Home State. The Regulated Social Worker must maintain compliance with the requirements of Section 4(A) to be eligible to renew a Multistate License.

F. The Regulated Social Worker's services in a Remote State are subject to that Member State's regulatory authority. A Remote State may, in accordance with due process and that Member State's laws, remove a Regulated Social Worker's Multistate Authorization to Practice in the Remote State for a specific period of time, impose fines, and take any other necessary actions to protect the health and safety of its citizens.

G. If a Multistate License is encumbered, the Regulated Social Worker's Multistate Authorization to Practice shall be deactivated in all Remote States until the Multistate License is no longer encumbered.

H. If a Multistate Authorization to Practice is encumbered in a Remote State, the regulated Social Worker's Multistate Authorization to Practice may be deactivated in that State until the Multistate Authorization to Practice is no longer encumbered.

SECTION 5: ISSUANCE OF A MULTISTATE LICENSE

A. Upon receipt of an application for Multistate License, the Home State Licensing Authority shall determine the applicant's eligibility for a Multistate License in accordance with Section 4 of this Compact.

B. If such applicant is eligible pursuant to Section 4 of this Compact, the Home State Licensing Authority shall issue a Multistate License that authorizes the applicant or Regulated Social Worker to practice in all Member States under a Multistate Authorization to Practice.

C. Upon issuance of a Multistate License, the Home State Licensing Authority shall designate whether the Regulated Social Worker holds a Multistate License in the Bachelors, Masters, or Clinical category of Social Work.

D. A Multistate License issued by a Home State to a resident in that State shall be recognized by all Compact Member States as authorizing Social Work Practice under a Multistate Authorization to Practice corresponding to each category of licensure regulated in each Member State.

SECTION 6: AUTHORITY OF INTERSTATE COMPACT COMMISSION AND MEMBER STATE LICENSING AUTHORITIES

A. Nothing in this Compact, nor any Rule of the Commission, shall be construed to limit, restrict, or in any way reduce the ability of a Member State to enact and enforce laws, regulations, or other rules related to the practice of Social Work in that State, where those laws, regulations, or other rules are not inconsistent with the provisions of this Compact.

B. Nothing in this Compact shall affect the requirements established by a Member State for the issuance of a Single State License.

C. Nothing in this Compact, nor any Rule of the Commission, shall be construed to limit, restrict, or in any way reduce the ability of a Member State to take Adverse Action against a Licensee's Single State License to practice Social Work in that State.

D. Nothing in this Compact, nor any Rule of the Commission, shall be construed to limit, restrict, or in any way reduce the ability of a Remote State to take Adverse Action against a Licensee's Multistate Authorization to Practice in that State.

E. Nothing in this Compact, nor any Rule of the Commission, shall be construed to limit, restrict, or in any way reduce the ability of a Licensee's Home State to take Adverse Action against a Licensee's Multistate License based upon information provided by a Remote State.

SECTION 7: REISSUANCE OF A MULTISTATE LICENSE BY A NEW HOME STATE

A. A Licensee can hold a Multistate License, issued by their Home State, in only one Member State at any given time.

B. If a Licensee changes their Home State by moving between two Member States:

1. The Licensee shall immediately apply for the reissuance of their Multistate License in their new Home State. The Licensee shall pay all applicable fees and notify the prior Home State in accordance with the Rules of the Commission.

2. Upon receipt of an application to reissue a Multistate License, the new Home State shall verify that the Multistate License is active, unencumbered and eligible for reissuance under the terms of the Compact and the Rules of the Commission. The Multistate License issued by the prior Home State will be deactivated and all Member States notified in accordance with the applicable Rules adopted by the Commission.

3. Prior to the reissuance of the Multistate License, the new Home State shall conduct procedures for considering the criminal history records of the Licensee. Such procedures shall include the submission of fingerprints or other biometric-based information by applicants for the purpose of obtaining an applicant's criminal history record information from the Federal Bureau of Investigation and the agency responsible for retaining that State's criminal records.

4. If required for initial licensure, the new Home State may require completion of jurisprudence requirements in the new Home State.

5. Notwithstanding any other provision of this Compact, if a Licensee does not meet the requirements set forth in this Compact for the reissuance of a Multistate License by the new Home State, then the Licensee shall be

subject to the new Home State requirements for the issuance of a Single State License in that State.

C. If a Licensee changes their primary State of residence by moving from a Member State to a non-Member State, or from a non-Member State to a Member State, then the Licensee shall be subject to the State requirements for the issuance of a Single State License in the new Home State.

D. Nothing in this Compact shall interfere with a Licensee's ability to hold a Single State License in multiple States; however, for the purposes of this Compact, a Licensee shall have only one Home State, and only one Multistate License.

E. Nothing in this Compact shall interfere with the requirements established by a Member State for the issuance of a Single State License.

SECTION 8. MILITARY FAMILIES

An Active Military Member or their spouse shall designate a Home State where the individual has a Multistate License. The individual may retain their Home State designation during the period the service member is on active duty.

SECTION 9. ADVERSE ACTIONS

A. In addition to the other powers conferred by State law, a Remote State shall have the authority, in accordance with existing State due process law, to:

1. Take Adverse Action against a Regulated Social Worker's Multistate Authorization to Practice only within that Member State, and issue subpoenas for both hearings and investigations that require the attendance and testimony of witnesses as well as the production of evidence. Subpoenas issued by a Licensing Authority in a Member State for the attendance and testimony of witnesses or the production of evidence from another Member State shall be enforced in the latter State by any court of competent jurisdiction, according to the practice and procedure of that court applicable to subpoenas issued in proceedings pending before it. The issuing Licensing Authority shall pay any witness fees, travel expenses, mileage, and other fees required by the service statutes of the State in which the witnesses or evidence are located.

2. Only the Home State shall have the power to take Adverse Action against a Regulated Social Worker's Multistate License.

B. For purposes of taking Adverse Action, the Home State shall give the same priority and effect to reported conduct received from a Member State as it would if the conduct had occurred within the Home State. In so doing, the Home State shall apply its own State laws to determine appropriate action.

C. The Home State shall complete any pending investigations of a Regulated Social Worker who changes their Home State during the course of the investigations. The Home State shall also have the authority to take appropriate action(s) and shall promptly report the conclusions of the investigations to the administrator of

the Data System. The administrator of the Data System shall promptly notify the new Home State of any Adverse Actions.

D. A Member State, if otherwise permitted by State law, may recover from the affected Regulated Social Worker the costs of investigations and dispositions of cases resulting from any Adverse Action taken against that Regulated Social Worker.

E. A Member State may take Adverse Action based on the factual findings of another Member State, provided that the Member State follows its own procedures for taking the Adverse Action.

F. Joint Investigations:

1. In addition to the authority granted to a Member State by its respective Social Work practice act or other applicable State law, any Member State may participate with other Member States in joint investigations of Licensees.

2. Member States shall share any investigative, litigation, or compliance materials in furtherance of any joint or individual investigation initiated under the Compact.

G. If Adverse Action is taken by the Home State against the Multistate License of a Regulated Social Worker, the Regulated Social Worker's Multistate Authorization to Practice in all other Member States shall be deactivated until all Encumbrances have been removed from the Multistate License. All Home State disciplinary orders that impose Adverse Action against the license of a Regulated Social Worker shall include a statement that the Regulated Social Worker's Multistate Authorization to Practice is deactivated in all Member States until all conditions of the decision, order or agreement are satisfied.

H. If a Member State takes Adverse Action, it shall promptly notify the administrator of the Data System. The administrator of the Data System shall promptly notify the Home State and all other Member State's of any Adverse Actions by Remote States.

I. Nothing in this Compact shall override a Member State's decision that participation in an Alternative Program may be used in lieu of Adverse Action.

J. Nothing in this Compact shall authorize a Member State to demand the issuance of subpoenas for attendance and testimony of witnesses or the production of evidence from another Member State for lawful actions within that Member State.

K. Nothing in this Compact shall authorize a Member State to impose discipline against a Regulated Social Worker who holds a Multistate Authorization to Practice for lawful actions within another Member State.

SECTION 10. ESTABLISHMENT OF SOCIAL WORK LICENSURE COMPACT COMMISSION

A. The Compact Member States hereby create and establish a joint government agency whose membership consists of all Member States that have enacted the compact known as the Social Work Licensure Compact Commission. The Commission is an instrumentality of the Compact States acting jointly and not an instrumentality of any one State. The Commission shall come into existence on or after the effective date of the Compact as set forth in Section 14.

B. Membership, Voting, and Meetings

1. Each Member State shall have and be limited to one (1) delegate selected by that Member State's State Licensing Authority.

2. The delegate shall be either:

   a. A current member of the State Licensing Authority at the time of appointment, who is a Regulated Social Worker or public member of the State Licensing Authority; or

   b. An administrator of the State Licensing Authority or their designee.

3. The Commission shall by Rule or bylaw establish a term of office for delegates and may by Rule or bylaw establish term limits.

4. The Commission may recommend removal or suspension any delegate from office.

5. A Member State's State Licensing Authority shall fill any vacancy of its delegate occurring on the Commission within 60 days of the vacancy.

6. Each delegate shall be entitled to one vote on all matters before the Commission requiring a vote by Commission delegates.

7. A delegate shall vote in person or by such other means as provided in the bylaws. The bylaws may provide for delegates to meet by telecommunication, videoconference, or other means of communication.

8. The Commission shall meet at least once during each calendar year. Additional meetings may be held as set forth in the bylaws. The Commission may meet by telecommunication, video conference or other similar electronic means.

C. The Commission shall have the following powers:

1. Establish the fiscal year of the Commission;

2. Establish code of conduct and conflict of interest policies;

3. Establish and amend Rules and bylaws;

4. Maintain its financial records in accordance with the bylaws;

5. Meet and take such actions as are consistent with the provisions of this Compact, the Commission's Rules, and the bylaws;

6. Initiate and conclude legal proceedings or actions in the name of the Commission, provided that the standing of any State Licensing Board to sue or be sued under applicable law shall not be affected;

7. Maintain and certify records and information provided to a Member State as the authenticated business records of the Commission, and designate an agent to do so on the Commission's behalf;

8. Purchase and maintain insurance and bonds;

9. Borrow, accept, or contract for services of personnel, including, but not limited to, employees of a Member State;

10. Conduct an annual financial review

11. Hire employees, elect or appoint officers, fix compensation, define duties, grant such individuals appropriate authority to carry out the purposes of the Compact, and establish the Commission's personnel policies and programs relating to conflicts of interest, qualifications of personnel, and other related personnel matters;

12. Assess and collect fees;

13. Accept any and all appropriate gifts, donations, grants of money, other sources of revenue, equipment, supplies, materials, and services, and receive, utilize, and dispose of the same; provided that at all times the Commission shall avoid any appearance of impropriety or conflict of interest;

14. Lease, purchase, retain, own, hold, improve, or use any property, real, personal, or mixed, or any undivided interest therein;

15. Sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property real, personal, or mixed;

16. Establish a budget and make expenditures;

17. Borrow money;

18. Appoint committees, including standing committees, composed of members, State regulators, State legislators or their representatives, and consumer representatives, and such other interested persons as may be designated in this Compact and the bylaws;

19. Provide and receive information from, and cooperate with, law enforcement agencies;

20. Establish and elect an Executive Committee, including a chair and a vice chair;

21. Determine whether a State's adopted language is materially different from the model compact language such that the State would not qualify for participation in the Compact; and

22. Perform such other functions as may be necessary or appropriate to achieve the purposes of this Compact.

D. The Executive Committee

1. The Executive Committee shall have the power to act on behalf of the Commission according to the terms of this Compact. The powers, duties, and responsibilities of the Executive Committee shall include:

a. Oversee the day-to-day activities of the administration of the compact including enforcement and compliance with the provisions of the compact, its Rules and bylaws, and other such duties as deemed necessary;

b. Recommend to the Commission changes to the Rules or bylaws, changes to this Compact legislation, fees charged to Compact Member States, fees charged to Licensees, and other fees;

c. Ensure Compact administration services are appropriately provided, including by contract;

d. Prepare and recommend the budget;

e. Maintain financial records on behalf of the Commission;

f. Monitor Compact compliance of Member States and provide compliance reports to the Commission;

g. Establish additional committees as necessary;

h. Exercise the powers and duties of the Commission during the interim between Commission meetings, except for adopting or amending Rules, adopting or amending bylaws, and exercising any other powers and duties expressly reserved to the Commission by Rule or bylaw; and

i. Other duties as provided in the Rules or bylaws of the Commission.

2. The Executive Committee shall be composed of up to eleven (11) members:

a. The chair and vice chair of the Commission shall be voting members of the Executive Committee; and

b. The Commission shall elect five voting members from the current membership of the Commission.

c. Up to four (4) ex-officio, nonvoting members from four (4) recognized national Social Work organizations.

d. The ex-officio members will be selected by their respective organizations.

3. The Commission may remove any member of the Executive Committee as provided in the Commission's bylaws.

4. The Executive Committee shall meet at least annually.

a. Executive Committee meetings shall be open to the public, except that the Executive Committee may meet in a closed, non-public meeting as provided in subsection F.2 below.

b. The Executive Committee shall give seven (7) days' notice of its meetings, posted on its website and as determined to provide notice to persons with an interest in the business of the Commission.

c. The Executive Committee may hold a special meeting in accordance with subsection F.1.b. below.

E. The Commission shall adopt and provide to the Member States an annual report.

F. Meetings of the Commission

1. All meetings shall be open to the public, except that the Commission may meet in a closed, non-public meeting as provided in subsection F.2 below.

a. Public notice for all meetings of the full Commission of meetings shall be given in the same manner as required under the Rulemaking provisions in Section 12, except that the Commission may hold a special meeting as provided in subsection F.1.b below.

b. The Commission may hold a special meeting when it must meet to conduct emergency business by giving 48 hours' notice to all commissioners, on the Commission's website, and other means as provided in the Commission's Rules. The Commission's legal counsel shall certify that the Commission's need to meet qualifies as an emergency.

2. The Commission or the Executive Committee or other committees of the Commission may convene in a closed, non-public meeting for the Commission or Executive Committee or other committees of the Commission to receive legal advice or to discuss:

a. Non-compliance of a Member State with its obligations under the Compact;

b. The employment, compensation, discipline or other matters, practices or procedures related to specific employees;

c. Current or threatened discipline of a Licensee by the Commission or by a Member State's Licensing Authority;

d. Current, threatened, or reasonably anticipated litigation;

e. Negotiation of contracts for the purchase, lease, or sale of goods, services, or real estate;

f. Accusing any person of a crime or formally censuring any person;

g. Trade secrets or commercial or financial information that is privileged or confidential;

h. Information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;

i. Investigative records compiled for law enforcement purposes;

j. Information related to any investigative reports prepared by or on behalf of or for use of the Commission or other committee charged with responsibility of investigation or determination of compliance issues pursuant to the Compact;

k. Matters specifically exempted from disclosure by federal or Member State law; or

l. Other matters as promulgated by the Commission by Rule.

3. If a meeting, or portion of a meeting, is closed, the presiding officer shall state that the meeting will be closed and reference each relevant exempting provision, and such reference shall be recorded in the minutes.

4. The Commission shall keep minutes that fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, and the reasons therefore, including a description of the views expressed. All documents considered in connection with an action shall be identified in such minutes. All minutes and documents of a closed meeting shall remain under seal, subject to release only by a majority vote of the Commission or order of a court of competent jurisdiction.

G. Financing of the Commission

1. The Commission shall pay, or provide for the payment of, the reasonable expenses of its establishment, organization, and ongoing activities.

2. The Commission may accept any and all appropriate revenue sources as provided in subsection C(13).

3. The Commission may levy on and collect an annual assessment from each Member State and impose fees on Licensees of Member States to whom it grants a Multistate License to cover the cost of the operations and activities of the Commission and its staff, which must be in a total amount sufficient to cover its annual budget as approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount for Member States shall be allocated based upon a formula that the Commission shall promulgate by Rule.

4. The Commission shall not incur obligations of any kind prior to securing the funds adequate to meet the same; nor shall the Commission pledge the credit of any of the Member States, except by and with the authority of the Member State.

5. The Commission shall keep accurate accounts of all receipts and disbursements. The receipts and disbursements of the Commission shall be subject to the financial review and accounting procedures established under its bylaws. However, all receipts and disbursements of funds handled by the Commission shall be subject to an annual financial review by a certified or licensed public accountant, and the report of the financial review shall be included in and become part of the annual report of the Commission.

H. Qualified Immunity, Defense, and Indemnification

1. The members, officers, executive director, employees and representatives of the Commission shall be immune from suit and liability, both personally and in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error, or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided that nothing in this paragraph shall be construed to protect any such person from suit or liability for any damage, loss, injury, or liability caused by the intentional or willful or wanton misconduct of that person. The procurement of insurance of any type by the Commission shall not in any way compromise or limit the immunity granted hereunder.

2. The Commission shall defend any member, officer, executive director, employee, and representative of the Commission in any civil action

seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of Commission employment, duties, or responsibilities, or as determined by the Commission that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities; provided that nothing herein shall be construed to prohibit that person from retaining their own counsel at their own expense; and provided further, that the actual or alleged act, error, or omission did not result from that person's intentional or willful or wanton misconduct.

3. The Commission shall indemnify and hold harmless any member, officer, executive director, employee, and representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error, or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from the intentional or willful or wanton misconduct of that person.

4. Nothing herein shall be construed as a limitation on the liability of any Licensee for professional malpractice or misconduct, which shall be governed solely by any other applicable State laws.

5. Nothing in this Compact shall be interpreted to waive or otherwise abrogate a Member State's state action immunity or state action affirmative defense with respect to antitrust claims under the Sherman Act, Clayton Act, or any other State or federal antitrust or anticompetitive law or regulation.

6. Nothing in this Compact shall be construed to be a waiver of sovereign immunity by the Member States or by the Commission.

SECTION 11. DATA SYSTEM

A. The Commission shall provide for the development, maintenance, operation, and utilization of a coordinated Data System.

B. The Commission shall assign each applicant for a Multistate License a unique identifier, as determined by the Rules of the Commission.

C. Notwithstanding any other provision of State law to the contrary, a Member State shall submit a uniform data set to the Data System on all individuals to whom this Compact is applicable as required by the Rules of the Commission, including:

1. Identifying information;

2. Licensure data;

3. Adverse Actions against a license and information related thereto;

4. Non-confidential information related to Alternative Program participation, the beginning and ending dates of such participation, and other information related to such participation not made confidential under Member State law;

5. Any denial of application for licensure, and the reason(s) for such denial;

6. The presence of Current Significant Investigative Information; and

7. Other information that may facilitate the administration of this Compact or the protection of the public, as determined by the Rules of the Commission.

D. The records and information provided to a Member State pursuant to this Compact or through the Data System, when certified by the Commission or an agent thereof, shall constitute the authenticated business records of the Commission, and shall be entitled to any associated hearsay exception in any relevant judicial, quasi-judicial or administrative proceedings in a Member State.

E. Current Significant Investigative Information pertaining to a Licensee in any Member State will only be available to other Member States.

1. It is the responsibility of the Member States to report any Adverse Action against a Licensee and to monitor the database to determine whether Adverse Action has been taken against a Licensee. Adverse Action information pertaining to a Licensee in any Member State will be available to any other Member State.

F. Member States contributing information to the Data System may designate information that may not be shared with the public without the express permission of the contributing State.

G. Any information submitted to the Data System that is subsequently expunged pursuant to federal law or the laws of the Member State contributing the information shall be removed from the Data System.

SECTION 12. RULEMAKING

A. The Commission shall promulgate reasonable Rules in order to effectively and efficiently implement and administer the purposes and provisions of the Compact. A Rule shall be invalid and have no force or effect only if a court of competent jurisdiction holds that the Rule is invalid because the Commission exercised its rulemaking authority in a manner that is beyond the scope and purposes of the Compact, or the powers granted hereunder, or based upon another applicable standard of review.

B. The Rules of the Commission shall have the force of law in each Member State, provided however that where the Rules of the Commission conflict with the laws

of the Member State that establish the Member State's laws, regulations, and applicable standards that govern the practice of Social Work as held by a court of competent jurisdiction, the Rules of the Commission shall be ineffective in that State to the extent of the conflict.

C. The Commission shall exercise its Rulemaking powers pursuant to the criteria set forth in this Section and the Rules adopted thereunder. Rules shall become binding on the day following adoption or the date specified in the rule or amendment, whichever is later.

D. If a majority of the legislatures of the Member States rejects a Rule or portion of a Rule, by enactment of a statute or resolution in the same manner used to adopt the Compact within four (4) years of the date of adoption of the Rule, then such Rule shall have no further force and effect in any Member State.

E. Rules shall be adopted at a regular or special meeting of the Commission.

F. Prior to adoption of a proposed Rule, the Commission shall hold a public hearing and allow persons to provide oral and written comments, data, facts, opinions, and arguments.

G. Prior to adoption of a proposed Rule by the Commission, and at least thirty (30) days in advance of the meeting at which the Commission will hold a public hearing on the proposed Rule, the Commission shall provide a Notice of Proposed Rulemaking:

1. On the website of the Commission or other publicly accessible platform;

2. To persons who have requested notice of the Commission's notices of proposed rulemaking, and

3. In such other way(s) as the Commission may by Rule specify.

H. The Notice of Proposed Rulemaking shall include:

1. The time, date, and location of the public hearing at which the Commission will hear public comments on the proposed Rule and, if different, the time, date, and location of the meeting where the Commission will consider and vote on the proposed Rule;

2. If the hearing is held via telecommunication, video conference, or other electronic means, the Commission shall include the mechanism for access to the hearing in the Notice of Proposed Rulemaking;

3. The text of the proposed Rule and the reason therefor;

4. A request for comments on the proposed Rule from any interested person; and

5. The manner in which interested persons may submit written comments.

I. All hearings will be recorded. A copy of the recording and all written comments and documents received by the Commission in response to the proposed Rule shall be available to the public.

J. Nothing in this section shall be construed as requiring a separate hearing on each Rule. Rules may be grouped for the convenience of the Commission at hearings required by this section.

K. The Commission shall, by majority vote of all members, take final action on the proposed Rule based on the Rulemaking record and the full text of the Rule.

1. The Commission may adopt changes to the proposed Rule provided the changes do not enlarge the original purpose of the proposed Rule.

2. The Commission shall provide an explanation of the reasons for substantive changes made to the proposed Rule as well as reasons for substantive changes not made that were recommended by commenters.

3. The Commission shall determine a reasonable effective date for the Rule. Except for an emergency as provided in Section 12.L, the effective date of the rule shall be no sooner than 30 days after issuing the notice that it adopted or amended the Rule.

L. Upon determination that an emergency exists, the Commission may consider and adopt an emergency Rule with 48 hours' notice, with opportunity to comment, provided that the usual Rulemaking procedures provided in the Compact and in this section shall be retroactively applied to the Rule as soon as reasonably possible, in no event later than ninety (90) days after the effective date of the Rule. For the purposes of this provision, an emergency Rule is one that must be adopted immediately in order to:

1. Meet an imminent threat to public health, safety, or welfare;

2. Prevent a loss of Commission or Member State funds;

3. Meet a deadline for the promulgation of a Rule that is established by federal law or rule; or

4. Protect public health and safety.

M. The Commission or an authorized committee of the Commission may direct revisions to a previously adopted Rule for purposes of correcting typographical errors, errors in format, errors in consistency, or grammatical errors. Public notice of any revisions shall be posted on the website of the Commission. The revision shall be subject to challenge by any person for a period of thirty (30) days after posting. The revision may be challenged only on grounds that the revision results in a material change to a Rule. A challenge shall be made in writing and delivered to the Commission prior to the end of the notice period. If no challenge is made, the revision will take effect without further action. If the revision is

challenged, the revision may not take effect without the approval of the Commission.

N. No Member State's rulemaking requirements shall apply under this compact.

SECTION 13. OVERSIGHT, DISPUTE RESOLUTION, AND ENFORCEMENT

A. Oversight

1. The executive and judicial branches of State government in each Member State shall enforce this Compact and take all actions necessary and appropriate to implement the Compact.

2. Except as otherwise provided in this Compact, venue is proper and judicial proceedings by or against the Commission shall be brought solely and exclusively in a court of competent jurisdiction where the principal office of the Commission is located. The Commission may waive venue and jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute resolution proceedings. Nothing herein shall affect or limit the selection or propriety of venue in any action against a Licensee for professional malpractice, misconduct or any such similar matter.

3. The Commission shall be entitled to receive service of process in any proceeding regarding the enforcement or interpretation of the Compact and shall have standing to intervene in such a proceeding for all purposes. Failure to provide the Commission service of process shall render a judgment or order void as to the Commission, this Compact, or promulgated Rules.

B. Default, Technical Assistance, and Termination

1. If the Commission determines that a Member State has defaulted in the performance of its obligations or responsibilities under this Compact or the promulgated Rules, the Commission shall provide written notice to the defaulting State. The notice of default shall describe the default, the proposed means of curing the default, and any other action that the Commission may take, and shall offer training and specific technical assistance regarding the default.

2. The Commission shall provide a copy of the notice of default to the other Member States.

C. If a State in default fails to cure the default, the defaulting State may be terminated from the Compact upon an affirmative vote of a majority of the delegates of the Member States, and all rights, privileges and benefits conferred on that State by this Compact may be terminated on the effective date of termination. A cure of the default does not relieve the offending State of obligations or liabilities incurred during the period of default.

D. Termination of membership in the Compact shall be imposed only after all other means of securing compliance have been exhausted. Notice of intent to suspend or terminate shall be given by the Commission to the governor, the majority and minority leaders of the defaulting State's legislature, the defaulting State's State Licensing Authority and each of the Member States' State Licensing Authority.

E. A State that has been terminated is responsible for all assessments, obligations, and liabilities incurred through the effective date of termination, including obligations that extend beyond the effective date of termination.

F. Upon the termination of a State's membership from this Compact, that State shall immediately provide notice to all Licensees within that State of such termination. The terminated State shall continue to recognize all licenses granted pursuant to this Compact for a minimum of six (6) months after the date of said notice of termination.

G. The Commission shall not bear any costs related to a State that is found to be in default or that has been terminated from the Compact, unless agreed upon in writing between the Commission and the defaulting State.

H. The defaulting State may appeal the action of the Commission by petitioning the U.S. District Court for the District of Columbia or the federal district where the Commission has its principal offices. The prevailing party shall be awarded all costs of such litigation, including reasonable attorney's fees.

I. Dispute Resolution

1. Upon request by a Member State, the Commission shall attempt to resolve disputes related to the Compact that arise among Member States and between Member and non-Member States.

2. The Commission shall promulgate a Rule providing for both mediation and binding dispute resolution for disputes as appropriate.

J. Enforcement

1. By majority vote as provided by Rule, the Commission may initiate legal action against a Member State in default in the United States District Court for the District of Columbia or the federal district where the Commission has its principal offices to enforce compliance with the provisions of the Compact and its promulgated Rules. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing party shall be awarded all costs of such litigation, including reasonable attorney's fees. The remedies herein shall not be the exclusive remedies of the Commission. The Commission may pursue any other remedies available under federal or the defaulting Member State's law.

2. A Member State may initiate legal action against the Commission in the U.S. District Court for the District of Columbia or the federal district where the Commission has its principal offices to enforce compliance with the provisions of the Compact and its promulgated Rules. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing party shall be awarded all costs of such litigation, including reasonable attorney's fees.

3. No person other than a Member State shall enforce this compact against the Commission.

SECTION 14. EFFECTIVE DATE, WITHDRAWAL, AND AMENDMENT

A. The Compact shall come into effect on the date on which the Compact statute is enacted into law in the seventh Member State.

1. On or after the effective date of the Compact, the Commission shall convene and review the enactment of each of the first seven Member States ("Charter Member States") to determine if the statute enacted by each such Charter Member State is materially different than the model Compact statute.

a. A Charter Member State whose enactment is found to be materially different from the model Compact statute shall be entitled to the default process set forth in Section 13.

b. If any Member State is later found to be in default, or is terminated or withdraws from the Compact, the Commission shall remain in existence and the Compact shall remain in effect even if the number of Member States should be less than seven.

2. Member States enacting the Compact subsequent to the seven initial Charter Member States shall be subject to the process set forth in Section 10(C)(21) to determine if their enactments are materially different from the model Compact statute and whether they qualify for participation in the Compact.

3. All actions taken for the benefit of the Commission or in furtherance of the purposes of the administration of the Compact prior to the effective date of the Compact or the Commission coming into existence shall be considered to be actions of the Commission unless specifically repudiated by the Commission.

4. Any State that joins the Compact subsequent to the Commission's initial adoption of the Rules and bylaws shall be subject to the Rules and bylaws as they exist on the date on which the Compact becomes law in that State. Any Rule that has been previously adopted by the

Commission shall have the full force and effect of law on the day the Compact becomes law in that State.

B. Any Member State may withdraw from this Compact by enacting a statute repealing the same.

1. A Member State's withdrawal shall not take effect until 180 days after enactment of the repealing statute.

2. Withdrawal shall not affect the continuing requirement of the withdrawing State's Licensing Authority to comply with the investigative and Adverse Action reporting requirements of this Compact prior to the effective date of withdrawal.

3. Upon the enactment of a statute withdrawing from this compact, a State shall immediately provide notice of such withdrawal to all Licensees within that State. Notwithstanding any subsequent statutory enactment to the contrary, such withdrawing State shall continue to recognize all licenses granted pursuant to this compact for a minimum of 180 days after the date of such notice of withdrawal.

C. Nothing contained in this Compact shall be construed to invalidate or prevent any licensure agreement or other cooperative arrangement between a Member State and a non-Member State that does not conflict with the provisions of this Compact.

D. This Compact may be amended by the Member States. No amendment to this Compact shall become effective and binding upon any Member State until it is enacted into the laws of all Member States.

SECTION 15. CONSTRUCTION AND SEVERABILITY

A. This Compact and the Commission's rulemaking authority shall be liberally construed so as to effectuate the purposes, and the implementation and administration of the Compact. Provisions of the Compact expressly authorizing or requiring the promulgation of Rules shall not be construed to limit the Commission's rulemaking authority solely for those purposes.

B. The provisions of this Compact shall be severable and if any phrase, clause, sentence or provision of this Compact is held by a court of competent jurisdiction to be contrary to the constitution of any Member State, a State seeking participation in the Compact, or of the United States, or the applicability thereof to any government, agency, person or circumstance is held to be unconstitutional by a court of competent jurisdiction, the validity of the remainder of this Compact and the applicability thereof to any other government, agency, person or circumstance shall not be affected thereby.

C. Notwithstanding subsection B of this section, the Commission may deny a State's participation in the Compact or, in accordance with the requirements of

Section 13.B, terminate a Member State's participation in the Compact, if it determines that a constitutional requirement of a Member State is a material departure from the Compact. Otherwise, if this Compact shall be held to be contrary to the constitution of any Member State, the Compact shall remain in full force and effect as to the remaining Member States and in full force and effect as to the Member State affected as to all severable matters.

SECTION 16. CONSISTENT EFFECT AND CONFLICT WITH OTHER STATE LAWS

A. A Licensee providing services in a Remote State under a Multistate Authorization to Practice shall adhere to the laws and regulations, including laws, regulations, and applicable standards, of the Remote State where the client is located at the time care is rendered.

B. Nothing herein shall prevent or inhibit the enforcement of any other law of a Member State that is not inconsistent with the Compact.

C. Any laws, statutes, regulations, or other legal requirements in a Member State in conflict with the Compact are superseded to the extent of the conflict.

D. All permissible agreements between the Commission and the Member States are binding in accordance with their terms.

SOCIAL WORK LICENSURE COMPACT

BYLAWS

ARTICLE I

Commission Purpose, Function and Bylaws

Section 1. Purpose.

Pursuant to the terms of the Social Work Licensure Compact, (the "Compact"), the Social Work Licensure Compact Commission (the "Commission") is established to fulfill the objectives of the Compact, through a means of joint cooperative action among the Member States, namely, to facilitate the interstate practice of social work and improve public access to social work services by establishing a pathway for a Regulated Social Worker to obtain multistate licenses to authorize practice in other states participating in the Compact.

Section 2. Functions.

In pursuit of the fundamental objectives set forth in the Compact, the Commission shall, as necessary or required, exercise all of the powers and fulfill all of the duties delegated to it by the Member States. The Commission's activities shall include, but are not limited to, the following: the promulgation of binding rules and operating procedures; equitable distribution of the costs, benefits and obligations of the Compact among the Member States; enforcement of Commission Rules, Operating Procedures and Bylaws; provision of dispute resolution; Coordination of training and education; and the collection and dissemination of information concerning the activities of the Compact, as provided by the Compact, or as determined by the Commission to be warranted by, and consistent with, the objectives and provisions of the Compact.

Section 3. Bylaws.

As required by the Compact, these Bylaws shall govern the management and operations of the Commission. As adopted and subsequently amended, these Bylaws shall remain at all times subject to, and limited by, the terms of the Compact.

ARTICLE II

Membership

Section 1. Purpose.

The Commission Membership shall be comprised as provided by the Compact.

Section 2. Commissioners.

Each Member State shall have and be limited to one delegate. A delegate shall be referred to as the Commissioner of the Member State, or alternatively, a "Commission Member" for purposes of these Bylaws. Each Member State shall forward the name of its Commissioner to the national

office of the Commission, who will advise the Commission chairperson. The national office of the Commission shall promptly advise the appropriate appointing authority of the Member State of the need to appoint a new Commissioner upon the expiration of a designated term or the occurrence of mid-term vacancies. If a resignation of a Commissioner occurs or a change is made by the state appointing authority, it is the responsibility of the Member State to inform the Commission of the vacancy or change.

ARTICLE III

Officers

Section 1. Election and Succession.

The officers of the Commission shall include a Chairperson, Vice Chairperson, Secretary, Treasurer and Past Chair. The officers shall be duly appointed Commission Members. Officers shall be elected annually by the Commission at any meeting at which a quorum is present and shall serve for one year or until their successors are elected by the Commission. The officers so elected shall serve without compensation or remuneration, except as provided by the Compact.

Section 2. Duties.

The officers shall perform all duties of their respective offices as provided by the Compact and these Bylaws. Such duties shall include, but are not limited to, the following:

a. *Chairperson.* The Chairperson shall call and preside at all meetings of the Commission, shall prepare agendas for such meetings, shall make appointments to all committees of the Commission and, in accordance with the Commission's directions, or subject to ratification by the Commission, shall act on the Commission's behalf during the interims between Commission meetings.

b. *Vice Chairperson.* The Vice Chairperson shall, in the absence or at the direction of the Chairperson, perform any or all of the duties of the Chairperson. In the event of a vacancy in the office of Chairperson, the Vice Chairperson shall serve as acting until a new Chairperson is elected by the Commission.

c. *Secretary.* The Secretary shall keep minutes of all Commission meetings and shall act as the custodian of all documents and records pertaining to the status of the Compact and the business of the Commission.

d. *Treasurer.* The Treasurer, with the assistance of the Commission's executive director, shall act as custodian of all Commission funds and shall be responsible for monitoring the administration of all fiscal policies and procedures set forth in the Compact or adopted by the Commission. Pursuant to the Compact, the treasurer shall execute such bond as may be required by the Commission covering the treasurer, the executive director and any other officers, Commission Members and Commission personnel, as determined by the Commission, who may be responsible for the receipt, disbursement, or management of Commission funds.

e. *Past Chair.* The Past Chair is the most recent previous Chair who is still serving as a Commission member and shall perform such duties as may be requested by the Commission.

Section 3. Costs and Expense Reimbursement.

Subject to the availability of budgeted funds, the officers shall be reimbursed for any actual and necessary costs and expenses incurred by the officers in the performance of their duties and responsibilities as officers of the Commission.

ARTICLE IV

Executive Committee

Section 1. Powers, Duties, and Responsibilities.

The Executive Committee shall have the power to act on behalf of the Commission according to the terms of this Compact. The powers, duties and responsibilities of the Executive Committee shall include:

a. Overseeing the day-to-day activities of the administration of the Compact including compliance with the provisions of the Compact, the Commission's Rules and bylaws;

b. Recommending to the Commission changes to the Rules or bylaws, changes to this Compact legislation, fees charged to Compact Participating States, fees charged to Licensees and other fees;

c. Ensuring Compact administration services are appropriately provided, including by contract;

d. Preparing and recommending the budget;

e. Maintaining financial records on behalf of the Commission;

f. Monitoring Compact compliance of Participating States and providing compliance reports to the Commission;

g. Establishing additional committees as necessary;

h. Exercising the powers and duties of the Commission during the interim between Commission meetings, except for adopting or amending Rules, adopting or amending these Bylaws and exercising any other powers and duties expressly reserved to the Commission by Rule or these Bylaws.

Section 2. Composition of Executive Committee

The Executive Committee shall be composed of seven (7) members:

a. The Chair, Vice Chair, Secretary and Treasurer [optional: Past Chair] of the Commission and any other members of the Commission who serve on the Executive Committee shall be voting members of the Executive Committee; and

b. Other than the Chair, Vice Chair, Secretary and Treasurer [optional: and Past Chair], the Commission shall elect three (3) [alternative if Past Chair is included: two (2)] voting members from the current membership of the Commission.

c. Ex-Officio: The Compact authorizes up to four (4) ex-officio, nonvoting members from four (4) recognized national Social Work organizations. The ex-officio, nonvoting members of the Executive Committee are as follows:

    a.

The Commission may remove any member of the Executive Committee by an affirmative vote of a majority of the current membership of the Commission

Section 3. Executive Committee Meetings.

The Executive Committee shall meet at least once each calendar year at a time and place to be determined by the Executive Committee.

All meetings at which the Executive Committee intends to take formal action on a matter shall be open to the public, except that the Executive Committee may meet in a closed, non-public session of a public meeting when dealing with any of the matters for which the Commission is authorized to convene in a closed, non-public meeting under the Compact.

The Executive Committee shall give five (5) business days' notice of its public meetings, posted on its website and as it may otherwise determine to provide notice to persons with an interest in the public matters the public matters the Executive Committee intends to address at those meetings.

The Executive Committee may hold an emergency meeting when acting for the Commission to:

a. Meet an imminent threat to public health, safety or welfare;

b. Prevent a loss of Commission of Participating State funds; or

c. Protect public health and safety.

ARTICLE V

Qualified Immunity, Defense and Indemnification

Section 1. Immunity.

The members, officers, executive director, employees and representatives of the Commission shall be immune from suit and liability, both personally and in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of

any actual or alleged act, error, or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided that nothing in this paragraph shall be construed to protect any such person from suit or liability for any damage, loss, injury or liability caused by the intentional or willful or wanton misconduct of that person. The procurement of insurance of any type by the Commission shall not in any way compromise or limit the immunity granted hereunder.

Section 2. Defense.

Subject to the provisions of the Compact and Rules promulgated thereunder, the Commission shall defend any member, officer, executive director, employee and representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties or responsibilities, or as determined by the Commission that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided that nothing herein shall be construed to prohibit that person from retaining their own counsel at their own expense; and provided further, that the actual or alleged act, error or omission did not result from that person's intentional or willful or wanton misconduct.

Section 3. Indemnification.

Notwithstanding Section 1 of this Article V, should any member, officer, executive director, employee or representative of the Commission be held liable for the amount of any settlement or judgment arising out of any actual or alleged act, error or omission that occurred within the scope of that individual's employment, duties or responsibilities for the Commission, or that the person to whom that individual is liable had a reasonable basis for believing occurred within the scope of the individual's employment, duties or responsibilities for the Commission, the Commission shall indemnify and hold harmless such individual, provided that the actual or alleged act, error or omission did not result from the intentional or willful or wanton misconduct of the individual.

ARTICLE VI

Meetings of the Commission

Section 1. Meetings and Notice.

The Commission shall meet at least once each calendar year at a time and place to be determined by the Commission. Additional meetings may be scheduled at the discretion of the chairperson, and must be called upon the request of a majority of Commission Members, as provided by the Compact. All Commission Members shall be given written notice of Commission meetings at least thirty (30) days prior to their scheduled dates. Final agendas shall be provided to all Commission Members no later than ten (10) days prior to any meeting of the Commission. Thereafter, additional agenda items requiring Commission action may not be added to the final agenda, except by an affirmative vote of a majority of the Members. All Commission meetings shall be open to the public, except as set forth in Commission Rules or as otherwise provided by the Compact. Prior public notice shall be posted on the Commission's website at least thirty (30) days prior to the public meeting. A meeting may be closed to the public where the Commission determines by two-

thirds (2/3rds) vote of its Members that there exists at least one of the conditions for closing a meeting, as provided by the Compact or Commission Rules.

Section 2. Quorum.

Commission Members representing a majority of the Member States shall constitute a quorum for the transaction of business, except as otherwise required in these Bylaws. The participation of a Commission Member from a Member State in a meeting is sufficient to constitute the presence of that state for purposes of determining the existence of a quorum, provided the Member present is entitled to vote on behalf of the Member State represented. The presence of a quorum must be established before any vote of the Commission can be taken.

Section 3. Voting.

Each Member State represented at any meeting of the Commission by its Member is entitled to one vote. A Member shall vote himself or herself and shall not delegate his or her vote to another Member. Members may participate in meetings by telephone or other means of telecommunication or electronic communication. Except as otherwise required by the Compact or these Bylaws, any question submitted to a vote of the Commission shall be determined by a simple majority.

Section 4. Procedure.

Matters of parliamentary procedure not covered by these Bylaws shall be governed by Robert's Rules of Order.

ARTICLE VII

Committees

The Commission may establish such committees as it deems necessary to carry out its objectives, which shall include, but not be limited to Finance, Rules, Compliance, Training, Communications and Outreach, and Leadership Nomination. The composition, procedures, duties, budget and tenure of such committees shall be determined by the Commission.

ARTICLE VIII

Finance

Section 1. Fiscal Year.

The Commission's fiscal year shall begin on July 1 and end on June 30.

Section 2. Budget.

The Commission shall operate on an annual budget cycle and shall, in any given year, adopt budgets for the following fiscal year or years only after notice and comment as provided by the Compact.

Section 3. Accounting and Audit.

The Commission, through the Executive Committee, shall keep accurate and timely accounts of its internal receipts and disbursements of the Commission funds, other than receivership assets. The Commission's financial accounts and reports, including the Commission's system of internal controls and procedures, shall be audited annually by an independent certified or licensed public accountant. As required by the Compact, the report of such independent audit shall be included in and become part of the Commission's annual report to the Member States. The Commission's internal accounts, any workpapers related to any internal audit and any workpapers related the independent audit shall be confidential; provided, that such materials shall be made available: 1) in compliance with the order of any court of competent jurisdiction; ii) pursuant to such reasonable rules as the Commission shall promulgate; and iii) to any Commissioner of a Member State, or their duly authorized representatives.

Section 4. Public Participation in Meetings.

Upon prior written request to the Commission, any person who desires to present a statement on a matter that is on the agenda shall be afforded an opportunity to present an oral statement to the Commission at an open meeting. The chairperson may, depending on the circumstances, afford any person who desires to present a statement on a matter that is on the agenda an opportunity to be heard absent a prior written request to the Commission. The chairperson may limit the time and manner of any such statements at any open meeting.

Section 5. Debt Limitations.

The Commission shall monitor its own and its committees' affairs for compliance with all provisions of the Compact, its rules and these Bylaws governing the incursion of debt and the pledging of credit.

Section 6. Travel Reimbursements.

Subject to the availability of budgeted funds and unless otherwise provided by the Commission, Commission Members shall be reimbursed for any actual and necessary expenses incurred pursuant to their attendance at all duly convened meetings of the Commission or its committees as provided by the Compact.

ARTICLE IX

Withdrawal, Default, and Termination

Member States may withdraw from the Compact only as provided by the Compact. The Commission may terminate a Member State as provided by the Compact.

ARTICLE X

Adoption and Amendment of Bylaws

Any Bylaw may be adopted, amended or repealed by a majority vote of the Members, provided that written notice and the full text of the proposed action is provided to all Commission Members at least thirty (30) days prior to the meeting at which the action is to be considered. Failing the

required notice, a two-thirds (2/3rds) majority vote of the Members shall be required for such action.

ARTICLE XI

Dissolution of the Compact

The Compact shall dissolve effective upon the date of the withdrawal or the termination by default of a Member State which reduces Membership in the Compact to one Member State as provided by the Compact. Upon dissolution of the Compact, the Compact becomes null and void and shall be of no further force or effect, and the business and affairs of the Commission shall be concluded in an orderly manner and according to applicable law. Each Member State in good standing at the time of the Compact's dissolution shall receive a pro rata distribution of surplus funds based upon a ratio, the numerator of which shall be the amount of its last paid annual assessment, and the denominator of which shall be the sum of the last paid annual assessments of all Member States in good standing at the time of the Compact's dissolution. A Member State is in good standing if it has paid its assessments timely.

Social Work Licensure Compact Commission

Title of Rule: Rule on Rulemaking

Reason for Rule: To further outline and clarify the rule promulgation process of the Social Work Licensure Compact Commission.

Chapter 1: Rulemaking

Authority:

Section 10: Establishment of Social Work Licensure Compact Commission

Section 12: Rulemaking

Section 14: Effective Date, Withdrawal, and Amendment

1.0 Purpose: Pursuant to Section 12 of the Compact, the Social Work Licensure Compact Commission shall promulgate reasonable and lawful uniform rules to facilitate and coordinate implementation and administration of the Social Work Licensure Compact. This Rule will become effective upon passage by the Social Work Licensure Compact Commission as provided in Section 12 of the Social Work Licensure Compact.

1.1 Definition(s): (a) **"Commission"** means: the Social Work Licensure Compact Commission, which is the joint administrative body whose membership consists of all Member States.

(b) **"Commissioner"** means: the individual appointed by a Member State to serve as the member of the Commission for that Member State.

(c) **"Compact"** means the Social Work Licensure Compact.

(d) "**Member State**" means a state that has enacted the Compact and been admitted to the Commission in accordance with the Compact and the Commission Rules, and which has not withdrawn or been terminated from the Compact.

(d) **"Rule"** means: a regulation, principle or directive promulgated by the Commission pursuant to the criteria set forth in Section 12 of the Compact that has the force and effect of law in a Member State and includes the amendment, repeal, or suspension of an existing Rule.

(e) "**Rules Committee**" means: a committee that is established as a standing committee to develop reasonable and lawful uniform rules for consideration

by the Commission and subsequent implementation by the states and to review existing rules and recommend necessary changes to the Commission for consideration.

(f) "**Social Work Services**" means the application of social work theory, knowledge, methods, ethics, and the professional use of self to restore or enhance social, psychosocial, or biopsychosocial functioning of individuals, couples, families, groups, organizations, and communities through the care and services provided by a Regulated Social Worker as set forth in the Member State's statutes and regulations in the State where the services are being provided.

(g) **"State"** means: any state, commonwealth, district, or territory of the United States of America.

1.2 Proposed Rules or Amendments: Rules shall be adopted by majority vote of the Member States of the Commission pursuant to the criteria set forth in Section 12 of the Compact and in the following manner:

(a) New rules and amendments to existing rules proposed pursuant to the Compact and the Commission Bylaws shall be submitted to the Commission office for referral to the Rules Committee in any of the following ways:

(1) Any Commissioner may submit a proposed Rule for referral to the Rules Committee during the next scheduled Commission meeting.

(2) Standing Committees of the Commission may propose Rules amendments by majority vote of that Committee.

1.3 Drafting of Proposed Rules: The Rules Committee shall prepare a draft of all proposed rules and provide the draft to the Executive Committee to provide to all Commissioners for review and comments. Based on the comments made by the Commissioners, the Rules Committee shall prepare a final draft of the proposed rule(s) or amendments for consideration by the Commission not later than 30 days prior to the next Commission meeting.

1.4 Notice of Proposed Rulemaking Prior to Public Hearing: Prior to promulgation and adoption of a final Rule, the Commission shall hold a public hearing and allow persons to provide oral and written comments, data, facts, opinions, and arguments. At least 30 days prior to the public hearing, the Commission shall provide a Notice of Proposed Rulemaking:

1. On the website of the Commission or other publicly accessible platform; and

2. To persons who have requested notice of the Commission's notices of proposed rulemaking.

1.5 Contents of Notice of Proposed Rulemaking: The Notice of Proposed Rulemaking shall include:

(a) The time, date, and location of the public hearing at which the Commission will hear public comments on the proposed Rule and, if different, the time, date, and location of the meeting where the Commission will consider and vote on the proposed Rule;

(b) The mechanism for access to the hearing if the hearing is to be held via telecommunication, video conference, or other electronic means;

(c) The text of the proposed Rule and the reason for the proposed Rule.

(d) A request for comments on the proposed Rule from any interested person; and

(e) The manner in which interested persons may submit notice to the Commission of their intention to attend the public meeting and any written comments.

1.6 Public Hearings: All persons wishing to be heard at the public hearing shall notify the executive director of the Commission or other designated member in writing of their desire to appear and testify at the hearing not less than five (5) business days before the scheduled date of the hearing.

Hearings shall be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing.

All hearings shall be recorded. A copy of the recording shall be made available upon request.

Nothing in this chapter shall be construed as requiring a separate hearing on each Rule. Rules may be grouped for the convenience of the Commission at hearings required by this chapter.

The Commission shall consider all written and oral comments received prior to taking final action on the proposed Rule.

1.7 Final Adoption of Rule: At a regular or special meeting of the Commission**,** which may be held at the same date and location as the public hearing, the Commission shall, by majority vote of all Commissioners, take final action on the proposed Rule based on the rulemaking record.

The Commission may adopt changes to the proposed Rule provided the changes do not enlarge the original purpose of the proposed Rule. The Commission shall provide an explanation of the reasons for substantive changes made to the proposed Rule as well as reasons for substantive changes not made that were recommended by commenters.

The Commission shall determine a reasonable effective date for the Rule. Except for an emergency as provided in Section 1.9, the effective date of the Rule shall be no sooner than thirty (30) days after the Commission issues the notice that it adopted the Rule.

1.8 Status of Rules Upon Adoption of Compact By Additional Member States; Applicability: Any state that joins the Compact subsequent to the Commission's initial adoption of the rules shall be subject to the rules as they exist on the date on which the Compact becomes law in that state. Any Rule that has been previously adopted by the Commission shall have the full force and effect of law on the day the Compact becomes law in that state.

No Member State's rulemaking requirements shall apply under this Compact.

The Rules of the Commission shall have the force of law in each Member State, provided, however, that where the Rules of the Commission conflict with the laws of the Member State which establish the Member State's scope of permissible Social Work Services as held by a court of competent jurisdiction, the rules of the Commission shall be ineffective in that State to the extent of the conflict.

If, within four (4) years of the date of adoption of a Rule, a majority of the legislatures of the Member States rejects the Rule by the enactment of statutes in the same manner such legislatures used to adopt the Compact, the Rule shall have no further force and effect in any Member State.

1.9 Emergency Rulemaking: Upon determination that an emergency exists, the Commission may consider and adopt an emergency Rule with twenty-four (24) hours' notice, with the opportunity to comment, provided that the usual rulemaking procedures provided in the Compact and in this section shall be retroactively applied to the rule as soon as reasonably possible, in no event later than ninety (90) days after the effective date of the Rule. For the purposes of this provision, an emergency rule is one that must be adopted immediately in order to:

1. Meet an imminent threat to public health, safety, or welfare,
2. Prevent a loss of Commission or Member State funds;
3. Meet a deadline for the promulgation of a Rule that is established by federal law or rule;
4. Protect public health and safety.

2.0 Non-Substantive Rule Revisions: The Commission or an authorized committee of the Commission may direct revisions to a previously adopted Rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency, or grammatical errors. Public notice of any revisions shall be posted on the website of the Commission. The revision shall be subject to challenge by any person for a period of thirty (30) days after posting. The revision may be challenged only on grounds that the revision results in a material change to a Rule. A challenge shall be made in writing and delivered to the Commission prior to the end of the notice period. If no challenge is made, the revision will take effect without further action. If the revision is challenged, the revision may not take effect without the approval of the Commission.

Elections Information: Positions and Duties

The Commission will elect two officers, five members-at-large to serve on the Executive Committee from among the current delegates to the Commission, and up to four ex-officio, nonvoting members from four recognized national social work organizations. All eleven of those elected will be members of the Executive Committee.

Below are descriptions of the duties of the Executive Committee and its officers as written in Compact bylaws.

The Commission's officers shall perform all duties of their respective offices as the Compact and these Bylaws provide. Their duties shall include, but are not limited to, the following:

A. Chair: The Chair shall call and preside at Commission and Executive Committee meetings; prepare agendas for the meetings; act on Commission's behalf between Commission meetings.

B. Vice Chair: The Vice Chair shall perform the duties of the Chair in their absence or at the Chair's direction. In the event of a vacancy in the Chair's office, the Vice Chair shall serve until the Commission elects a new Chair.

C. Members-at-large (5 positions open): fulfill duties of the Executive Committee as outlined below.

The Executive Committee shall:

a. The Executive Committee shall have the power to act on behalf of the Commission according to the terms of this Compact. The powers, duties, and responsibilities of the Executive Committee shall include:
b. Oversee the day-to-day activities of the administration of the compact including enforcement and compliance with the provisions of the compact, its Rules and bylaws, and other such duties as deemed necessary;
c. Recommend to the Commission changes to the Rules or bylaws, changes to this Compact legislation, fees charged to Compact Member States, fees charged to Licensees, and other fees;
d. Ensure Compact administration services are appropriately provided, including by contract;

e. Prepare and recommend the budget;
f. Maintain financial records on behalf of the Commission;
g. Monitor Compact compliance of Member States and provide compliance reports to the Commission;
h. Establish additional committees as necessary;
i. Exercise the powers and duties of the Commission during the interim between Commission meetings, except for adopting or amending Rules, adopting or amending bylaws, and exercising any other powers and duties expressly reserved to the Commission by Rule or bylaw; and
j. Other duties as provided in the Rules or bylaws of the Commission.

D. Ex-officio Members (4 positions open): The ex-officio members will be selected by their respective organizations.

Overview of Commission Finances and Management

Compact	Annual Budget	Secretariat	Funding Sources
Nursing	$ 62,971.23	NCSBN	$50,000 secretariat fee to NCSBN
Medicine	$ 5,273,603.05	FSMB	Fees from licensees
Psychology	$ 459,018.00	FSPPB	MOU with FSPPB
PT	$ 160,733.00	FSPTB	Line of credit with FSPTB
Counseling	$ 367,500.00	CAMS	Funding from ACA, NBCC
OT	$ 450,808.28	ASMI	Funding from AOTA, NBCOT
Speech Pathology/Audiology	$ 287,000.00	NCSB	Funding from ASHA, AAA
EMS	approx. $150,000	NREMT	Grant from NREMT

Memo

To: The Social Work Compact Interstate Commission

From: Dan Logsdon, National Center for Interstate Compacts

Date: July 30th, 2024

RE: Document Team Discussion of Ex Officio Members

The Social Work Compact allows for 4 ex officio members to the Executive Committee. The compact doesn't provide guidance about specific organizations, which was by design from the Document Team. However, the Document Team did mention four organizations during their discussions.

The organizations that were discussed:

- The Association of Social Work Boards (ASWB)
    - ASWB is the nonprofit organization composed of the social work regulatory boards and colleges of all 50 U.S. states, the District of Columbia, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and all 10 Canadian provinces.
- The National Association of Social Workers (NASW)
    - Founded in 1955, the National Association of Social Workers (NASW) is the largest membership organization of professional social workers in the world. NASW works to enhance the professional growth and development of its members, to create and maintain professional standards, and to advance sound social policies
- Clinical Social Work Association
    - CSWA's membership currently consists of licensed clinical social workers, new professionals (clinical social workers who have graduated within the last four years), emeritus members, students and affiliated state societies.
- Council on Social Work (CSWE)
    - Founded in 1952, the Council on Social Work Education (CSWE) is the national association representing social work education in the United States. Its members include over 750 accredited baccalaureate and master's degree social work programs, as well as individual social work educators, practitioners, and agencies dedicated to advancing quality social work education.

The Social Work Compact Commission has the sole authority to appoint the ex officio members. This memo is meant only to provide background information for commission deliberations.

Social Work Compact Executive Director

Draft RFP Job Description

Job Title	**Group**	**Date Posted**
Director, Social Work Compact Commission	Social Work Compact Commission	
Accountable to: SOCIAL WORK COMPACT COMMISSION/Chair/Executive Committee		**Authority** SOCIAL WORK COMPACT Section 10.C (11) Bylaws Article IV, Section 1

Job Summary:

Serves as the lead staff executive for the SOCIAL WORK COMPACT COMMISSION, a joint government agency of member states. Directs the day-to-day operations of the organization, including but not limited to projects, relationships and staff. Works in concert with the Commission leadership, and its Executive Committee to fulfil the intent and purpose of the Social Work Compact.

Tasks	**Principle Responsibilities**	**Frequency**
1	Manages the day-to day operations of the SOCIAL WORK COMPACT. Provides support to the Commission Chair, Delegates, Committee Chairs and Executive Committee in the execution of its responsibilities, under the Compact Bylaws. Works in consultation with Commission Chair to develop meeting agendas, materials, minutes, and reports. Provides executive level staff support and ensures effective planning, promotion, and execution of commission meetings.	20%
2	Conducts outreach and public relations related to the SOCIAL WORK COMPACT. Effectively manages external stakeholder relationships while representing the Commission. Serves as the SOCIAL WORK COMPACT training officer; provides training to member state boards of social work. Facilitates the orientation of new Commissioners. Develops and maintains a repository of informational, educational, and training materials regarding the SOCIAL WORK COMPACT. Provides external presentations and education and technical assistance for legislative enactments, as needed.	20%
3	Participates in the development and implementation of the Social Work Commission strategic plan and objectives. Collaborates with the Executive Committee in setting the overall strategic direction.	10%
4	In conjunction with the Commission and its committees, oversees and monitors regulatory compliance of member states with statute, bylaws, and rules.	15%
5	Responsible for supervising the staff and independent contractors of the Commission. Develops and submits to the Commission for consideration the administrative personnel policies governing the recruitment, hiring, management, compensation, and dismissal of Commission staff.	15%
6	In conjunction with the Treasurer and Executive Committee, responsible for managing the annual operating budget and reserves, and monitoring the Commissions financial performance. Maintains records of the Commission. May serve as Secretary to the Commission; coordinates Executive Committee elections.	20%

Job Specifications

(Education, Certification, Special Knowledge and Skills)

Bachelor's degree required, Master's or JD preferred. Background in business, management, healthcare administration or related field. Five or more years of member-based association management/governance and committee management experience preferred.

Knowledge of occupational licensure, administrative law and operations management preferred.

Excellent oral and written communication, presentation, technical, organizational, customer service, problem solving, analytical and critical thinking, and problem-solving skills are required.
Ability to work independently to resolve member issues and collectively to establish a positive working rapport with members and stakeholders. Facilitates effective meetings with stakeholders. Domestic travel will be required.
Ability to build, maintain, communicate, and manage professional relationships with members, stakeholders, and public and governmental agencies, with an emphasis on political awareness, public perceptions, and SOCIAL WORK COMPACT initiatives and details.

Social Work Compact Commission Support Draft Request for Proposal for Secretariat

Proposal Title and Purpose:

Social Work Compact Commission Support

The purpose of this Request for Proposal (RFP) is to solicit a secretariat who will help commence, implement, and sustain the work of the Social Work Compact Commission (Commission).

Background/Entity Descriptions:

The Association of Social Work Boards (ASWB) is working to create the Social Work Licensure Compact. Work on this endeavor began in late 2020, as The Council of State Governments (CSG) selected ASWB to receive technical assistance with the development of a compact through funding from the Department of Defense (DoD). Since that time, ASWB and CSG have worked closely with state boards and associations to introduce compact legislation.

The bill stipulates a minimum of 7 states must approve the legislation before the Social Work Compact Commission can be assembled and begin its operations. One state approved the bill in 2023 and in the 2024 state legislative session, an additional 21 states approved the legislation.

Now that the minimum state requirement has been met, the Social Work Compact Commission is being formed with one state regulatory representative being appointed from each jurisdiction who has passed the legislation. The Social Work Compact Commission, a joint governmental agency composed of an elected representative from each state that passed compact legislation, will hold its inaugural meeting September 17th, 2024.

The secretariat awarded this contract will be responsible for working with the Social Work Compact Commission, the commission's executive committee, and its executive director to develop all necessary commission infrastructure, secure a national licensure data system which includes licensure information and disciplinary actions, and implement management of all activities.

Proposal Request Schedule:

The Social Work Compact Commission seeks proposals from a secretariat to provide administrative and management services to help implement the Commission's responsibilities and strategic initiatives and handle day-to-day operations.

Deadline for proposal submission is xx/xx/xxxx

Terms of Contract:

The Social Work Compact Commission desires to enter into an agreement with the successful awardee for a period of three (3) years, with the option to renew in one-year increments for an additional three (3) years. The anticipated commencement date is to be determined.

Project Goals:

Work with the Social Work Compact Commission, its Executive Committee and other Committees, and its Executive Director to:

- Provide all necessary management infrastructure including appropriate staffing, technology, and resources as needed
- Convene meetings with Social Work Compact Commission as needed
- Prepare an annual budget
- Apply for grants
- Establish national policies and procedures
- Secure a national licensure data system (including disciplinary actions)
- Work with each state board of social work or state agency on the interface and implementation of the database
- Develop all initial reporting templates
- Develop all initial routine communication templates
- Prepare all initial public facing communications
- Process all practitioner requests for a compact license
- Respond to all state boards of social work administrators requests to confirm disciplinary action information
- Prepare data and reports, as needed

Nothing herein shall inappropriately delegate Commission responsibilities to the secretariat. The Commission shall approve all actions taken by the secretariat as determined by the Commission.

Scope of Work:

The scope of all expectations for assistance with the work outlined in this RFP must be completed as follows:

Convene meetings with Social Work Compact Commission as needed	xx/xx/xxxx
Provide all necessary management infrastructure including appropriate staffing, technology, and resources as needed	xx/xx/xxxx
Secure a national licensure data system	xx/xx/xxxx
Work with each state board of social work or state agency on interface and implementation of the database	xx/xx/xxxx
Prepare annual budget	xx/xx/xxxx
Apply for grants	xx/xx/xxxx
Establish national policies and procedures	xx/xx/xxxx
Develop all initial reporting templates	xx/xx/xxxx
Develop all initial routine communication templates	xx/xx/xxxx
Prepare all initial public facing communications	xx/xx/xxxx
Prepare and implement a marketing strategy and messaging to state regulatory boards who may be interested in the compact legislation	Ongoing
Process all practitioner requests for a compact license	Ongoing
Respond to all state board of social work administrators requests to confirm disciplinary action information	Ongoing
Prepare data and reports, as needed for the Social Work Compact Commission	Ongoing

Dates are subject to change at the Compact Commission's discretion

Budget:

The Social Work Compact Commission's budget for calendar year xxxx will be approximately xxxxxx These monies will cover development and operational expenses with the understanding funding for the disciplinary action database is yet to be determined and will be provided separately.

How Can Current Roadblocks and Barriers be Removed:

Risks

- Insufficient management resources
- Database inefficiency
- Database security
- Insufficient start-up funding

Support of the Social Work Compact Commission and the necessary database is essential to ensure the success of the Social Work Compact. Secretariats can mediate these risks by thoroughly indicating methods to address these issues. An established system and process with past successes will be considered.

Proposal Requirements

A. Company Information

1. Provide the company name, address, telephone number, website, and any social media handles.

2. Provide the name, title, and email address of the individual who will serve as the company's primary contact.

3. Describe the company's history, ownership and affiliations.

4. Describe the mission and philosophy that distinguishes the company from competitors.

5. List the company's complete scope of services.

6. Describe the size of your company in employees and revenue.

B. Clients & References

7. Provide a list of the company's current clients in order of annual billings, length of time with the company, and the services provided.

8. Identify clients the company gained and lost during the last 12 months, describing why the company was selected or the relationship was severed.

9. List any current or past clients that are affiliated with ASWB and the social work profession.

10. Provide a minimum of three client references, ideally with prior experience of similar scope and magnitude to the services requested within this RFP. Include name, organization, phone number, email address, a brief description of the work completed on behalf of each client, and samples.

C. Relevant Experience & Strategic Approach

11. Provide a summary of the company's qualifications, experience, and competitive advantages in providing the services outlined in this RFP.

D. Project Management

12. Describe the company's approach to client relationships.

13. Provide detailed implementation plan for a contract awarded as a result of this RFP.

E. Staff & Partners

14. Provide a breakdown of the company's employees by function and location.

15. Provide a list of individuals who would service the Social Work Compact Commission's project if awarded, including staff responsibilities, locations, and brief bios.

F. Financial Proposal

16. Please bid your services for the *administration and management services in* one comprehensive amount with detailed costs for major components (such as the national licensure data system).

17. Describe the company's policy with regard to methods of compensation

Submission Requirements of the Proposal:

All proposals must be sent to the Social Work Compact Commission Chair by email no later than 11:59 PM Eastern on xx/xx/xxxx. Failure to adhere to the dates indicated below may result in bidder disqualification.

Request for Proposal released to vendors by Commission	xx/xx/xxxx
Intent to participate in RFP indicated by vendors	Xx/xx/xxx
Deadline for written questions or requests for clarification	xx/xx/xxxx
Response to questions and requests by Commission	xx/xx/xxxx
Deadline for proposal submission	xx/xx/xxxx
Evaluation of proposals by Commission	xx/xx/xxxx
*Commission vote to accept RFP and execution of contract by Commission	xx/xx/xxxx
*Awardee commencement of project	xx/xx/xxxx

*Subject to change at the Compact Commission's discretion

Evaluation Metrics and Criteria:

Once the secretariat has been selected, the following evaluation criteria will be used to assess the secretariat's performance:

Is the secretariat responding to requests/needs of the Social Work Compact Commission and its Executive Director in a timely manner?
Has the secretariat provided appropriate assistance to the Social Work Compact Commission and its Executive Director to complete national policy and procedural documents?
Has the Social Work Compact disciplinary action database been secured by the secretariat?
Have the implementation timelines established in the contact been adhered to by the secretariat?
Is the secretariat proactive in working with the Social Work Compact Commission and its Executive Director in addition to problem solving solutions to challenges?
In conjunction with the Social Work Compact Commission and its Executive Director, what kind of marketing initiatives has the secretariat implemented to further educate and work with other state boards of social work who may be interested in the compact legislative initiative?

Contact Information:

All questions and requests for clarification should be directed to the Chair of the Social Work Compact Commission, (Name of Chair)

Email: xxxx@xxxx
Phone: xxx-xxx-xxxx

Proposed Transition Plan: Social Work Compact Operations

Internal procedures and policies

- Discuss and adopt by-laws
- Adopt Rule on Rulemaking
- Discuss future rules for consideration
- Discussion of committees' structure and function
- Election of Social Work Compact Executive Committee
- Discuss dates of first Executive and Rules Committee meetings
- Request for committee participants

Introductions and Commission Personnel

- Introduce State Commissioners
- Governance and legislative review
- Discuss Social Work Compact Commission finances
- Discuss RFP for secretariat services and timeline
- Role of CSG for Social Work Compact Commission
- Role of CSG under the current contract in support of the Association of Social Work Boards (ASWB)
    - State level technical assistance
    - State legislative technical assistance
    - Legal services
    - Continued outreach on status of state enactments of the Social Work Compact
    - Continued maintenance of Social Work Compact website
    - Temporary secretariat services

Subsequent meetings of the Social Work Compact Commission and Executive Committee will consider the following items for action:

- Discuss additional rules and policies
- Develop MOU for financial support

- Develop and approve budget
- Select secretariat for Social Work Compact Commission
- Discuss Social Work Compact Commission data system

Social Work Compact Commission Administrative Policy

Code of Conduct

I. Introduction

As a joint government entity created by the enactment of the Social Work Compact (Compact) by its member states, the Social Work Compact Commission (Commission) affords great deference to its member states in selecting the Social Work Compact Commissioners (Commissioners) to represent them. The diverse personal, educational, and professional backgrounds of Commissioners are one of the Commission's greatest assets. However, this diversity means that some Commissioners may have personal pecuniary interests which are affected by the outcomes of management and other decisions which must be made concerning the administration of the Compact Commission at times. This policy was implemented to ensure transparency, accountability, and integrity in the Commission's decision-making process.

II. Code of Conduct

Commissioners and their Temporary Representatives appointed by the states are responsible for upholding the integrity of the Commission and its member states. No Commissioner or Temporary Representative shall engage in criminal or unethical conduct prejudicial to the Commission, any other Commissioner, or any other state.

No Commissioner or Temporary Representative shall vote or participate in debate upon a matter in which they have a direct or indirect financial or other personal interest resulting in a personal benefit that conflicts with the fair and impartial conduct of official duties. The Executive Committee shall have the sole authority to consider allegations of breaches of this code, including appeals from Commissioners alleged to be in violation herewith. In the case of a breach, the Executive Committee may direct the Chair to notify the appropriate appointing authority in the Commissioner's home state.

III. Definition

A Conflict of Interest is a set of circumstances that creates a risk that professional judgement or actions regarding a primary interest will be unduly influenced by a secondary personal interest economic or otherwise.

IV. Disclosure of Conflicts of Interest

1. All Commissioners and Temporary Representatives are required to complete a Code of Conduct form. The form constitutes an agreement by each Commissioner and Temporary Representative to disclose personal interests that may impact the ability of a Commissioner or Temporary Representative to conduct business in a "fair and

impartial" manner and that the Commissioner or Temporary Representative will recuse from debating or voting on such a matter in fulfilling the duties of a Social Work Compact Commissioner or Temporary Representative.

2. Completed Code of Conduct forms must be submitted as soon as possible after a state has appointed a Commissioner or Temporary Representative. A Commissioner or Temporary Representative cannot vote at a meeting until this form is completed. For the first year of implementation of this policy, all Commissioners and Temporary Representatives must complete the form prior to inaugural meeting.

3. Completed Code of Conduct forms are public documents which may be disclosed by the Commission upon request.

V. Commissioner and Temporary Representative Recusal

Prior to the discussion of an issue in which a Commissioner or Temporary Representative believes a conflict of interest may exist, the Commissioner or Temporary Representative must announce to the Committee or Commission meeting that they are recusing themself from participating in the caucus and voting. Once recused, the Commissioner or Temporary Representative will not be able to participate in the debate or the vote concerning the matter which led to the recusal.

VI. Concerns over Financial Disclosure and Conflict of Interest

Concerns over conflicts of interest should be brought to the attention of the Chair of the Commission for consideration by the Executive Committee. The Executive Committee, in consultation with legal counsel, will determine if any of the provisions of the Commission's Policy on Conflicts of Interest have been violated and decide the appropriate action, if any.

VII. Notification of Home State Appointing Authority

If any of the following conditions are met, the Commission may notify the appropriate appointing authority in the home state of the Commissioner or Temporary Representative regarding its concern about the ability of the Commissioner or Temporary Representative to perform his/her duties in a fair and impartial manner.

1. The Commissioner or Temporary Representative has a substantial financial conflict of interest in the outcome of the matter, such as the awarding of a contract for services or employment;

2. The Commissioner or Temporary Representative has a substantial positional conflict of interest in the outcome of the matter, such as a leadership position for another organization whose purpose is contrary to that of the Commission;

3. The Commissioner or Temporary Representative has been found in violation of criminal or civil state or federal statute or regulation;

4. The Executive Committee determines that a Commissioner or Temporary Representative is not performing their duties consistent with this policy.

Code of Conduct Form

Commissioners or Temporary Representatives appointed by the states are responsible for upholding the integrity of the Commission and its member states. No Commissioner or Temporary Representatives shall engage in criminal or unethical conduct prejudicial to the Commission, any other Commissioner, or any other state. No Commissioner or Temporary Representative shall have a direct or indirect financial interest that conflicts with the fair and impartial conduct of official duties. The Executive Committee, in consultation with Legal Counsel to the Commission, shall have the sole authority to consider allegations of breaches of this code, including appeals from Commissioners alleged to be in violation herewith. In the case of a breach, the Executive Committee may direct the Chair to notify the appropriate appointing authority in the Commissioner or Temporary Representative's home state.

I,_____,
(print name)

_____for the State of _____
(title—Commissioner or temporary representative)

hereby swear or affirm that I have read and understand the Social Work Compact Commission Code of Conduct and will comply with said policy in all matters pertaining to my duties and obligations as a Commissioner, Temporary Representative, or Officer of the Commission, including my obligation to recuse myself from consideration, debate or voting on any matter that conflicts with the fair and impartial conduct of my official duties.

_____

(Signature)

Dated this ___ day of _____, 20__.

Social Work Licensure Compact Commission
Inaugural Meeting Agenda
September 17th, 2024: 10am ET – 3pm ET
Zoom: https://csg-org.zoom.us/meeting/register/tZYvdeqtrzkrHt1_qNWwyfVCqaRb0BVxxdAn

I. Attendees

a. Delegates Present:

i. Alabama- Rachel Dickinson
ii. Arizona-Tobi Zavala
iii. Colorado-Reina Sbarbaro-Gordon
iv. Connecticut-Chris Andresen
v. Georgia- Deborah Sills
vi. Iowa-Tony Alden
vii. Kansas-David Fye
viii. Louisiana-Hyacinth Mckee
ix. Kentucky-Hank Cecil
x. Maine-Angela Fileccia
xi. Minnesota-Youa Yang
xii. Missouri-Justin Bennett
xiii. New Hampshire-Bethany Cottrell
xiv. Nebraska-Sean Loving
xv. Ohio-Kevin Fowler
xvi. Rhode Island- Laura Mello
xvii. South Dakota- Kelli Willis
xviii. Tennessee-Tara Watson
xix. Utah- Jana Johansen
xx. Vermont-Noura Eltabbakh
xxi. Virginia-Jaime Hoyle
xxii. Washington-Lana Crawford

b. Interim Chair Present:
   i. Laura Groshong, CSWA
c. Interim Legal Counsel:
   i. Samantha Nance, EMWN
d. Interim Staff Present:
   i. Matt Shafer, CSG
   ii. Dan Logsdon, CSG
   iii. Kaitlyn Bison, CSG

II. Welcome and Introductions of Interim Staff

a. Interim Staff: M. Shafer outlined housekeeping and introduced interim staff, including Dan Logsdon, Kaitlyn Bison, and Samantha Nance.

b. CSG's Role: M. Shafer detailed CSG's involvement and role with DDH compact.

III. Call to Order

a. L. Groshong calls on delegates by state alphabetical order to introduce themselves and elaborate on their role on the board.

b. *Agenda Review*: M. Shafer reviewed and asked for questions about the agenda (none received).

IV. Legislative Update/Legal Opinion on Legislative Deviations

a. K. Bison describes the legislative review process and affirms that no material deviations were enacted.

b. K. Bison provided an update on state enactments and pending bills. No material deviations reported.

c. S. Nance explains non-material changes and requests delegates to flag any potential amendments to compact legislation in their states.

d. S. Nance invites questions from delegates.

    i. H. Cecil- KY asks if CSG will continue to monitor and M. Shafer explains the timeline of CSG's role with the commission.

V. Discussion of Data System

a. L. Groshong calls on Isabel Eliassen to present update on Compact Connect

b. I. Eliassen invites questions.

    i. A. Fileccia-ME asks how the data system will be chosen.

    ii. J. Bennet-MO asks if there is an anticipated launch date.

    iii. I. Eliassen addresses all of the questions stating that the executive committee will choose the vendor, and there is not an anticipated launch date as of yet.

VI. Review Commission Governance Structure

a. L. Groshong hands over to S. Nance to review the commission governance structure.

b. S. Nance provides an overview of the governance structure, including the delegates' responsibilities.

c. S. Nance invites questions (none received).

VII. Discussion of Compact Commission By-Laws

a. S. Nance reviewed the draft by-laws and governance structure and expected roles.

b. S. Nance continues with an overview of the by-laws and rulemaking within the confines of the compact language.

c. S. Nance discusses item in blue of optional provision of Past Chair that would be filled at officer level – merely option and provides for governance continuity.

d. S. Nance points to meeting requirements that mirror the compact language.
e. S. Nance overviews public notice of meetings, and the ability of the commission to establish appropriate committees (ex. Finance committees, etc.)
f. S. Nance asks for any delegate questions (none received).

VIII. Discussion of Rule on Rulemaking

a. S. Nance discussed rulemaking processes and common misconceptions.
b. S. Nance recommend this rule to be adopted quickly to allow for future rules to be made.
c. S. Nance asks for questions from delegates.
d. T. Watson -TN asks what the threshold will be for public comments.
e. S. Nance gives examples of other commission thresholds, but it will be up to the commission to decide.
f. L. Mello-RI comments about how a number threshold may not be appropriate as very few comments are usually received.
g. S. Nance mentions that that is useful and could set the threshold very low to adjust.

IX. Discussion of Leadership Nominations

a. L. Groshing calls on M. Shafer to discuss available leadership roles and future procedures for voting and nomination.
b. M. Shafer explains further leadership positions for executive committees.
c. M. Shafer asks for questions from delegates.
    i. A. Muhammad- OH, asks if alternates can be on committees.
    ii. S. Nance mentions that elections are for individuals, may need to flip delegate and alternate for operations purposes.
    iii. H. Cecil-KY asks if that can be included in the by-laws.
    iv. S. Nance mentions that it could be clarified further in the bylaws and state outright.

X. Lunch

XI. Discussion of Commission Finances and Staff Hiring

a. L. Groshing calls on M Shafer to discuss commission finances.
b. M. Shafer emphasized the commission's unique opportunity to utilize existing data systems and discussed funding, staffing, and secretariat roles.
c. CSG is contracted with ASWB until the end of 2025, with staffing decisions to be made later.
d. Jennifer Henkel is called on to provide information on ASWB's HRSA grant, which provides $150,000 annually until 2029 for commission development and support.
e. L. Mello-RI inquired about grant resources for states implementing the compact, and J. Henkel confirmed that similar support could be offered.

XII. Discussion of Future Rules for Consideration

a. L. Groshong calls on M. Shafer to discuss potential rule introductions.
b. M. Shafer proposed future rules regarding definitions and administrative issues.
c. The qualifying national exam definition will be broad, allowing the commission to specify the ASWB exam.
d. S. Nance emphasized that this flexibility is common across professions and welcomes questions from delegates.
    i. L. Mello-RI asked if RI licensees could take the compact exam if the exam is suspended.
    ii. J. Bennett-MO inquired about changes to state language if alternative pathways are identified.
        1. S. Nance indicated that changes could be necessary depending on the commission's decisions.
    iii. L. Mello-RI questioned whether "substantial equivalency" supports alternative pathways.
        1. S. Nance agreed that it does allow for such pathways.
    iv. R. Dickinson-AL asked if a state could deny applicants wanting to take the exam first.
        1. M. Shafer clarified that adopting substantial equivalency would not give grounds for denial.
e. M. Shafer mentions the aim to establish the ASWB exam as the national qualifying exam, with future discussions on alternative pathways.
f. M. Shafer will introduce potential rules for adoption at the next meeting, focusing on the qualifying exam, interstate compact authority, and administrative issues.
g. S. Nance explained the broad language in the rules for flexibility.
h. L. Mello- RI expressed concern that the exam requirement may exclude licensees from compact privileges.
i. C. Andresen-CT raised concerns about disparities in ASWB exam pass rates.
j. R. Dickinson-AL stated that they would not accept licensees without exam completion, even outside the compact.
k. L. Mello-RI highlighted bias against certain demographics in the exam results.
l. M. Shafer discussed the need for consistent language regarding supervised practice equivalency.
m. C. Andresen-CT mentioned issues faced in professional alliance or alternative disciplinary programs.
    i. S. Nance confirmed that states are not prohibited from using such programs.
n. J. Bennett-MO requested information on fee structures for compact licenses to ensure accessibility.
    i. M. Shafer explained that fees are set by the state, with an example being a nominal fee of $45 for the PT compact.

XIII. Ex Officio Organization Selection

a. Summary:
    i. Various organizations were proposed for selection, and a motion was made to establish a rotating seat among the ex-officio members. After some discussion and clarifications, the motion to create a rotational seat passed with majority support.
    ii. Concerns were raised about including organizations not present for discussion, but the decision was made to send invitations to gauge interest in filling the rotating seat.
b. L. Groshong calls on M. Shafer to discuss the memo and compact language and calls on Samantha to explain the role of ex-officio members.
    i. Up to four national social work associations will be selected.
c. Establishing a rotating seat:
    i. J. Bennett-MO asked if the fourth ex-officio seat could be a rotating member, which S. Nance said is open for discussion.
    ii. Hank Cecil suggested considering various organizations:
        1. Council on Social Work Education
        2. National Association of Black Social Workers
        3. Social Welfare Action Alliance
        4. Case Management Society of America
    iii. A. Fileccia-ME supported the inclusion of the Council on Social Work Education.
d. M. Shafer called on representatives from four national organizations to introduce themselves and clarified that the organizations must be nationally recognized.
e. J. Bennett called for a motion to establish a rotating seat, seconded by Deborah Sills.
    i. Tony Alden sought clarification on which organization was being discussed.
    ii. Hank Cecil proposed splitting the motion to consider NABSW separately and make it a rotating seat, which J. Bennett seconded.
    iii. H. McKee raised a question about how the rotation would be decided.
f. Tony Alden moved to approve a rotating seat for niche organizations to be decided later, and the motion passed with 19 yes votes, 1 no vote and 1 abstaining.
g. The amended motion included a rotational vote for the list including CASW.
    i. T. Zavala – AZ expressed concern about including organizations not previously contacted.
h. A motion to designate one seat as rotational was made.
    i. J. Johansen - UT inquired about the rotation process, questioning who would determine it.
    ii. S. Nance indicated they are working on a framework.
    iii. J. Bennett - MO confirmed with S. Nance that ex-officio members would participate in larger commission and executive meetings.
    iv. D. Sills - GA questioned the selection process for organizations.

v. H. McKee - LA mentioned sending formal invitations to other organizations.

i. A voice vote passed the motion to establish a rotating chair among the four seats.
    i. J. Bennett - MO suggested reaching out to other organizations of interest.
    ii. S. Nance clarified the need for a formal invitation outlining responsibilities for the rotating seat, which was seconded by H. Cecil and Kelli S.
    iii. H. McKee-LA proposed using a list of organizations from the ASWB coalition as a starting point.

j. A voice vote to send invitations passed.
    i. H. Cecil - KY identified ASWB, NASW, and CSWA as three spots for representation.
    ii. D. Sills - GA mentioned viewing CSWE as more of an accrediting body, while B. Cottrell suggested tabling the motion until invitations were sent.

k. J. Johansen-UT seconded the motion to table.
    i. T. Alden - IA raised concerns about notifying organizations not present at the meeting.
    ii. T. Zavala - AZ noted that only the four invited organizations were involved in discussions.
    iii. R. Dickinson - AL supported starting with the initial four organizations.
    iv. J. Bennett - MO emphasized that these organizations represent the profession and its clients.

l. The motion to table the decision on the three organizations as ex-officio seats passed with 20 yes votes, 1 no vote, and 1 abstaining.

m. S. Nance indicated that the executive committee would not be formed yet.

n. There will be one rotating seat, and CSG will reach out to gauge interest in filling that position.

o. L. Groshong asked if ex-officio members could join committees.
    i. S. Nance stated that committees are formed by the commission, and it depends on specific needs and mandates, as there might arise a need for a committee with ex-offcio members.

p. T. Alden – IA highlighted the need for in-person engagement in discussions for the next meeting.

XIV. Questions from Delegates/Public Comment from Non-Delegate Attendees

a. Laura asked for questions from delegates (none received).

b. She invited members of the public to raise their hands or submit questions/comments in the chat, explaining the expected nature of public comments.
    i. Dana Paglia from Michigan discussed pursuing exam alternatives and emphasized that NASW Michigan is fully engaged. She encouraged the commission to consider the importance of these initiatives.

ii. Dr. Jasmine Smith from NASW California noted the absence of their organization in the licensure process. She supported including additional organizations in future discussions and stressed the need for equitable policies regarding the ASWB exam and alternative processes.
iii. Pilar Binilla, a public social worker, expressed concern about the legal implications of ASWB's significant role in funding and committee membership, highlighting potential conflicts of interest and the importance of inclusivity.
iv. Henry O'Keefe, a contract lobbyist and private attorney in Oregon representing NASW, shared his insights on proposed changes to the licensing board before they are enacted in Oregon, and requested assistance with meetings regarding deviations from compact language.

XV. Review Transition Plan and Next Steps

a. L. Groshong calls on K. Bison to present overview of transition plan.
b. K. Bison presents on timeline of commission set up, next steps, and wraps up meeting – asks about format of next meeting.
    i. Overall preference from delegate for hybrid meeting

XVI. Adjourn

a. L. Groshong calls for a voice vote to adjourn the meeting and the motion passes.

Exam Program

August 15, 2024

The Association of Social Work Boards publishes new research on disparities in pass rates for social work licensing exams

Tags: Assessment research Exams Regulatory research

Reports outline complex factors influencing test-taker outcomes

The Association of Social Work Boards today published a three-part series of research reports analyzing the social work licensing examination pass rate disparities. The goal of the exam report series, based on additional analyses of data on ASWB exam pass rates and those of other professions, is to inform ASWB's and the social work profession's approach to addressing the complex individual, institutional, and community factors influencing the testing experience and exam results.

"We are in this for the long haul. ASWB has continuously invested in initiatives that will help us better understand the pass rate analysis findings, support educators and licensure candidates, and facilitate collaborative solutions with our partners across the profession," said ASWB CEO Stacey Hardy-Chandler, Ph.D., J.D., LCSW, PGDip. "We know that systems affect people and their experiences and that those same systems also impact social work licensure candidates. This research makes it abundantly clear that addressing the pass rate disparities will require a systemwide approach."

> *Together these reports give us a much fuller, richer picture of examinees' experiences with the exam and the context of their lives leading up to it. Dr. Kim's findings will help inform exam development moving forward and our ongoing efforts to collaboratively address the persistent disparities.*
>
> — ASWB Senior Director of Examination Services Lavina Harless, LCSW

The exam report series represents a collaboration between ASWB and Joy Kim, MSW, Ph.D., of Rutgers University School of Social Work, along with her associate Michael Joo, MSW, Ph.D. Kim and Joo conducted an inquiry into the sources of pass rate disparities, including analyses of pass rates that control for the individual, institutional, and community factors that test-takers carry with them throughout their lives.

"Dr. Kim's expertise in social work regulatory research — and licensure standards across multiple professions — is unmatched and will help the field of social work move forward collaboratively," said Hardy-Chandler.

The research series begins with a report that profiles social work licensing examinees using ASWB data, continues with a review of other professions' literature on licensing and certification exam pass rate disparities, and concludes with an analysis of the effects of race and ethnicity on Clinical exam outcomes.

"The goal was to look at ASWB exam data from several angles to more fully understand factors impacting the examinees. These findings are reflected in three distinct but complementary reports," said Kim.

The three-part series of research reports includes:

- **Report 1 – The Profile of Social Work License Examinees: A Racially Patterned Educational and Training Journey Before the Exams** – evaluates demographic, educational, and employment characteristics impacting social work candidates' experiences leading up to the social work licensing exam. For example, compared to white examinees, higher percentages of Black examinees took longer to earn their social work degree and had more years of employment in non-direct service jobs prior to taking the exam. The report concludes that the demographic, educational, and employment characteristics indicate that some social work candidates' journeys to the profession might have been far more disrupted and delayed than others even before they attempted the licensing exams for the first time.
- **Report 2 – The Determinants of Licensing Exam Outcomes: The Compounding Effects of Individual, Institutional, and Community Factors** – provides an overview of research findings from the literature of other professions to understand the factors that may contribute to the disparate pass rates in social work. The analysis shows that significant racial and ethnic disparities exist across many professions, including medicine, nursing, and psychology, suggesting that outcomes reflect broader societal challenges. This research also indicates a link between an increased percentage of certified or licensed faculty and improved performance by a program's examinees. The report emphasizes the need for more research to better understand and begin to reduce pass rate disparities.
- **Report 3 – The Effects of Race/Ethnicity on Clinical Exam Outcomes: Diminished (yet Persistent) Effects When Other Determinants Are Controlled** – outlines the significant impact of key factors on Clinical exam pass rates, including age, gender, primary language, educational background, and employment experiences. The findings suggest that if historically marginalized groups had access and opportunities similar to those of white examinees and experienced equitable institutional and community environments, the pass rate gap would narrow significantly.

Based on the findings from all three reports, Kim and Joo conclude that the exam pass rate disparities present the social work profession with a unique opportunity to embrace a systems-based approach to locating and addressing the sources of these disparities. The reports recommend that professional stakeholders commit to collaborative research and strategic interventions focused on the societal factors that influence pass rate outcomes.

"Now that we better understand the complex and often deeply entrenched sources of the gaps and inequities, we can try to intervene," Dr. Kim added.

The exam report series is part of ASWB's ongoing initiative to expand understanding of and increase responsiveness to the factors that disproportionately affect certain examinees.

"Together these reports give us a much fuller, richer picture of examinees' experiences with the exam and the context of their lives leading up to it. Dr. Kim's findings will help inform exam development moving forward and our ongoing efforts to collaboratively address the persistent disparities," said ASWB Senior Director of Examination Services Lavina Harless, MSW, LCSW.

Learn more about this research effort and read the full reports

The Profile of Social Work License Examinees:

A Racially Patterned Educational and Training Journey Before the Exams

Prepared for
Association of Social Work Boards (ASWB)

Exam Report No. 1

Joy Kim, MSW, PhD & Michael Joo, MSW, PhD

Rutgers School of Social Work

Contents

Executive Summary

Becoming a licensed professional social worker is a lifelong journey. The journey begins with obtaining a qualifying educational degree and continues with taking a necessary licensing exam. **This report is the first in the Exam Report Series, designed to provide a deeper understanding of demographically disparate exam pass rates by presenting basic statistics on the demographic, educational, and employment characteristics of social work candidates** who undertook the journey. The report is based on the analyses of U.S. candidates who took the ASWB exams at least once in 2022. It is based on the analyses of 25,088 Clinical examinees, 26,550 Masters examinees, and 3,588 Bachelors examinees in the United States. The key takeaways of the findings include the following:

- ✓ Significantly higher shares of examinees from historically marginalized groups — Black, Hispanic/Latino, and multiracial examinees — began their postsecondary education with an associate's degree.
- ✓ Examinees from historically marginalized groups earned their educational degrees and took their first licensing exam at significantly older ages than their white counterparts.
- ✓ Examinees from historically marginalized groups had significantly more years of work experience, typically in non-direct service jobs, which may not have helped them advance their social work competence.
- ✓ These demographic, educational, and employment characteristics of examinees from historically marginalized groups — particularly Black examinees — signal that their educational and training journeys to the profession might have been affected by cumulative lifetime disadvantages.

The major characteristics of ASWB examinees are summarized below by exam category, and significant racial/ethnic differences are highlighted to understand the examinees' diverse backgrounds.

Clinical Examinees

Table E-1 suggests that the mean age at which the Clinical examinees earned their bachelor's and Master of Social Work (MSW) degrees was 26 and 32, respectively. The mean age at which they took their first Clinical exam was around 38, six years after completing an MSW. However, half of the examinees took the exam for the first time by age 35.

Table E-1. Clinical Examinee Age at Degree and First Exam Attempt, 2022

	Age at Bachelor's Degree	Age at MSW	Age at First Exam Attempt
Median	23	29	35
Mean	26.22	31.72	37.58

About 9% of the Clinical examinees used English as a second language, and 4% took the exam with accommodations related to the Americans with Disabilities Act (ADA). More than 26% began their postsecondary education with an associate's degree, and 38% held a BSW. They

had about five to six years of work experience at the time of the exam, and 53% held a direct service job.

Significantly higher shares of Black, Hispanic/Latino, and multiracial examinees, compared to white examinees, began their postsecondary education with an associate's degree. Black examinees also had significantly longer work experiences than their white counterparts.

Charts E-1 and E-2 also show that **most examinees from historically marginalized groups took a delayed journey in obtaining the degrees and taking the Clinical exam for the first time**.

Chart E-1. Clinical Examinee Median Age, by Race/Ethnicity, 2022

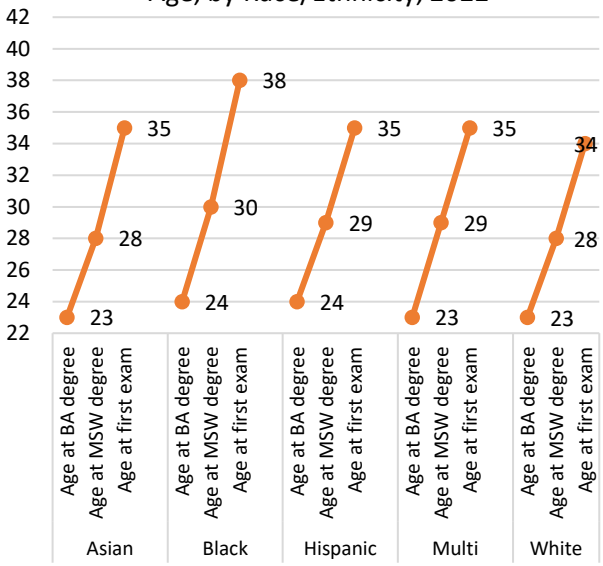
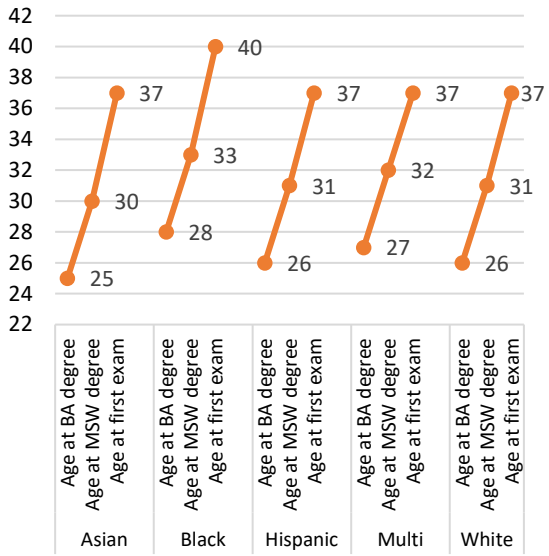


Chart E-2. Clinical Examinee Mean Age, by Race/Ethnicity, 2022



According to Charts E-1 and E-2, examinees from historically marginalized groups earned their educational degrees and took the Clinical exam for the first time at older ages than their white counterparts. Compared to white examinees, Hispanic/Latino and multiracial examinees were slightly older at each milestone. However, Black examinees were significantly older, especially when they took the exam for the first time (40 years old for Black examinees versus 37 years old for white, based on the mean age difference).

Masters Examinees

Table E-2 shows the mean age at which Masters examinees earned their bachelor's and MSW degrees was 26 and 32, respectively. They took their first Masters exam at around age 33. However, half of the examinees took the exam for the first time by age 30.

Table E-2. Masters Examinee Age at Degree and First Exam Attempt, 2022

	Age at Bachelor's Degree	Age at MSW Degree	Age at First Exam Attempt
Median	23	29	30
Mean	26.23	31.96	33.32

About 7% of the Masters examinees used English as a second language, and 3% used ADA-related exam accommodations. Nearly 31% were located in the Middle Atlantic region. More than 26% began their postsecondary education with an associate's degree, and 40% held a BSW. They had about one to two years of work experience, and only about 28% held a direct service job.

Significantly higher percentages of Black, Hispanic/Latino, and multiracial examinees held an associate's degree than their white counterparts. Black examinees had significantly more years of work experience than white examinees.

Charts E-3 and E-4 also demonstrate that Hispanic/Latino and multiracial examinees attained the degrees and took the first exam at slightly older ages than white examinees. **Black examinees, however, were significantly older than white examinees at each milestone. Not only did they obtain their MSWs three years later than white examinees, but they were four years older when they took their first Masters exam.**

Chart E-3. Masters Examinee Median Age, by Race/Ethnicity, 2022

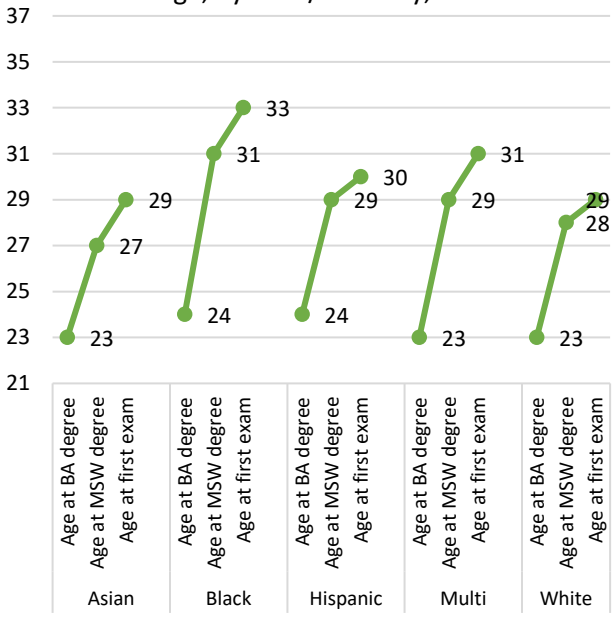
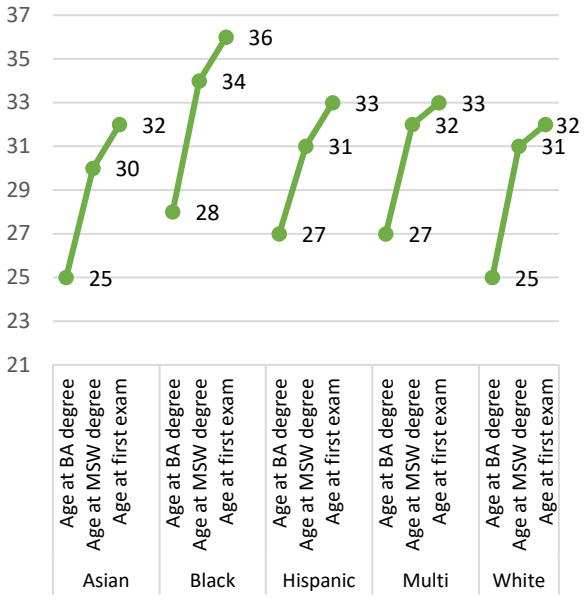


Chart E-4. Masters Examinee Mean Age, by Race/Ethnicity, 2022



Bachelors Examinees

As Table E-3 shows, although half the Bachelors examinees earned their BSWs by age 24, the mean age of the degree attainment was 28, suggesting many earned their BSWs at older than the mean age. The examinees took their first exam at age 31, three years after completing their BSW.

Table E-3. Bachelors Examinee Age at Degree and First Exam, 2022

	Age at BSW	Age at First Exam Attempt
Median	24	27
Mean	28.02	31.26

Approximately 6% of the Bachelors examinees used English as a second language, and more than 2% used ADA-related exam accommodations. More than 37% of the examinees were located in the East North Central region. Slightly more than 32% began their postsecondary education with an associate's degree, and around 95% held a BSW. On average, they had about two years of work experience, and more than 73% held a non-direct service job.

Compared to white examinees, **significantly higher percentages of Black, Hispanic/Latino, and multiracial examinees held associate's degrees than their white counterparts. As seen in other exam categories, Black examinees had more years of work experience than white examinees.**

Charts E-5 and E-6 below also demonstrate that **Black examinees completed their BSWs at older ages than their white counterparts and took their first Bachelors exam at a significantly older age.**

Chart E-5. Bachelors Examinee Median Age, by Race/Ethnicity, 2022

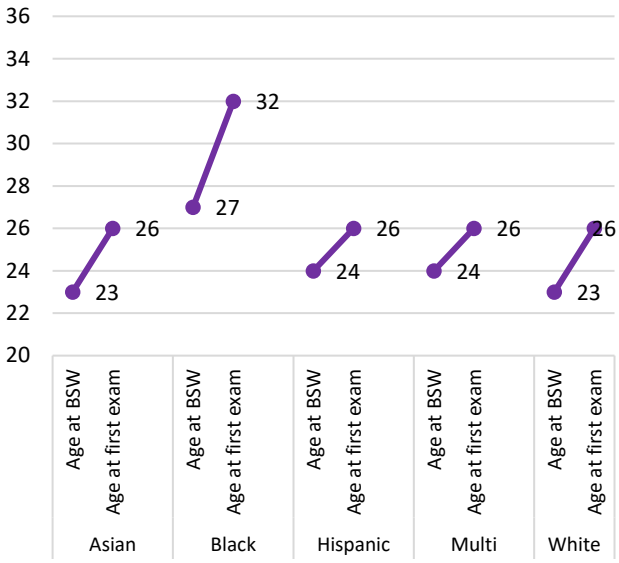
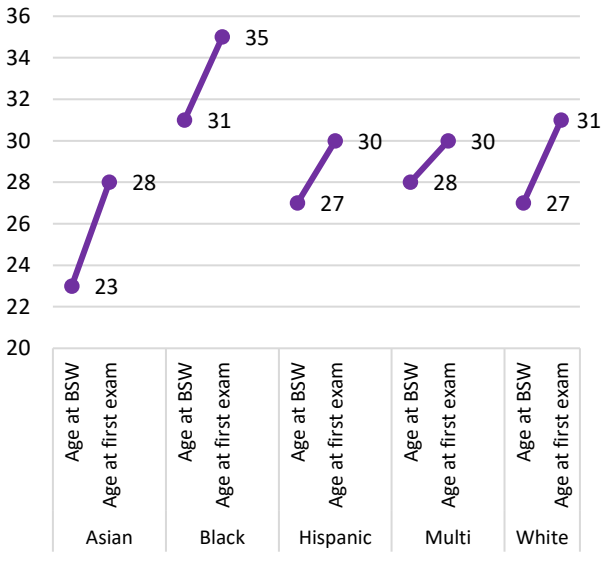


Chart E-6. Bachelors Examinee Mean Age, by Race/Ethnicity, 2022



Background and Purpose

The social work workforce is part of the behavioral healthcare workforce that provides vital mental health and substance abuse services to individuals and communities throughout the United States. As with the 76% of the U.S. healthcare workforce that is certified or licensed (U.S. Bureau of Labor Statistics, 2023), licensure is available for social work candidates who meet their jurisdictions' educational, certification, and other licensure requirements (e.g., background check). Certification is a profession-wide attestation of an individual's professional competence, typically provided through competence assessments such as an exam. It is a critical part of the licensure process that ensures social workers have minimum competence for effective, ethical, and safe practices. The Association of Social Work Boards provides the licensing exams for U.S. jurisdictions and Canadian provinces in five exam categories: Associate, Bachelors, Masters, Advanced Generalist, and Clinical. In 2022, ASWB published its *2022 ASWB Exam Pass Rate Analysis*, an analysis of exam pass rates between 2011 and 2021 (ASWB, 2022), showing substantial differences in pass rates by race/ethnicity, age group, and primary language.

Social work candidates take the licensing exams toward the end of their professional education and training journeys to enter the profession. Their journeys are affected by many community, institutional, and structural factors, and socioeconomic and racial inequalities can impact their access to quality education and training and eventually influence their exam outcomes (Espahbodi et al., 2023). While it is difficult to measure those cumulative structural inequalities, population-level subgroup differences in lifetime outcomes — such as delayed education — may indicate the prevalence and magnitude of such inequalities (Goldrick-Rab, 2006; Roksa & Velez, 2012).

With this background, **this report aims to explore subgroup differences in the population of social work licensing examinees.** By examining the examinees' demographic, educational, and employment characteristics and, more importantly, how those characteristics are patterned by race/ethnicity, we aim to detect indicators of cumulative, structural inequalities that some subgroups of social work candidates might have experienced before they took the social work licensing exams.

The analyses are based on 2022 exam data provided by U.S. examinees. The exam registration forms collect basic information about registrants, including their (1) demographic characteristics (age, gender, race/ethnicity, use of English as a second language, use of Americans with Disabilities Act accommodations, and exam authorizing states), (2) educational characteristics (years of associate's, bachelor's, and master's degrees, names of educational institutions, and undergraduate major), and (3) employment characteristics (years of employment and job type).

To provide a national profile of the examinees, the analyses included all examinees in the United States who took the exam in 2022. Repeat examinees were included in the analyses only once. Associate examinees (N=433) and Advanced Generalist examinees (N=172) were not included because their numbers were too small for detailed analyses. Throughout the report, the word "significant" is used to refer to statistical significance between racial/ethnic groups.

Statistical significance means that a finding in the data is unlikely to have happened by chance, and there is a relationship between the variables studied in the larger population.

Detailed descriptive statistics are provided in the Appendix tables A-1 through A-6 at the end of this report.

Demographic Characteristics

Gender

The overwhelming majority of examinees across all three exam categories were women. As Table 1 shows, about 86% of Clinical and Masters examinees and 90% of the Bachelors examinees were women. Approximately 1% of the examinees identified as a gender not listed or did not answer the gender question.

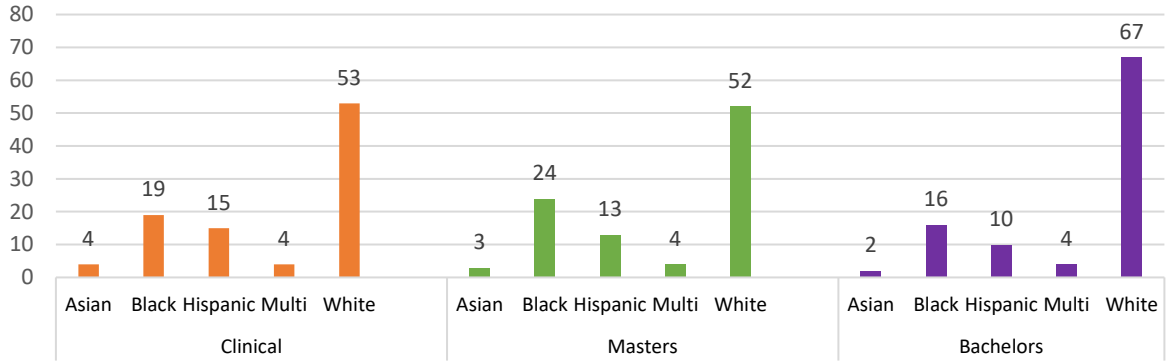
Table 1. Percentage of Women and Men, by Exam Category, 2022

	Clinical Exam	Masters Exam	Bachelors Exam
Women	86	86	90
Men	13	13	10

Race and Ethnicity

Approximately 53% of Clinical examinees and 52% of Masters examinees were white, and nearly 67% of Bachelor's examinees were white. Black examinees comprised 19% of Clinical, 24% of Masters, and 16% of Bachelors examinees. Hispanic/Latino examinees comprised approximately 15% of Clinical, 13% of Masters, and 10% of Bachelors examinees. Examinees who identified as multiracial comprised roughly 4% of Clinical and Masters examinees. Approximately 2 to 4% of the Clinical, Masters, and Bachelors examinees identified as Asian. In addition, while examinees were given the option to select "Native American/Indigenous Peoples" when they registered for an exam, the number who chose that option is too small for analyses; data for that group was not used in this report. Note that between 2% and 4% of the examinees did not provide race/ethnicity information, as shown in the last columns of Appendix Tables A-2, A-4, and A-6.

Chart 1. Percentage of Racial/Ethnic Groups, by Exam Category, 2022



Age

Table 2 shows that half of the Clinical exam-takers were older than 36. The median age of the Masters examinees was 31, and the median age of the Bachelors examinees was 28.

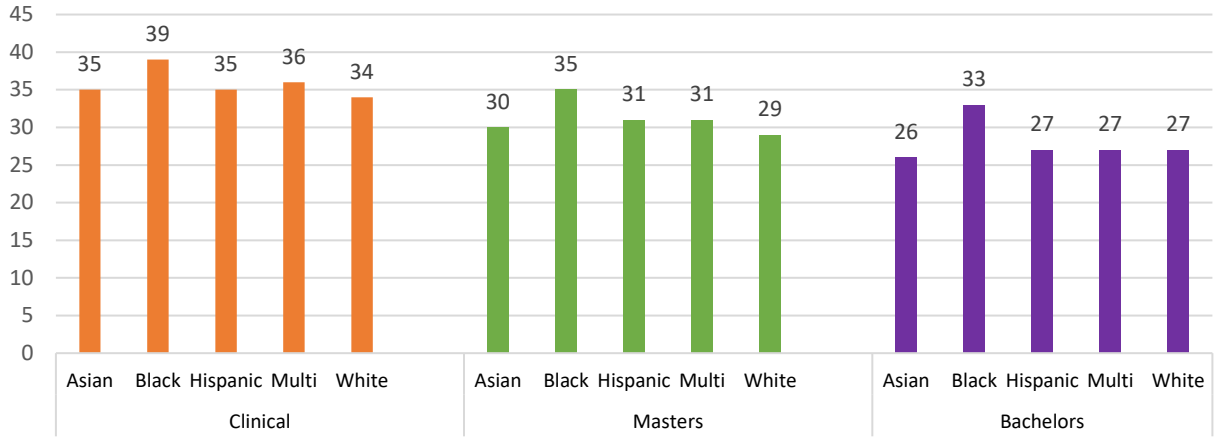
The mean ages of the examinees were two to four years older than the median ages across the exam categories. The mean age of the Clinical, Masters, and Bachelors examinees was around 38, 34, and 32, respectively.

Table 2. Examinee Age, by Exam Category, 2022

	Clinical Exam	Masters Exam	Bachelors Exam
Median	36	31	28
Mean	38.40	34.03	31.82

There was a significant age difference by race and ethnicity. Across all exam categories, while Black examinees were the oldest group, measured either by the mean or median ages, test-takers who were white and from other racial/ethnic groups were similar in their mean and median ages at the time of the exams. Black examinees who took the Clinical exam, for example, had a median age of 39, five years older than that of their white counterparts. For the Masters exam, Black examinees' median age was 35, six years older than their white counterparts. The same was true for the Bachelors exam, as shown in Chart 2 below.

Chart 2. Median Age at Exam, by Race/Ethnicity and Exam Category, 2022



Disability-Related Accommodation

Across the exam categories, approximately 2 to 4% of the examinees used nonstandard testing accommodations associated with the ADA. More specifically, 4.21% of the Clinical examinees, 3.03% of the Masters examinees, and 2.12% of the Bachelors examinees used accommodations to take the exams.

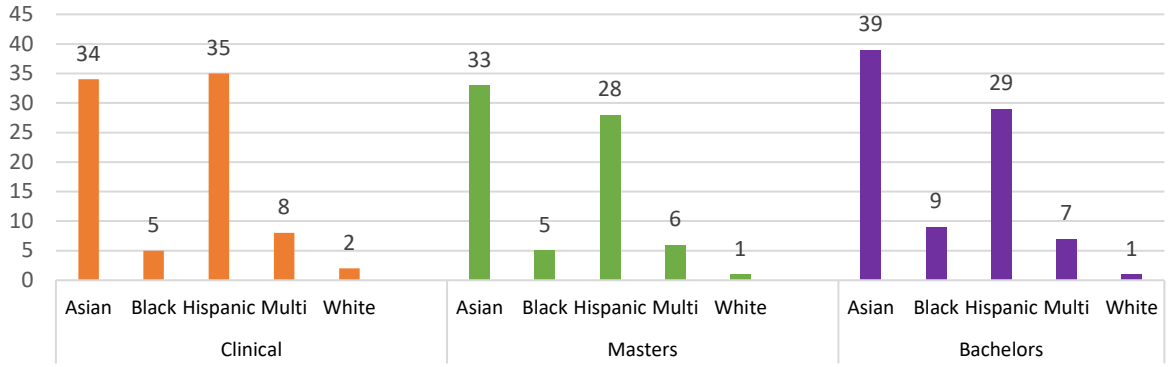
Notably, approximately 6% of Black Clinical examinees used ADA-related accommodations, nearly double their white counterparts (3%).

English as a Second Language

Approximately 9%, 7%, and 6% of the Clinical, Masters, and Bachelors examinees, respectively, used English as a second language.

As Chart 3 shows, most examinees who used English as a second language, across all exam categories, identified as Hispanic/Latino and Asian. Still, a non-negligible percentage of Black and multiracial examinees also used English as a second language.

Chart 3. Percentage of Examinees Who Used English as a Second Language, by Race/Ethnicity and Exam Category, 2022



Region of Residence

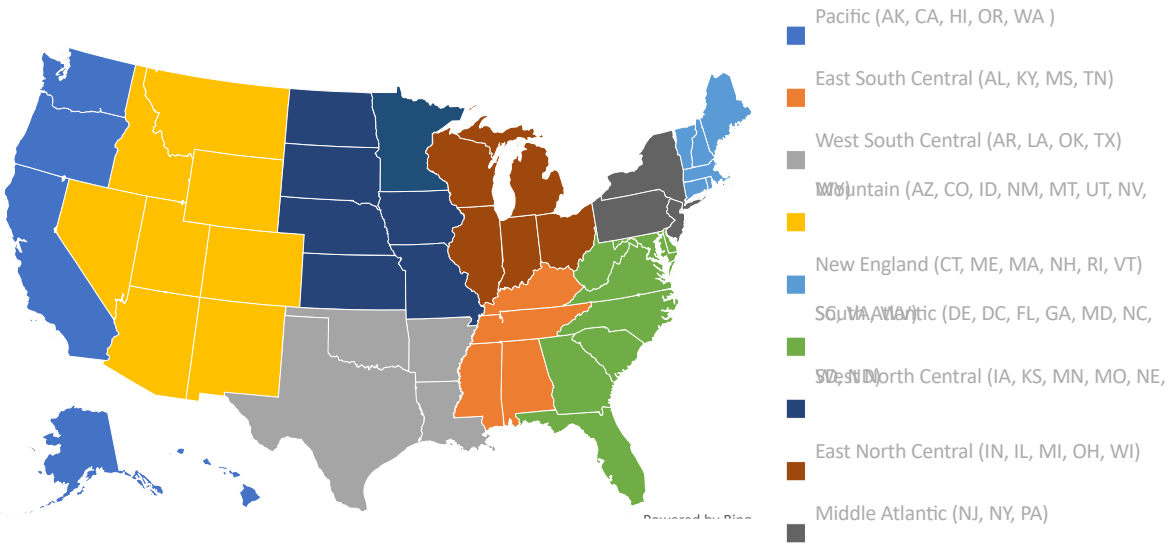
Examinees were not evenly distributed across the U.S. Census regions, partly because not all licensure categories are available in all states and population densities differ by state. Figure 1 below shows the states included in each census region.

Clinical exam: About 54% of all Clinical examinees were located in the South Atlantic (19%), East North Central (17%), and Pacific (18%) regions. Compared to white Clinical examinees, examinees from historically marginalized groups were concentrated in particular regions. More specifically, 37% of Black examinees were from the South Atlantic region, and 40% and 47% of Hispanic/Latino and Asian examinees, respectively, were from the Pacific region.

Masters exam: Nearly 60% of Masters examinees were located in the Middle Atlantic (31%), West South Central (15%), and South Atlantic (12%). The Middle Atlantic region was dense with large groups of examinees from historically marginalized groups. Black examinees were concentrated in the Middle Atlantic (29%) and South Atlantic (22%) regions. Hispanic/Latino examinees were primarily located in the Middle Atlantic (37%) and West South Central (28%) regions.

Bachelors exam: Most Bachelors examinees were found in the East North Central (38%) and West North Central (18%) regions. About 42% of white and 37% of Black Bachelor's examinees were in the East North Central region, but 44% of Hispanic/Latino examinees lived in the West South Central region. A large group (41%) of Asian examinees were from the West North Central area.

Figure 1. U.S. Census Regional Division to Understand Examinees' Density



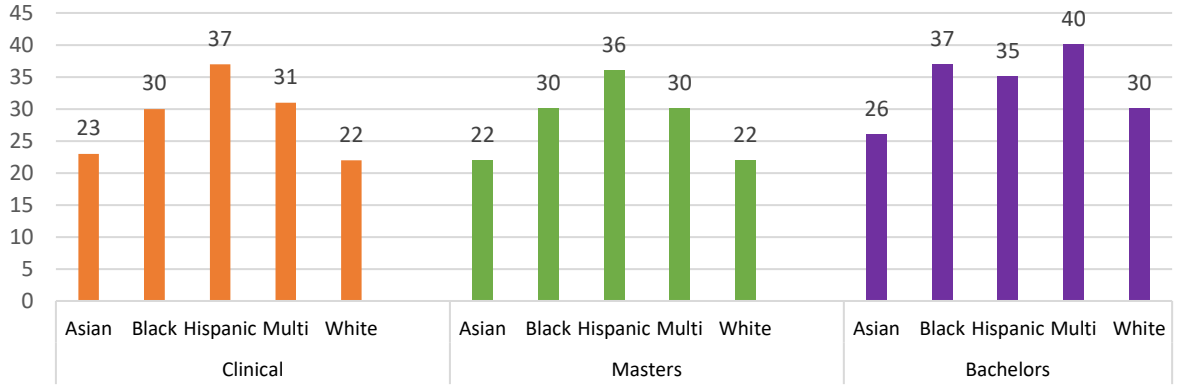
Educational Characteristics

An Associate's Degree

Approximately 26% of Clinical and Masters examinees held an associate's degree as their first postsecondary degree. Among Bachelors examinees, roughly 32% held an associate's degree.

Across the exam categories, significantly higher shares of examinees from historically marginalized groups — except for Asians — began their postsecondary education with an associate's degree, as Chart 4 below shows. For the Clinical and Masters exams, Hispanic/Latino examinees were the largest group of associate's degree holders at 37% and 36%, respectively. For the Bachelors exam, 40% of multiracial examinees and 37% of Black examinees began their postsecondary education with an associate's degree.

Chart 4. Percentage of Examinees with an Associate's Degree, by Race/Ethnicity and Exam Category, 2022



Age at Bachelor's Degrees

The median age at which the Clinical and Masters examinees obtained their bachelor's degrees was 23. However, the mean age at which they earned the degree was about three years older (26). This median–mean difference suggests that a substantial number of the examinees earned the degree at later ages. The Bachelors examinees earned their bachelor's degrees slightly later than those who took Clinical and Masters exams.

Table 3. Age at Which Examinees Earned Bachelor's Degree, by Exam Category, 2022

	Clinical Exam	Masters Exam	Bachelors Exam
Median	23	23	24
Mean	26.22	26.23	28.02

As depicted in Charts 5 and 6 below, there was a significant racial difference in the timing of bachelor's degrees. Black examinees earned their degrees at older ages than their white counterparts across all three exam categories. This difference was considerable for the Masters and Bachelors exams. Specifically, for the Masters exams, the mean age at which Black examinees obtained bachelor's degrees was 28, three years older than their white counterparts. For the Bachelors exams, the median and mean ages of Black examinees were 27 and 31, respectively — four years older than their white counterparts.

Chart 5. Median Age at Bachelor's Degree, by Race/Ethnicity and Exam Category, 2022

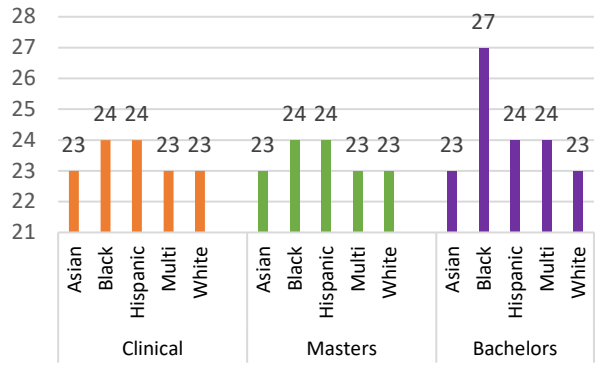
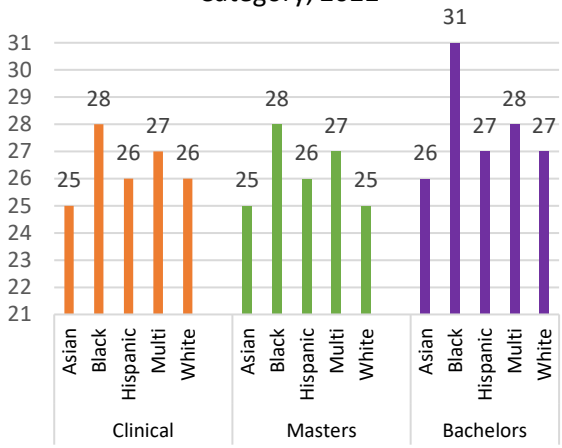


Chart 6. Mean Age at Bachelor's Degree, by Race/Ethnicity and Exam Category, 2022



Age at MSW

As Table 4 shows, half of the Clinical and Masters examinees obtained their MSW by age 29, but the mean age at which the examinees earned their MSW was nearly 32.

Table 4. Age at Which Examinees Earned MSW, by Exam Category, 2022

	Clinical Exam	Masters Exam	Bachelors Exam
Median	29	29	n/a
Mean	31.72	31.96	n/a

As Charts 7 and 8 show, a similar pattern of racial difference discussed above appeared in the timing of MSW attainment. Hispanic/Latino and multiracial examinees earned their MSW at slightly older ages than white examinees, and Asian examinees earned the degree at a younger age than their white counterparts.

Notably, among the Clinical and Masters examinees, Black examinees earned their MSW at the oldest ages. Among the Masters examinees, Black examinees were three years older than their white counterparts when they obtained their MSWs; among the Clinical examinees, they were two years older than their white counterparts, measured in median and mean ages.

Chart 7. Median Age at MSWs, by Race/Ethnicity and Exam Category, 2022

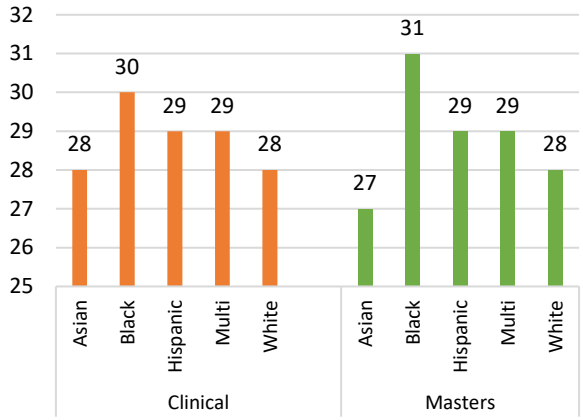
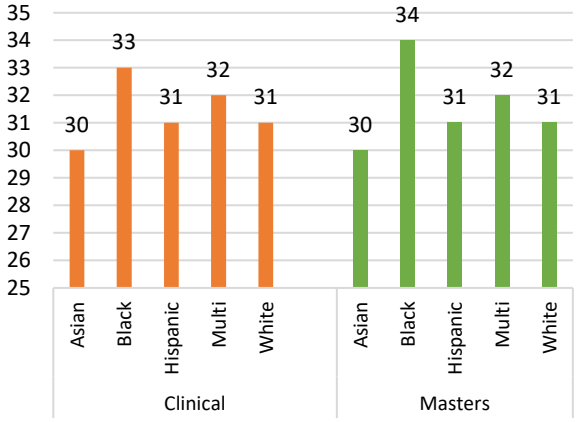


Chart 8. Mean Age at MSWs, by Race/Ethnicity and Exam Category, 2022



Employment Characteristics

Years of Employment

Table 5 demonstrates that half of the Clinical examinees had more than four years of employment. The mean number of years of employment among the Clinical examinees was about six.

Half of the Masters and Bachelors examinees had less than a year of employment. However, the Masters and Bachelors examinees had approximately two years of employment, on average.

Table 5. Years of Employment, by Exam Category, 2022

	Clinical Exam	Masters Exam	Bachelors Exam
Median	4 years	Less than a year	Less than a year
Mean	5.56 years	1.65 years	1.99 years

A closer look at the data revealed that examinees from some racial and ethnic groups, particularly Black examinees, had more years of employment. Charts 9 and 10 below suggest that among Clinical examinees, Black examinees had two more years of employment than their white counterparts, measured either by median or mean years. Members of other racial groups also had more years of employment than white test-takers, but the differences were not as significant as those between Black and white examinees.

Chart 9. Median Years of Employment, by Race/Ethnicity and Exam Category, 2022

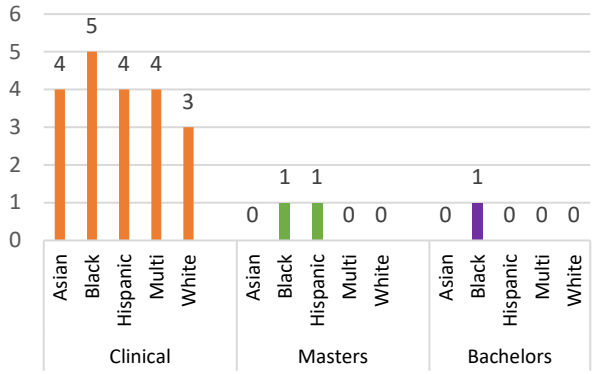
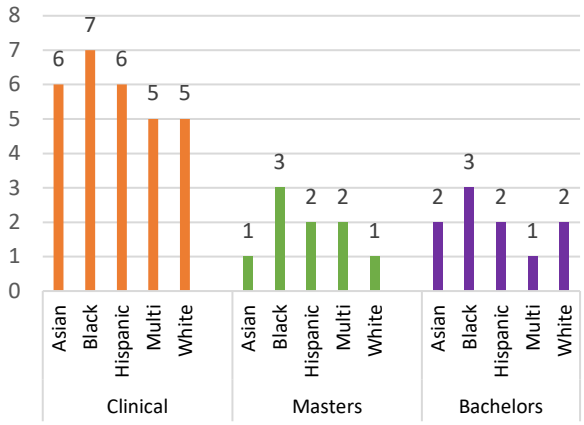


Chart 10. Mean Years of Employment, by Race/Ethnicity and Exam Category, 2022



Job Position

As Table 6 demonstrates, more than half (53%) of the Clinical examinees reported working in a direct service position. On the other hand, nearly 60% of Masters examinees worked in either a non-direct service position or an "other" position. The combined percentage of those working in a non-direct service or other position was even greater (73%) for Bachelors examinees.

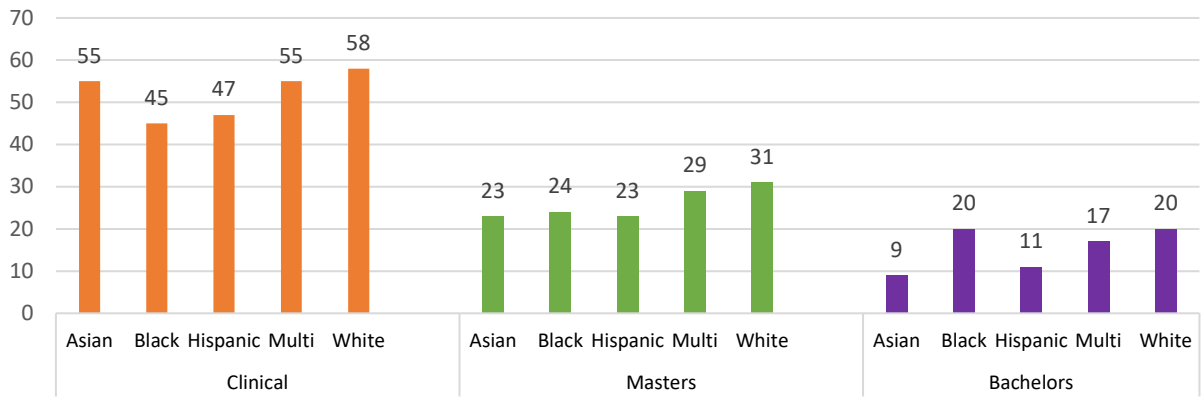
Table 6. Type of Job Position, by Exam Category, 2022

	Clinical Exam	Masters Exam	Bachelors Exam
Direct service	53.34	27.64	18.65
Non-direct service	28.14	35.66	40.36
Other[1]	5.74	24.31	32.89
Not applicable	12.79	12.39	8.11

1. Note: No information is available about the "Other" job characteristics in the exam data.

The type of job position varied by race/ethnicity across the exam categories. Chart 11 shows that lower percentages of examinees from historically marginalized groups, compared to white examinees, held a direct service job across almost all exam types. Among the Clinical examinees, for example, 45% of Black examinees and 47% of Hispanic/Latino examinees reported working in a direct service job, and these rates were significantly lower than the rate for their white counterparts (58%).

Chart 11. Percentage of Examinees with a Direct Service Position, by Race/Ethnicity and Exam Category, 2022



Exam Decision

Age at First Exam Attempt

Table 7 below shows that half of the Clinical exam-takers took their first exam by age 35. The median age for the first exam was 31 among Masters examinees and 28 among Bachelors examinees.

The mean ages of the examinees were approximately three to four years older than the median ages across the exam categories. The median–mean difference suggests that many examinees took their first exam at older ages. The mean age at which the Clinical examinees took the exam for the first time was about 38; for Masters, it was 34; and for Bachelors, it was approximately 32.

Table 7. Age at First Exam Attempt, by Exam Category, 2022

	Clinical Exam	Masters Exam	Bachelors Exam
Median	35	31	28
Mean	37.58	34.03	31.82

There was a significant racial/ethnic difference in the timing of the first exam attempt. As Charts 12 and 13 show, across the exam categories, Black examinees took their first exams at the oldest ages of all racial/ethnic groups. Half of all Black examinees took their first Clinical exam by age 38 — four years later than their white counterparts. Similarly, half of all Black examinees took their first Masters exam by age 33, four years later than their white

counterparts. For the Bachelors exam, the median age of the first exam attempt for Black examinees was 32, six years later than their white counterparts.

Chart 12. Median Age at First Exam Attempt, by Race/Ethnicity and Exam Category, 2022

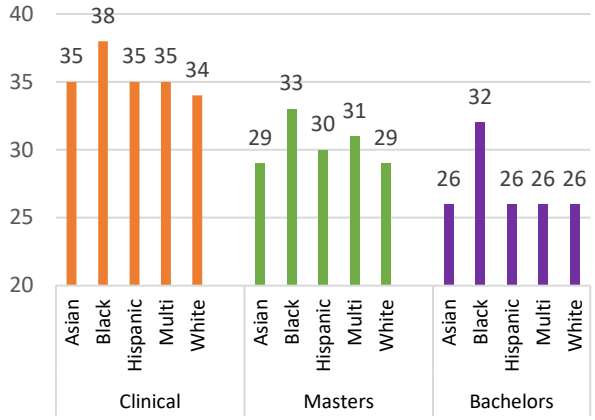
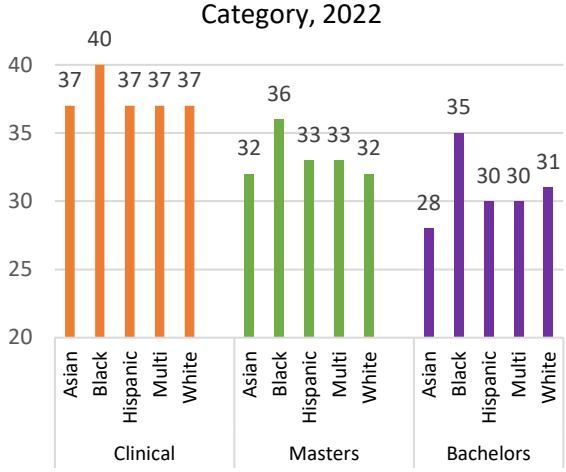


Chart 13. Mean Age at First Exam Attempt, by Race/Ethnicity and Exam Category, 2022



Number of Exam Attempts

In 2022, approximately 74% of all Clinical examinees took the exam for the first time, 11% for the second time, and 15% for the third or additional time.

Table 8 shows that a slightly lower percentage of Masters examinees were repeat examinees as compared to the Clinical examinees. The Bachelors exam had the smallest percentage of repeat examinees who attempted the exam at least three times.

Table 8. Percentage with N^{th} Exam Attempts, by Exam Category, 2022

	Clinical Exam	Masters Exam	Bachelors Exam
First attempt	73.54	77.40	82.02
Second attempt	11.42	10.71	11.71
Third or higher-order attempt	15.04	11.89	6.27

Charts 14 and 15 show the percentages of examinees who took the exam two or more times by race/ethnicity and exam category. The charts suggest that higher percentages of examinees from historically marginalized groups were repeat examinees. Black examinees represented the highest share of repeat examinees across all three exam categories, followed by Hispanic/Latino, Asian, and multiracial examinees.

Chart 14. Percentage Attempting the Exam the Second Time, by Race/Ethnicity and Exam Category, 2022

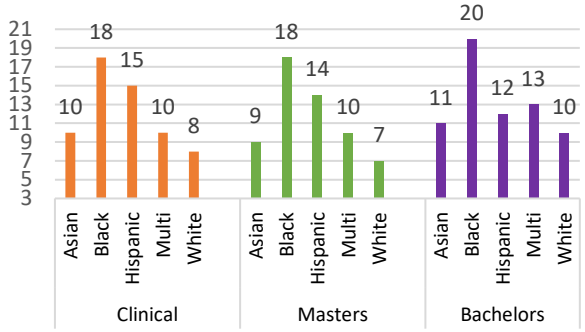
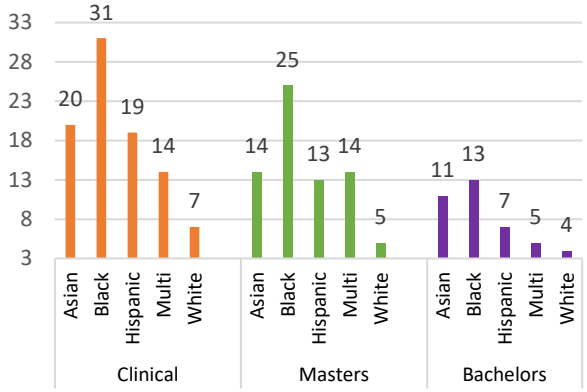


Chart 15. Percentage Attempting the Exam At Least The Third Time, by Race/Ethnicity and Exam Category, 2022



Conclusion

This report provides a national profile of U.S. social work candidates using 2022 ASWB exam data. The overall findings suggest that compared to white examinees, higher percentages of examinees from historically marginalized groups — particularly Black examinees — began their postsecondary education with an associate's degree and took longer to earn their qualifying educational degrees for the social work licensing exams. More importantly, they took significantly longer to take the exams for the first time. They also had more years of employment in non-direct service positions that may not have helped them advance their social work competence. The demographic, educational, and employment characteristics indicate that some social work candidates' journeys to the profession might have been far more disrupted and delayed than others, even before they attempted the licensing exams for the first time.

The exam data does not provide any additional variables beyond those analyzed here to offer more insight into why such significant racial/ethnic patterns in social work candidates' journey to the exams were observed. Nonetheless, these patterns may indicate the prevalence and magnitude of structural inequalities in our educational and labor market institutions that could have also affected the exam outcomes. The findings call for further and longer-term research into potential causes and solutions.

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Appendix Tables for Detailed Descriptive Statistics by Exam Category and Race/Ethnicity

Table A-1. Clinical Examinee Median and Mean Ages, by Race/Ethnicity

	All		Asian		Black		Hispanic		Multiracial		White		No response	
	Median	**Mean**	Median	Mean	Median	Mean	Median	Mean	Median	Mean	Median	Mean	Median	Mean
Age at bachelor's degree[1]	23	**26.22**	23	24.83	24	27.75	24	26.36	23	26.58	23	25.61	24	27.38
Age at MSW[2]	29	**31.72**	28	30.31	30	33.18	29	31.25	29	31.88	28	31.30	31	33.13
Age at first exam attempt[3]	35	**37.58**	35	36.85	38	39.86	35	36.89	35	37.37	34	36.87	37	39.39
Age at 2022 exam	36	**38.40**	35	37.77	39	41.61	35	37.85	36	38.14	34	37.28	38	40.60
Years of employment [4]	4	**5.56**	4	5.95	5	6.93	4	5.67	4	5.20	3	5.00	4	5.94

Note:

1. All racial means are significantly different from the mean of white examinees.
2. All racial means, except for Hispanics/Latinos', are significantly different from the mean of white examinees.
3. The means of Black and no-response groups are significantly different from the mean of white examinees.
4. All racial means, except for the multiracial group, are significantly different from the mean of white examinees.

Table A-2. Clinical Examinee Characteristics, by Race/Ethnicity (Percentage Distribution)

	All	Asian	Black	Hispanic	Multiracial	White	No response
N	25088	998	4862	3680	1117	13370	1061
%	100	3.98	19.38	14.67	4.45	53.29	4.23
1. Demographic background							
Gender							
Women	85.91	83.67	87.06	85.30	87.02	86.50	76.25
Men	12.90	15.63	12.71	14.24	11.28	12.48	13.57
Gender not listed or did not answer	1.19	0.70	0.23	0.46	1.70	1.02	10.18
Age							
18-29	18.76	17.33	10.47	15.35	18.44	23.64	8.86
30-39	44.36	47.80	39.90	50.41	45.03	43.87	45.99
40-49	20.78	23.45	25.17	21.22	22.02	18.47	24.41
50 +	16.10	11.42	24.45	13.02	14.5	14.02	20.74
Use of English as a second language	9.11	34.07	5.33	34.57	8.33	1.74	8.39
ESL[1] accommodation	1.47	4.11	1.97	4.67	1.79	0.18	1.51
ADA[2] accommodation	4.21	3.51	6.07	4.70	4.92	3.19	6.79
Region of residence							
New England	7.90	4.91	4.28	5.35	5.46	10.42	7.07
Middle Atlantic	13.92	14.73	11.02	12.55	11.46	15.29	16.40
East North Central	17.35	9.02	17.19	8.45	14.59	20.85	15.55
West North Central	5.22	4.11	2.12	1.68	5.19	7.61	2.64
South Atlantic	19.01	9.52	36.96	14.76	15.58	14.22	24.32
East South Central	3.81	0.40	5.61	0.46	1.52	4.59	2.83
West South Central	7.55	5.21	9.79	8.59	7.52	6.70	6.69
Mountain	7.36	5.11	2.16	8.59	10.56	8.96	5.56
Pacific	17.89	46.99	10.86	39.57	28.11	11.36	18.94
2. Educational background							
Educational degree history							
Began PSE[3] with an associate's degree	26.48	22.95	30.15	36.79	30.98	21.75	32.14
BSW	37.93	32.26	44.59	36.60	33.12	36.93	34.97
Have a PhD	1.37	1.2	3.15	1.06	1.25	0.79	1.79
3. Employment background							
Years of employment							
0-1	10.88	10.92	12.46	10.71	9.85	10.43	11.03

2-3	34.34	30.36	20.07	29.78	36.08	41.42	28.18
4-5	23.17	24.75	21.68	25.87	24.17	22.75	23.28
6-9	16.37	16.43	21.31	18.45	17.1	13.64	20.17
10 or more	15.24	17.54	24.48	15.19	12.8	11.77	17.34
Job position							
Direct service	53.34	55.41	44.73	47.28	54.88	58.48	45.33
Non-direct service	28.14	29.36	31.47	35.52	27.93	24.31	34.68
Other	5.74	3.71	5.64	5.60	5.37	5.75	8.77
Not applicable	12.79	11.52	18.16	11.60	11.82	11.46	11.22
4. Exam decision							
Number of attempts							
First	73.54	69.64	51.58	66.60	75.29	84.61	60.60
Second	11.42	10.42	17.63	14.70	10.47	8.21	13.95
Third or higher	15.04	19.94	30.79	18.70	14.23	7.18	25.45

Note:

1. ESL: English as a second language
2. ADA: Americans with Disability Act
3. PSE: Post-secondary education

Table A-3. Masters Examinee Median and Mean Ages, by Race/Ethnicity

	All		Asian		Black		Hispanic		Multiracial		White		No response	
	Median	**Mean**	Median	Mean	Median	Mean	Median	Mean	Median	Mean	Median	Mean	Median	Mean
Age at bachelor's degree[1]	23	**26.23**	23	24.72	24	28.17	24	26.52	23	26.59	23	25.23	24	27.71
Age at MSW[2]	29	**31.96**	27	30.24	31	33.98	29	31.33	29	32.03	28	31.13	32	34.37
Age at first exam attempt[3]	30	**33.32**	29	31.93	33	35.81	30	32.54	31	33.49	29	32.28	34	35.73
Age at 2022 exam	31	**34.03**	30	32.65	35	37.33	31	33.29	31	34.11	29	32.57	35	36.98
Years of employment [4]	0	**1.65**	0	1.48	1	2.73	1	1.66	0	1.70	0	1.12	1	2.06

Note:

1. All means are significantly different from the mean of white examinees.
2. The means of Black, Asian, multiracial, and no-response groups are significantly different from the mean of white examinees.
3. The means of Black, multiracial, and no-response groups are significantly different from the mean of white examinees.
4. All means are significantly different from the mean of white examinees.

Table A-4. Masters Examinee Characteristics, by Race/Ethnicity (Percentage Distribution)

	All	Asian	Black	Hispanic	Multiracial	White	No response
N	26550	905	6359	3477	1157	13731	921
%	100	3.41	23.95	13.1	4.36	51.72	3.47
1. Demographic background							
Gender							
Women	86.19	82.43	87.92	86.89	84.44	86.33	75.46
Men	12.51	16.02	11.78	12.45	12.79	12.50	14.12
Gender not listed or did not answer	1.30	1.55	0.30	0.66	2.77	1.17	10.42
Age							
18-29	43.03	48.4	28.2	43.37	41.75	50.64	27.04
30-39	32.19	30.83	35.63	35.29	33.88	29.45	36.81
40-49	15.54	14.81	20.85	14.64	15.82	12.79	23.56
50 +	9.24	5.97	15.32	6.7	8.56	7.12	12.6
Use of English as a second language	7.28	32.71	4.99	28.19	6.22	1.30	9.55
ESL[1] accommodation	0.99	3.31	1.02	3.77	1.21	0.09	1.3
ADA[2] accommodation	3.03	3.65	3.52	3.05	3.54	2.62	4.45
Region of residence							
New England	8.86	7.30	4.97	7.48	8.21	11.14	9.34
Middle Atlantic	30.70	40.15	29.05	36.93	29.65	28.77	39.52
East North Central	8.64	6.75	6.13	3.45	6.48	11.67	4.89
West North Central	8.18	7.52	3.16	3.91	9.68	11.75	4.45
South Atlantic	11.72	7.63	22.27	4.43	8.30	9.15	12.92
East South Central	7.68	1.88	12.02	1.64	4.49	7.89	7.06
West South Central	15.37	14.38	19.27	27.55	18.84	10.36	13.79
Mountain	8.11	7.63	2.85	13.86	12.36	8.85	6.84
Pacific	0.74	6.75	0.28	0.75	1.99	0.42	1.19
2. Educational background							
Educational degree history							
Began PSE[3] with an associate's degree	26.50	21.99	30.10	35.98	29.90	21.97	33.66
BSW	40.14	29.17	44.5	44.06	37.08	38.31	36.92
Have a PhD	0.79	2.10	1.27	0.37	0.52	0.61	0.87
3. Employment background							
Years of employment							

0-1	75.66	77.68	61.52	73.22	77.61	82.94	69.49
2-3	10.52	10.39	14.48	12.45	9.16	8.21	12.05
4-5	4.94	4.75	7.72	6.04	4.24	3.34	6.41
6-9	4.45	3.09	8.05	4.23	3.37	2.88	6.51
10 or longer	4.44	4.09	8.22	4.06	5.62	2.64	5.54
Job position							
Direct service	27.64	23.43	23.57	22.72	28.69	31.20	24.00
Non-direct service	35.66	36.02	40.67	41.67	34.31	31.72	38.55
Other	24.31	29.61	17.72	22.26	23.68	27.59	24.10
Not applicable	12.39	10.94	18.04	13.34	13.31	9.49	13.36
4. Exam decision							
Number of attempts							
First	77.40	77.24	57.05	72.88	80.64	88.66	63.30
Second	10.71	8.95	17.96	13.72	10.20	6.50	14.33
Third or higher	11.89	13.81	24.99	13.40	9.16	4.84	22.37

Note:

1. ESL: English as a second language
2. ADA: Americans with Disability Act
3. PSE: Post-secondary education

Table A-5. Bachelors Examinee Median and Mean Ages, by Race/Ethnicity

	All		Asian		Black		Hispanic		Multiracial		White		No Response	
	Median	**Mean**	Median	Mean	Median	Mean	Median	Mean	Median	Mean	Median	Mean	Median	Mean
Age at bachelor's degrees[1]	24	**28.02**	23	26.45	27	31.21	24	27.22	24	27.53	23	27.35	29.5	31.59
Age at first exam attempt[2]	27	**31.26**	26	28.17	32	35.12	26	29.97	26	30.00	26	30.57	33.5	35.39
Age at 2022 exam	28	**31.82**	26	28.62	33	36.38	27	30.50	27	30.55	27	30.96	35	36.31
Years of employment [3]	0	**1.99**	0	1.55	1	3.05	0	1.73	0	1.46	0	1.81	1	2.06

Note:

1. The means of Black and no-response groups are significantly different from the mean of white examinees.
2. The means of Black and no-response groups are significantly different from the mean of white examinees.
3. The mean of Black examinees is significantly different from that of white examinees.

Table A-6. Bachelors Examinee Characteristics, by Race/Ethnicity (Percentage Distribution)

	All	Asian	Black	Hispanic	Multiracial	White	No response
N	3588	66	573	361	128	2394	64
%	100	1.84	15.98	10.07	3.57	66.72	1.78
1. Demographic background							
Gender							
Women	89.91	90.91	87.26	88.37	88.37	91.06	81.54
Men	9.50	9.09	12.57	11.63	11.63	8.31	10.77
Gender not listed or did not answer	0.59	0	0.17	0	0	0.63	7.69
Age							
18-29	56.58	65.15	35.60	61.22	60.47	61.24	27.69
30-39	21.79	25.76	29.49	21.88	23.26	19.17	43.08
40-49	11.96	7.58	16.40	10.80	10.08	11.15	16.92
50 +	9.67	1.52	18.50	6.09	6.20	8.44	12.31
Use of English as a second language	6.02	39.39	9.42	28.53	6.98	0.84	6.15
ESL[1] accommodation	1.00	4.55	2.27	4.16	0	0.21	0
ADA[2] accommodation	2.12	1.52	1.75	1.66	3.1	2.13	6.15
Region of residence							
New England	7.36	4.55	6.64	4.99	5.43	8.02	9.23
Middle Atlantic	0.53	1.52	0.35	0.00	1.55	0.58	0.00
East North Central	37.52	18.18	36.71	14.13	41.09	41.60	36.92
West North Central	17.54	40.91	9.62	10.25	22.48	19.88	7.69
South Atlantic	5.66	3.03	8.39	2.22	3.10	5.64	9.23
East South Central	8.14	4.55	18.18	0.83	6.20	6.93	12.31
West South Central	12.21	7.58	16.08	44.04	13.18	6.56	12.31
Mountain	10.90	18.18	4.02	23.55	6.98	10.65	10.77
Pacific	0.14	1.52	0.00	0.00	0.00	0.13	1.54
2. Educational background							
Educational degree history							
Began PSE[3] with an associate's degree	32.13	25.76	37.17	34.9	39.53	30.24	33.85
BSW	94.93	1.52	1.75	3.32	4.65	6.18	7.69
3. Employment background							
Years of employment							
0-1	73.38	77.27	64.57	78.95	73.64	74.73	66.15
2-3	9.67	7.58	10.3	6.93	12.4	9.86	9.23

4-5	5.96	4.55	8.2	5.54	5.43	5.43	10.77
6-9	5.07	4.55	7.16	2.77	3.88	4.93	7.69
10 or longer	5.91	6.06	9.77	5.82	4.65	5.05	6.15
Job position							
Direct service	18.65	9.09	19.55	10.53	17.05	19.97	20.00
Non-direct service	40.36	53.03	43.28	46.81	31.78	38.76	41.54
Other	32.89	27.27	25.13	32.41	41.86	34.50	32.31
Not applicable	8.11	10.61	12.04	10.25	9.30	6.77	6.15
4. Exam Decision							
Number of attempts							
First	82.02	78.79	67.54	81.72	81.40	85.84	75.38
Second	11.71	10.61	19.55	11.63	13.18	9.86	9.23
Third or higher	6.27	10.61	12.91	6.65	5.43	4.30	15.38

Note:

1. ESL: English as a second language
2. ADA: Americans with Disability Act
3. PSE: Post-secondary education

The Determinants of Licensing Exam Outcomes:

The Compounding Effects of Individual, Institutional, and Community Factors

Prepared for
Association of Social Work Boards (ASWB)

Exam Report No. 2

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Contents

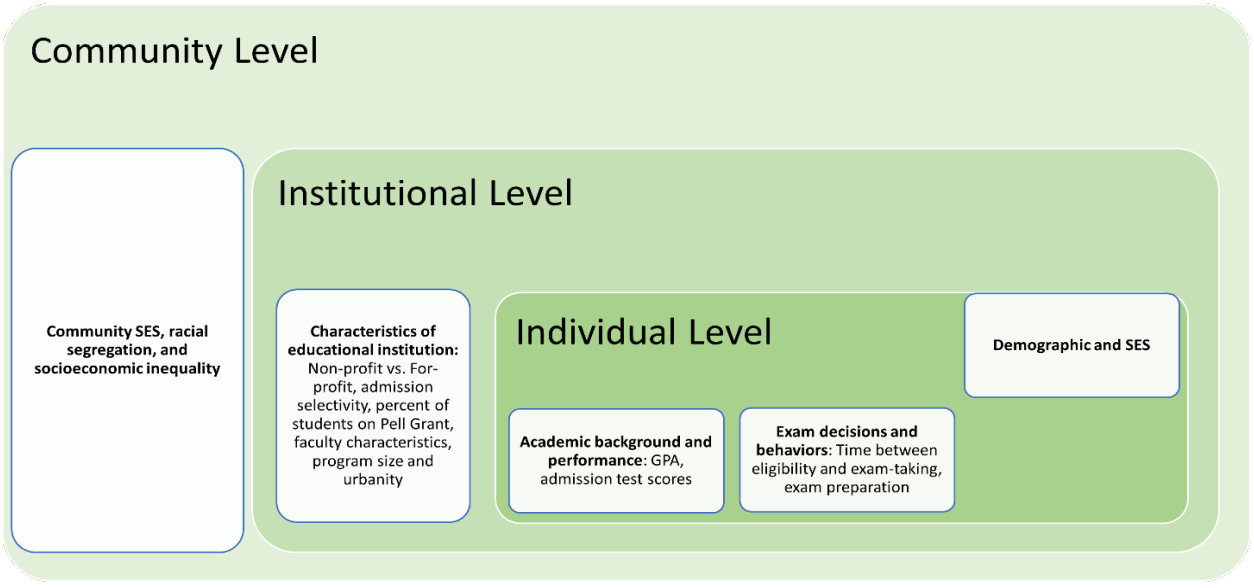
Executive Summary

The *2022 ASWB Exam Pass Rate Analysis* showed demographic disparities in exam pass rates by race/ethnicity, age, and primary language (ASWB, 2022). However, it did not provide insight into *why* pass rates varied significantly by demographic groups. The social science literature consistently documents significant racial/ethnic disparities in licensing exam pass rates across numerous professions. This report, the second in the Exam Report Series, intends to provide an overview of research findings from the literature of other professions to understand the factors that may contribute to the disparate pass rates in social work. Some of the takeaways of this review include the following:

- ✓ Licensing exam outcomes are affected by individual, institutional, and community factors that are associated with examinees' socioeconomic background.
  - **Individual factors:** Examinees who are younger, have a high GPA and high scores on admission tests, do not delay in taking the exam once eligible, and can study sufficient hours are more likely to pass a licensing exam.
  - **Institutional factors:** Examinees who attended institutions with selective admission, strong faculty, and a well-resourced large program are more likely to succeed on a licensing exam.
  - **Community factors:** Examinees who live in a more integrated and socioeconomically equal community are more likely to pass a licensing exam.
- ✓ Historically marginalized groups are more likely to experience negative effects from these contributing factors. However, when these multiple negative effects are taken into consideration, the effect of race/ethnicity on licensing exam outcomes is diminished.

Figure E-1 depicts the three levels of determinants of licensing exam outcomes from a person-in-environment perspective.

Figure E-1. Factors that Affect Licensing Exam Outcomes



Background and Purpose

Many professions certify workers with adequate knowledge, skills, and ethics so that consumers can distinguish those who are qualified to practice their profession competently and ethically from those who may not be. Most certifications are done by assessing the professional candidates' competencies, typically in standardized exams, along with other methods of assessment, including supervised practice or clinical assessments. Many professions, such as teaching, law, medicine, nursing, accounting, and psychology, certify their professionals using standardized exams, usually developed by analyzing incumbent practitioners' practices. **Passing a certification exam is one of the most critical steps for professional candidates to obtain a license.** While the purpose of such exams is clear from a consumer's perspective, the exams have been questioned for professional candidates in part because members of some demographic groups (e.g., those from historically marginalized groups, older individuals, and those who use English as a second language) pass the exams at lower rates than others.

Table 1 summarizes racial and other demographic disparities in first-attempt certification/licensing exam outcomes documented in *national studies or reports* for selected licensed professions in the United States. As the table shows, numerous professions report demographic disparities — especially racial/ethnic disparities — in exam outcomes. The social work profession is one of many professions with demographically disparate exam pass rates. The Association of Social Work Boards (2022) reported that between 2018 and 2021, the first-time pass rate for the Clinical social work licensing exam was 84% for white examinees. On the other hand, Black examinees had a pass rate of 45%, Hispanic/Latino examinees had a pass rate of 65%, and Asian examinees had a pass rate of 72%.

There have been debates at national and state levels following the report's publication about the use of ASWB exams for licensing and its impacts on social workers with historically marginalized backgrounds. **However, there have been limited efforts to identify the reasons behind the unequal exam outcomes. In the next section, as part of this second report in the Exam Report Series, we will make such an effort by reviewing the exam pass rates of other regulated professions**. We will specifically focus on professions that provide national pass rates by race/ethnicity, either in published works or on official licensing/professional agencies' websites.

We then provide a review of what those professions found as the potential determinants of disparate exam outcomes. To the extent possible, our review focuses on studies that tested theoretical hypotheses and generated original empirical evidence based on inferential statistical analyses of large national samples. We also focus on studies that examined examinees' outcomes rather than school-level outcomes on licensing exams. Our review excludes univariate analyses of pass rates, review articles, or commentaries that did not offer original empirical evidence on potential determinants. Also note that throughout this report, the word *significant* is used when it refers to statistical significance. Similarly, the word *affect* is used when a factor is found to be significantly related to licensing exam outcomes in a

multivariate analysis whose findings are generalizable to the population of a particular licensed profession.

Other Professions' Licensing Exam Pass Rates

In the 10 professional certification exams we reviewed, including social work's ASWB exams, for which pass rates were available by demographic groups, there were consistently significant racial/ethnic disparities in exam pass rates. Examinees from historically marginalized groups, especially Black examinees, had significantly lower pass rates than white examinees.

We have reviewed the racial disparities in licensing exam pass rates for 10 licensed professions, including social work. The pass rates for these professions are detailed in Table 1 below. In this section, we discuss these professions' pass rates in detail to provide context for the extent of the disparities in social work's ASWB exams.

First, the **Architect Registration Examination (ARE 5.0)** is a six-division exam for architectural licensure required by all state licensing boards in the country. The National Council of Architectural Registration Boards (NCARB) develops the examination. ARE 5.0 uses five question types, including multiple-choice, check-all-that-apply, and quantitative-fill-in-the-blank questions. According to the 2021 NCARB report, ARE 5.0 exam pass rates demonstrated substantial racial/ethnic disparities. Black examinees' pass rates were consistently the lowest in all six divisions of the exam compared to other racial/ethnic groups, as shown in Table 1 with men's scores. For example, for the first division of the exam, Practice Management, the pass rate was 73% for white examinees, 35% for Black examinees, 51% for Hispanic/Latino examinees, and 52% for Asian examinees. Although not shown in Table 1, men were also reported to have higher pass rates in all exam divisions than women. However, for Black examinees, women had higher pass rates than their male counterparts in four exam divisions (NCARB, 2022).

Second, to be a nationally **certified school psychologist (NCSP),** an individual must meet the National Association of School Psychologists (NASP) credentialing standards, part of which is to take and pass the Praxis School Psychologist Exam #5403 (previously #5402). Significant differences were reported in the Praxis #5402 and Praxis #5403 pass rates by race/ethnicity (Affrunti & Rossen, 2023). As shown in Table 1, examinees from historically marginalized groups consistently had lower pass rates than white examinees. For example, compare the pass rate for white examinees (96%) to that of Black examinees (76%) for Praxis Exam #5402.

Third, the **Uniform Certified Public Accountant (CPA) exam** is a four-section certification exam with multiple-choice questions and task-based simulations developed by the American

Institute of CPAs (AICPA). The National Association of State Boards of Accountancy (NASBA) acts as a clearinghouse to which all state Boards of Accountancy submit their CPA candidates' information. The AICPA Examination Review Board is charged with ensuring that the exam items measure what they intend to measure in a consistent way (i.e., the validity and reliability of the exam). NASBA published *Candidate Performance on the Uniform CPA Examination,* a report on the official exam analysis results, until 2019 when a new exam version was introduced. The report provided annual pass rates by jurisdiction, university, and examinee age. According to the report, younger students outperform older examinees. However, the report does not publish pass rates by race/ethnicity (NASBA, 2019, 2024). Nevertheless, a team of researchers led by Espahbodi (2023) studied the national CPA exam pass rates by race/ethnicity and gender using 2005–2016 NASBA data. Their descriptive findings demonstrate a significant racial disparity in the overall pass rate: 47.71% for white candidates, 20.25% for Black candidates, and 31.90% for Hispanic/Latino candidates. In addition, they found a gender disparity in pass rates, with 47.49% of men passing the exam compared to 41.31% of women.

Fourth, the **Uniform Bar Examination (UBE)** is a standardized bar exam developed by the National Conference of Bar Examiners (NCBE). The UBE consists of three parts: (1) The Multistate Bar Examination (MBE), weighted 50%, is made up of 200 multiple-choice questions used by almost all states to determine competence to practice law. (2) The Multistate Essay Examination (MEE), weighted 30%, is used to determine effective communication in writing. (3) The Multistate Performance Test (MPT), weighted 20%, is designed to assess examinees' ability to solve a fictional client's problem. Because each jurisdiction sets its passing score, the NCBE publishes the average exam scores, score distributions, and overall pass rates by jurisdiction (NCBE, 2024). The bar pass rates by race/ethnicity are collected by the American Bar Association (ABA) from law school reports. According to the most recent ABA report, the first-time bar exam pass rate was 83% for white examinees, 57% for Black examinees, 69% for Hispanic/Latino examinees, and 75% for Asian examinees (ABA, 2023). Consistent with other professions, there were significant disparities in bar pass rates by race/ethnicity.

Fifth, elementary teacher candidates are certified with the **Praxis Elementary Education: Multiple Subjects** to enter the teaching profession. Eighteen states require the Praxis test, which is optional in five other states, making it the most widely used test of the 23 elementary content tests on the market (National Council on Teacher Quality [NCTQ], 2019). Teacher candidates must separately pass four content area subjects — reading/language arts, mathematics, science, and social studies — to pass the certification. The composite pass rates varied considerably by race/ethnicity. While 75% of white candidates passed the tests, only 38% of Black candidates and 57% of Hispanic/Latino candidates passed them (NCTQ, 2019). To explain the low pass rates and pass rate disparities, the NCTQ report pointed out that the nation's 817 elementary teacher preparation programs did not adequately cover the subject content identified in the licensing tests.

Sixth**,** racial/ethnic disparities in licensing exam pass rates were also documented in the psychology and pharmacy professional exams, but with a small sample of one state or an individual school. The **Examination for Professional Practice in Psychology (EPPP)** is a licensure

requirement across 62 psychology boards. Sharpless (2021) obtained the data from the Connecticut State Board of Examiners of Psychologists and found that the failure rates differed by race/ethnicity. White candidates' failure rate was 5.75%, but Black and Hispanic/Latino candidates' failure rates were 23.33% and 18.60%, respectively. Moreover, PsyDs failed at a higher rate than PhDs (14.56% vs. 5.16%). Chisholm-Burns et al. (2017) reported that on the **North American Pharmacist Licensure Examination (NAPLEX),** white candidates scored consistently higher than Black candidates in Tennessee (Out of a possible score of 150, white candidates scored an average of 107 versus 93.4 for Black candidates.) The authors concluded that the NAPLEX total scaled score was significantly correlated with race/ethnicity.

Table 1. Racial Disparities in Licensing Exam Pass Rates (%) by Professional Exam

Exam		Source	Note	Asian	Black	Hispanic /Latino	White
1	Social Work	Association of Social Work Boards (2022)	Clinical[1]	72	45	65	84
			Masters[1]	71	45	63	86
			Bachelors[1]	60	33	53	76
2	Architect Registration Examination (ARE) 5.0	National Council of Architectural Registration Boards (NCARB) (2022)	Men's scores in six exam divisions	52	35	51	73
				49	30	39	59
				43	26	39	66
				53	26	42	69
				55	43	56	71
				45	20	36	59
3	Praxis School Psychologist Exam	Affrunti & Rossen (2023)	Praxis 5402	94-97[2]	76	80-81[2]	96
			Praxis 5403	86-96	84	82-89	98
4	Certified Public Accountant (CPA) Exam	Espahbodi et al. (2023)	Overall pass of all four sections between 2005 and 2016	Not available	20	32	48
5	Uniform Bar Exam (UBE)	American Bar Association (2023)	Summary bar pass rate	75	57	69	83
6	Praxis Elementary Education: Multiple Subjects	National Council on Teacher Quality (2019)	Composite pass rates for all four subjects	Not available	38	57	75
7	Examination for Professional Practice in Psychology (EPPP)	Sharpless (2021)	One state study (Connecticut)	97	77	81	94
8	American Board of Surgery (ABS)	Yeo et al. (2020)	Qualifying Exam (written exam)	White trainees who took the exam were nearly twice as likely to pass on the first try compared with trainees from historically marginalized groups.			

	Exam		Certifying Exam (oral exam)	Hispanic trainees were almost five times more likely not to attempt the exam compared with non-Hispanic trainees.
				Hispanic trainees were more than two times less likely to pass it on the first try.
				Single women examinees were more than 10 times more likely to pass the exam on the first try than married women with children.
9	United States Medical Licensing Examination (USMLE)	Rubright et al. (2019)	Step 1 score	Black examinees scored lower than white examinees by 16.52. Hispanic examinees scored lower than white examinees by 12.10.
			Step 2 score	Black examinees scored lower than white examinees by 15.97. Hispanic examinees scored lower than white examinees by 10.55.
			Step 3 score	Black examinees scored lower than white examinees by 15.94. Hispanic examinees scored lower than white examinees by 9.18.
10	National Physical Therapy Exam (NPTE)	Federation of State Boards of Physical Therapy (2023)	Domestic vs. Foreign graduates	Graduates of the U.S. program passed at 84%. Graduates of foreign programs passed at 40%.

1. The rates were first-time pass rates for 2018–2021.
2. Multiple Hispanic and Asian groups were reported in Affrunti & Rossen (2023).

Last, although national pass rates by race/ethnicity are not made available for the **American Board of Surgery Exam**, the **U.S. Medical Licensure Exam**, and the **National Physical Therapy Exam** by their respective professional organizations, empirical studies on those exams revealed demographically disparate exam outcomes. The bottom rows of Table 1 summarize that white examinees were more likely than examinees from historically marginalized groups to pass both qualifying and certifying exams of the American Board of Surgery (Yeo et al., 2020). Similarly, Rubright et al. (2019) reported that examinees from historically marginalized groups and those who use English as a second language scored lower on all components of the United States Medical Licensing Examination than white students and those who use English as a primary language, respectively (Rubright et al., 2019). Additionally, for the National Physical Therapy Exam, graduates of the U.S. programs were reported to pass the exam at 84%, a significantly higher rate than the pass rate of 40% for the graduates of foreign programs (Federation of State Boards of Physical Therapy, 2023).

Determinants of Licensing Exam Outcomes

The literature suggests that many professions, especially law (e.g., Devito et al., 2022), medicine (Rubright et al., 2019), teaching (Nettles et al., 2011), and accounting (Espahbodi et al., 2023), have experienced racially disparate licensing exam pass rates for decades. Researchers of those professions have amassed rigorous empirical evidence to understand why such significant disparities exist across demographic groups, particularly by race/ethnicity.

Researchers of the law and medical surgery professions have accumulated evidence from national longitudinal studies (e.g., Yeo et al., 2020; Wightman, 1998). Espahbodi and colleagues (2023) offer a comprehensive investigation of the accounting profession by merging exam data with measures of socioeconomic inequalities at the institutional and community levels. A close look at the evidence suggests that the factors that affect licensing exam pass rates can be organized into three categories: (1) individual factors, (2) institutional factors, and (3) community factors.

Individual factors include examinees' sociodemographic characteristics, such as age, race/ethnicity, and gender, as well as academic background and performance, particularly performance on admission tests and GPA. Individual factors also include exam decisions (when to take the exam once eligible) and preparation (e.g., time and resources devoted to studying for the exam) that are related to examinees' socioeconomic class. **Institutional factors** refer to the characteristics of educational institutions that examinees attend to acquire profession-specific education and training. Those factors include the type of institutions, institutions' admission selectivity, faculty qualification, and the characteristics of student bodies. **Community factors** refer to the opportunities and disadvantages in socioeconomically integrated or segregated neighborhoods where examinees grew up and lived. Altogether, the evidence suggests that **licensing exam disparities are influenced by these three factors, which are shaped by broad socioeconomic inequalities.**

The next section provides a detailed overview of each of the three factors. Once again, the discussion focuses on original empirical evidence based on inferential analyses of national data rather than simple descriptive analyses and analyses of one-school or one-state samples. (School or program-level studies are noted in the discussions.)

Individual Factors

Individual examinees' sociodemographic characteristics, admission test scores, GPAs, decisions about when to take the exam, and amount of exam preparation are important determinants of exam outcomes.

Sociodemographic Characteristics

Many licensed professions report that licensing exam outcomes are significantly affected by **examinees' age**. In an analysis of the Uniform Certified Public Accountant (CPA) Examination, Trinkle et al. (2016) found that younger examinees were more likely to succeed on the exam than older examinees. As examinees' age increased by one year, the probability of passing each section of the exam declined by 1.3% to 2.2%. Espahbodi et al. (2023) found that older CPA exam candidates are less likely to pass the four sections of the exam and more likely to drop

after the first attempt or the first section taken. They posited that the negative age effect is in part related to increased work-life responsibilities that burden many nontraditional or older students. Other researchers who examined CPA exam success also found a negative effect of examinee age on exam outcome (Bline et al., 2016; Mittestaedt & Morris, 2017; Trinkle et al., 2016). For the certified registered nurse anesthetist exam, Hoversten (2011) found that age predicted passing scores most reliably; younger students were more likely to pass than older students. Nguyen et al. (2021) reported that delaying the American Board of Surgery certification exam beyond one year after medical residency graduation significantly reduced the first-time pass rate. Similarly, Nayer and Grover Takahashi (2017) examined physiotherapists' pass rates in Ontario, Canada, by combining practitioners' data, Physiotherapy Competence Examination (PCE) data, and noncompliance disciplinary data. They found that older candidates achieved lower scores and lower pass rates on both the written and clinical components of the PCE than younger candidates.

Besides age, **race/ethnicity and gender** were found to be significantly related to licensing exam outcomes even after holding the effects of other factors constant. According to Nettles et al. (2011), for Praxis I and II exams for elementary school teachers, Black candidates had lower exam scores even after controlling for examinees' educational attainment, their parents' educational attainment, undergraduate major, and selectivity of attending institution.

Yeo et al. (2020) examined the association between **race/ethnicity** and the American Surgery Board certification process, which is comprised of qualifying and certifying exams. They found that Black examinees were less likely to pass the exams. The negative relationship was more robust in the passage of the certifying examination, an in-person oral examination of case-based scenarios, compared with the multiple-choice qualifying examination. Some experts in the profession suggest that the administration and grading of the in-person certifying exam may be susceptible to implicit bias, as it is impossible to prevent examiners from forming a perception of examinees' races. However, research by Ong et al. (2019) disputed the suspicion about the grading bias and concluded that the exam pass was not influenced by the gender of examinees or examiners. Rubright et al. (2019), who examined U.S. Medical Licensing Examination outcomes, also found that the effect of race was significant for each licensure step. However, the racial effect was reduced when examinees' academic performance (undergraduate GPA and college admission test scores) was factored into the analyses. This is an essential piece of evidence worth noting, as it is consistent with the findings supported by Wightman (1998) discussed below.

Evidence suggests that many other sociodemographic characteristics also affect licensing exam outcomes. Trinkle et al. (2016) conducted a survival analysis of CPA exam data between 2005 and 2013 that included nearly 260,000 unique examinees. They found a significant effect of **gender** on the exam outcome. Male examinees were more likely to pass three of four individual exam sections and 7% more likely to pass the entire exam than female examinees. Yeo et al. (2020) provide evidence from a rigorous longitudinal study about the relationship between demographic variables and licensing exam outcomes. They followed up with a 2007–8 national sample of U.S. general surgery interns for 10 years until the end of 2017 to understand

how sociodemographic background and medical school experiences affected the American Surgery Board (ASB) certification exam pass rates. It was the first study using longitudinal data from a national sample of general surgery trainees (N=1,048). They found that being Hispanic/Latino and having children were related to failing the certification exam and that white examinees, compared to those from historically marginalized backgrounds, were more likely to pass the exam. They observed that gender and marital status at the time of internship also had a significant association with whether an examinee passed the exams. Those who were married with children were more likely to fail either examination than their married but childless and single counterparts. Single women without children were 10 times more likely than those with children to pass the exams on their first attempt.

Academic Background and Performance

There appears to be a consensus among researchers in multiple professions and large-scale (some longitudinal) empirical studies that licensing exam outcomes are most affected by examinees' **academic performance, as measured by admission test scores and GPAs**. Multiple studies have found that examinees' academic performance was the most critical determinant of exam outcomes.

To explain racial disparities in Praxis I exams, Nettles et al. (2011) studied undergraduate GPA, candidates' educational attainment, socioeconomic status, and enrollment status in a teacher education program. The authors found a positive correlation between higher GPAs and increased mean Praxis I scores. Interestingly, however, they also observed that as GPAs increased, so did the gaps in scores between white and Black candidates. In a study of 45,154 U.S. Medical Licensing Examination (USMLE) examinees from 172 medical schools, Rubright et al. (2019) examined racial differences in exam outcomes while controlling for examinees' academic performance and backgrounds. According to their analysis, the difference between white and Black examinees in the USMLE Step 1 exam score was 16.52. However, the difference was reduced to 5.10 after they controlled for GPA and scores in the medical school entrance exam (MCAT) in the statistical analyses. Individuals with above-average GPA, composite MCAT, and Step 1 scores were predicted to have higher USMLE Step 1 exam scores. However, examinees with above-average age were predicted to perform poorly on the USMLE. The most important finding from this study is that adding the GPA and MCAT scores to the analyses reduced performance differences for Asian, Black, Hispanic/Latino examinees, as well as examinees who use English as a second language. For example, whereas Black test-takers scored 16 points lower on average than white test-takers across all Step examinations, the difference in scores was reduced to four or five points when GPA and MCAT scores were included in the analyses. This suggests that academic performance explains much of the demographic differences in licensing exam scores. According to their findings, although racial disparities in the exam scores appear large, the disparities reflect the lower mean MCAT scores and GPAs of underrepresented minority students (Rubright et al., 2019).

Wightman (1998) conducted one of the most comprehensive national longitudinal analyses of bar pass outcomes using data collected by the Law School Admission Council.

According to the author, the study was conceived in response to critics of affirmative action at historically white law schools during the 1980s who argued that the special admission programs for students from historically marginalized groups should be eliminated because the majority of those students could not pass the bar exam. The study collected multiple data points including (1) demographic and personal information of more than 23,000 bar examinees from their law school cohorts from the fall of 1991 for five years, (2) information on examinees' academic performance and school characteristics from their law schools, and (3) examinees' bar exam outcomes from the boards of bar examiners. The author reported that the eventual bar pass rate was lowest for Black examinees (77.6%) and highest for white examinees (96.7%), but that nearly 78% of Black law graduates eventually passed the bar, successfully refuting the affirmative action critics' claim about the function of the special admission programs. As for the factors that contributed to the racial disparities in bar pass rates, Wightman's analyses found that the **strongest predictors of bar exam pass for all examinees were (adjusted) law school GPAs and LSAT scores**.

Unfortunately, Black law school students had lower average law school GPAs and LSAT scores than their white counterparts. Wightman (1998) demonstrated that when the regression analyses included **law school GPAs and LSAT scores**, many other factors that were expected to be important to bar exam passage (undergraduate GPAs, selectivity of undergraduate school, language spoken at home, employment during undergraduate studies, and financial responsibility for others during law school) were *not* significantly related to the bar exam outcome. Still, the author found age to be a significant factor in bar pass for historically marginalized groups.

Wightman (1998) also noted that the regression analyses did not fully account for racial/ethnic disparities in bar exam passage. To improve the explanatory power of the regression model, the author developed an SES index to measure family income when the examinees were in high school, as well as the education and occupations of the examinees' parents. However, when the SES index was added to the regression analyses, the unique contribution of examinees' SES to bar exam outcome was found to be minimal. The author concluded that "whatever toll SES might play in education achievement may have already taken its toll" *before* the licensing exam (p. 41).

Klein and Bolus (1997) and Ripkey and Case (2007) also examined the correlation between bar pass outcomes and law students' academic performance, such as LSAT scores and GPA. The researchers found that examinees' academic performance *before* they entered law school already demonstrated racial and ethnic disparities. They stated that racial disparities in bar pass rates for all components of the exam (including the MBE, essays, performance tests, and total scores) mirror racial disparities in LSAT scores. In a school-level analysis of the Uniform Bar Exam pass rate, Devito et al. (2022) controlled for median LSAT scores and the proportion of Black students taking the exam, so that the contribution of each factor to the bar pass rate was observable. They found that while a one-point increase in median LSAT score was associated with as much as a 9.5 percentage point increase in the bar pass rate, a 1 percentage point

increase in the proportion of students who are Black was associated with only a 1.06 percentage point decrease in bar passage rates after controlling for median LSAT score.

Other smaller studies, which used samples from an individual graduate program or state, present similar findings about the importance of academic performance for licensing exam outcomes. Kane et al. (2007) conducted a multivariate analysis of New York bar exam outcomes. They reported that undergraduate GPA and LSAT exam scores, in addition to law school GPAs, explained about 56% of the variance in the bar exam scores. The analyses by Khan-Farooqui (2020) and Novalis et al. (2017) of the National Board of Certification in Occupational Therapy (NBCOT) exam showed that examinees' GPA in the occupational therapy program and pre-admission recommendation letters successfully predicted first-time NBCOT exam pass. This finding was echoed in a study of the nursing profession. Flowers et al. (2022) examined the NCLEX-RN exam pass rates of 92 nursing students who graduated from an urban public university in the spring of 2017. The authors used 10 predictors to examine NCLEX-RN exam success, including scores on the nursing program pre-admission test, science GPA, NCLEX-RN readiness assessment scores, and the end-of-nursing program assessment designed to assess and remediate nursing concepts. The authors' analyses revealed that examinees' science GPA and scores on the NCLEX-RN readiness assessment were the best predictors of NCLEX-RN pass. Based on their findings, the authors recommend a way to identify nursing students who need additional support to pass the licensing exam. Chisholm–Burns et al. (2017), who examined outcomes of the North American Pharmacist Licensure Examination (NAPLEX) using a sample of graduates of the University of Tennessee College of Pharmacy, reported that pharmacy GPA was the most critical determinant of the total scaled score on the exam. According to their regression analysis, pharmacy GPA explained more than 40% of the variance in the exam scores.

Exam Timing and Preparation

Several studies suggest that students who delay taking an exam once they become eligible experience more negative exam outcomes. According to Espahbodi et al. (2023), the longer an examinee waits to attempt the CPA exam, the further removed they are from college coursework, which the CPA exam primarily focuses on. The delay in taking the exam is, therefore, likely to affect examinees' performance negatively. The National Council of State Boards of Nursing, Inc., (NCSBN) examined the relationship between the timing of taking the NCLEX examination and exam outcomes (Eich & O'Neill, 2007). They found that **longer lag times between exam eligibility and exam-taking were associated with lower pass rates**. Relatedly, Nettles et al. (2011), who studied disparities in Praxis I and II exam outcomes between Black and white test-takers, also pointed out that Black teacher candidates take the exam at later ages (over 30 years old) than their white counterparts (about 25 years old).

Similarly, Robinson et al. (2016) examined whether a delay in taking Part I (computer-based exam) or Part II (oral exam) of the American Board of Physical Medicine and Rehabilitation (ABPMR) certification examinations influences the score or passing rates of candidates. Using national data between 2010 and 2014, the authors found that the exam pass rates declined as candidates delayed the examination. Those who did not delay had a pass rate

of 91%, but with a one- and two-year delay, the pass rates declined to 68% and 59%, respectively. The authors recommend that examinees take the exam as soon as they become eligible.

Eich and O'Neill (2007) also observed from the data that large volumes of repeat examinees and internationally educated first-time examinees of the nurse licensing exam (NCLEX) wait longer to take the exam and then perform poorly (Eich & O'Neill, 2007). The delayed exam-taking may be related to the examinees' socioeconomic status. Examinees who have both work and family responsibilities may lack sufficient time and resources to prepare for the exam. **Those without adequate time and resources to prepare for the exam may delay taking it or be more likely to fail**.

Additional evidence comes from a recent study of the Uniform Bar Exam (UBE), commissioned by the New York Board of Law Examiners and conducted by AccessLex Institute (2021) (Note that New York state uses the national UBE with a passing score of its own.) The study was based on a survey of 5,495 bar examinees from July 2016 to February 2018, which collected data about their academic performance, law school experience, bar participation, exam experiences, demographics, finances, and employment status. This study is unique because it examined if examinees' finances and post-exam employment status were related to bar exam success, controlling for their academic performance. The study found that the **key determinant of bar passage was having extensive time to prepare for the exam**. Bar passage increased as the number of weekly study hours increased. Examinees who failed on the first attempt succeeded on the second attempt with increased study time. The second-time examinees who studied 40 or more hours per week during the exam month were 45% more likely to pass the exam than those who studied fewer than 20 hours per week (21% likelihood of passing). As this result came from longitudinal data of repeat examinees, the authors considered the time spent studying for the exam a causal, rather than a correlational, factor of the exam outcome.

Additionally, researchers at the AccessLex Institute found that examinees with greater satisfaction with their law school experience were more likely to pass the bar exam after controlling for other factors such as LSAT score and law school selectivity. While financial support from family, friends, and a law firm was positively related to first-time bar passage, law school debt and unemployment were negatively associated with bar passage. Interestingly, however, law school debt and unemployment had a negative effect only on the first-time — not on second-time — bar passage after accounting for LSAT scores and other factors.

Institutional Factors

Institutional factors — the quality of the educational institution and its faculty, admission selectivity, program size, and geographic location — significantly affect licensing exam pass rates.

Type of Educational Institutions

Studies suggest that **the type of educational institutions that examinees attend is related to their licensing exam outcomes**. Trinkle et al. (2016) found that CPA examinees are more likely to pass the exam if they received a degree from a business school and an accounting program accredited by the Association to Advance Collegiate Schools of Businesses (AACSB). The AACSB accreditation is a supplementary, voluntary, and specialized accreditation that signifies the highest-quality programs (AACSB, 2024). The examinees who received a degree from AACSB-accredited colleges were 11–15% more likely to pass any or all sections of the exam. Those educated in separately AACSB-accredited accounting departments were 19–24% more likely to pass any or all sections of the exam. The CPA examinees were also more likely to pass the exam if they received a degree from a private university rather than a public university.

Mittelstaedt and Morris (2017) used 2005–2014 data from the National Association of State Boards of Accountancy (NASBA) to estimate the effects of educational institutions on CPA examinees' section score, section passage, and passage of all four sections. They found that examinees who graduated from for-profit institutions scored about 5.62 points lower, on average, and had less than half the probability of passing all four sections of the exam compared to graduates of nonprofit institutions (28% versus 66%) after controlling for gender, age, programs' AACSB accreditation status, year, and exam type. They also found that attending an institution not accredited by AACSB is negatively related to success on the CPA exam. They explained that while some private and public nonprofit universities have very competitive admission standards, for-profit institutions generally do not have admission requirements.

According to Espahbodi et al. (2023), the educational institution type affects examinees from historically marginalized groups more significantly than white examinees. In a comprehensive environmental study of racial disparities in CPA exam pass rates, they found that a higher percentage of Black examinees and (to a lesser extent) Hispanic/Latino and female examinees attended non-AACSB schools, for-profit schools, schools with lower average SAT scores, schools with higher percentages of Pell Grant recipients, and schools with annual tuitions less than $20,000. The authors argued that **disadvantages in educational institutions negatively affect Black and Hispanic/Latino examinees' performance on the CPA exams**.

Relatedly, the National Council of State Boards of Nursing (NCSBN) conducted a national study to identify evidence-based quality indicators and warning signs of nursing program performance (Spector et al., 2020). They identified an 80% NCLEX pass rate as one of their quality indicators of nursing program performance. Their analyses revealed that nursing programs with directors with a Ph.D., hybrid course delivery (compared to in-person or online programs), a longer history (compared to newer programs), multiple sites (compared to a single site), and public and not-for-profit status (compared to private for-profit status) were more likely to meet the target NCLEX pass rate. They also found that faculty characteristics were related to pass rates. As director attrition increased, programs were less likely to achieve the target pass rate.

Admission Selectivity and Percentage of Students on Pell Grants

Chaparro (2020) examined program-level determinants of psychology licensing exam (Examination for Professional Practice in Psychology, or EPPP) pass rates using data from 176 doctoral psychology programs. The author included GRE scores, percentage of students from historically marginalized groups, gender, program type (clinical PhD versus PsyD program), admission rate, years to degree completion, and APA internship match rates. The analysis revealed that the only significant determinant of the exam pass rate was the admission rate. **The higher a program's admission rate, the lower its exam pass rate**. Chaparro hypothesized that since graduate program admissions depend on GPA, GRE scores, and recommendation letters, the relationship between admission selectivity and licensing exam pass rates supports the importance of GPA and GRE scores for licensing exam outcomes.

Chaparro's (2020) analysis was at the program level, not the examinee level, and the study did not control for the examinee's academic performance. When Wightman (1998) investigated racial/ethnic disparities in bar pass rates at the examinee level, the author accounted for the effects of selectivity of undergraduate and law school admissions while controlling for examinees' LSAT scores and GPAs in both undergraduate and law school. Wightman found that admission selectivity did not have a unique contribution to bar pass outcome, contrary to Chaparro (2020).

Espahbodi et al. (2023) used the percentage of students who receive Pell Grants in an institution as a proxy for admission selectivity and student body income status. They noted that with the low amount of Pell Grant awards, many grant recipients are concentrated in the least selective, lower tuition (or for-profit) institutions that typically offer inferior education and limited resources for student success. (By contrast, in the most competitive institutions, only approximately 10% of all undergraduates receive Pell Grants.) They found that **attending an institution with higher percentages of Pell Grant recipients is negatively related to passing the CPA exam.** Their regression analysis found that a one-unit increase in the percentage of students receiving Pell Grants decreased the CPA examinees' probability of passing the exam by 0.9 percent.

Faculty Characteristics

Bline et al. (2016) studied the effects of faculty characteristics (specifically, research and teaching specialization and CPA certification status) on graduates' outcomes on the Uniform Certified Public Accountant Examination. The authors merged data from the NASBA (National Association of State Boards of Accountancy) on more than 675,000 first-time exam sittings during the 2005–2013 period with faculty data from examinees' business schools. They controlled for basic demographic characteristics of CPA examinees and the business schools that they attended, including the schools' admission selectivity (e.g., incoming student SAT scores at the institutional level). This study was unique as it simultaneously examined the effects of the individual characteristics of examinees as well as the characteristics of educational institutions on examinees' CPA exam scores on all four sections of the exam. Nevertheless, they did not control for examinees' academic performance, such as GPA. They found that (1) **both faculty teaching and research specialization and research productivity were significantly and positively related to examinees' scores on all four sections of the exam** and (2) **the higher the percentage of CPA-certified faculty in a program, the better the programs' examinees perform on the exam**. They also demonstrated that examinees from highly ranked research schools tend to score higher on the exam than those from lower-ranked schools.

Bushardt et al. (2012) also examined the relationship between faculty characteristics and licensing exam outcomes using pass rates from the National Physician Assistant Certifying Exam (PANCE). However, the study differed from Bline et al. (2016) as it examined exam pass rates at the institutional level using only institutional data. The authors conducted a simple linear regression to examine the relationship between the faculty size and faculty credentials of 152 schools and their PANCE pass rates. They found that schools with a master's degree program and a low student–teacher ratio have higher PANCE pass rates.

Program Size and Geographic Location

Falcone (2012) examined if first-time pass rates of the American Board of Pediatrics Certifying Examination were related to pediatrics residency programs' size, theorizing that larger residency programs may have more resources, leading to more robust educational curricula and programs, leading to higher pass rates on the certifying exam. Falcone's statistical analysis of 193 residency programs from 2008 and 2010 showed that exam pass rates were related to residency program size. However, Falcone acknowledged that the residency program's exam pass rates are complex and may depend on multiple factors, such as resident selection, curriculum structure, and faculty recruitment. In the following year, Falcone and Middleton (2013) studied the pass rates on the American Board of Family Medicine certification exam from 429 family medicine residency programs from 2007 to 2011. Their linear regression analysis revealed that **the programs' five-year pass rates were positively associated with program size**. The authors theorized that program size is correlated with the nature of curricula, the ability to attract specialized faculty, higher-quality residents, and established education

programs, all of which may help larger programs outperform smaller programs on the certification exam.

Some research suggests that an institution's proximity to urban locations is important for exam outcomes. Angelo et al. (2021) found **a positive relationship between a school location in or near a city and CPA exam outcomes**. Proximity to and availability of a large number of professional candidates are important in motivating exam-taking and exam performance. Examinees from large programs may have more resources and opportunities to perform well on an exam. Professional organizations are likely to be headquartered in cities and urban areas in which a large number of professionals are available. Because of the proximity to opportunities and resources, institutions' location in urban settings is important (Angelo et al., 2021).

Similarly, according to Falcone & Hamad (2012), first-time pass rates of the qualifying and certifying exams of the U.S. Medical Licensing Examination are significantly different by residency programs' geographic location. Residency programs located in the southern United States, specifically in Kentucky, Louisiana, Mississippi, and South Carolina, were associated with lower certification exam pass rates. Residency programs located in the western and southwestern parts of the county have higher qualifying exam pass rates.

Community Factors

Community-level opportunities and disadvantages as measured by indicators of segregation, economic inequality, and socioeconomic status affect licensing exam outcomes. Examinees from more integrated and affluent communities tend to perform better than their counterparts. This was particularly true for Black examinees.

Segregation, Inequality, and Socioeconomic Status

As seen in Table 1 earlier in this article, the accounting profession has one of the lowest licensing exam pass rates, particularly among historically marginalized groups. Recent empirical evidence by Espahbodi et al. (2023) presents a comprehensive conceptual framework to shed light on these disparate outcomes. The authors conceptualized that racial/ethnic gaps in most achievement gaps are associated with racial/ethnic gaps in SES, acknowledging that a large share of examinees from historically marginalized groups grew up in less affluent, segregated communities that negatively affected their lifetime outcomes. They investigated community and environmental factors from a person-in-environment perspective. They conducted a statistical analysis of national data for three sources of exam disparities — examinees, institutions, and communities. They compiled (1) examinees' demographic and exam data from the National

Association of State Boards of Accountancy (NASBA) between 2005 and 2016, (2) university characteristics data from the Department of Education, and (3) the indicators of community segregation, income gaps, and education gaps developed by the Center for Educational Policy Analysis at Stanford University.

Their descriptive analyses showed that white men performed better on the CPA exam, as did examinees who graduated from public, more selective, and AACSB-accredited universities that required higher admission standards (e.g., higher SAT scores). Their analyses tested (1) if CPA examinees' probability of passing all four sections of the CPA exam within 18 months was affected by the indicators of segregation, income gaps by race and gender, and educational gaps by race and gender in the communities where they lived and (2) if those indicators had different effects on historically marginalized groups. Their statistical models also controlled for the factors that previous studies identified as determinants of the exam outcomes, such as examinees' race/ethnicity, gender, age, type of university, the university's AACSB accreditation status, percentage of students on Pell Grant, and the 75th percentile SAT verbal scores of the admitted first-year students. They did not include examinees' GPAs or admission test scores in their statistical analyses.

Overall, their findings demonstrated that Black, Hispanic/Latino, and female examinees' underperformance on the CPA exam was affected by opportunities and disadvantages in their communities. In general, **CPA examinees who were from less segregated, more affluent, and more economically integrated communities scored higher compared to their counterparts**. More specifically, a one-unit increase in the **segregation index** was associated with a decreased probability of passing the exam by 29.4 percent. They also found that opportunity factors — indicated by income gaps and socioeconomic status — affected the performance of historically minoritized groups differently. For example, living in a community with **higher racial income gaps** negatively affected Black examinees' probability of passing the exam. Black examinees' success on the exam decreased by nearly 30% with every unit increase in the racial income gap. On the other hand, living in a **higher socioeconomic status** community was related to an increase in the probability that Black examinees would pass the exam. For every unit increase in socioeconomic status, Black examinees' probability of passing the exam increased by 8.7%. **Based on these findings, the authors argued that the profession must recognize the impact of socioeconomic factors on the development, recruitment, and retention of a diverse talent pool. They also advocate for long-term and systematic interventions to mitigate the negative effects of economic segregation and inequality on the accounting profession.**

Conclusion

The available evidence suggests that disparities in licensing exam results are influenced by a combination of individual, institutional, and community factors that are shaped by broad socioeconomic inequalities. Younger individuals, those with high GPAs and admission test scores, and those who do not delay taking the exam once eligible and have sufficient study

resources are more likely to pass a licensing exam. Additionally, those who attend institutions with selective admissions, strong faculty, and well-resourced programs are more likely to pass an exam. Individuals in more socioeconomically integrated and equal communities are also more likely to succeed on a licensing exam. Since licensing exams occur at the end of an individual's educational and training journey, the results are likely to reflect cumulative educational and training opportunities and disadvantages experienced throughout their lifetime.

When applying these findings to the social work profession, this report emphasizes the need for empirical research on the sources of racial/ethnic and other demographic disparities in the ASWB exam pass rates. We need to understand the extent and nature of these disparities at the examinee, institution, and community levels to evaluate necessary interventions. This review provides guidance for the empirical research that the social work profession should undertake to comprehend the sources of disparities and identify means of reducing them.

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The Effects of Race/Ethnicity on Clinical Exam Outcomes:

Diminished (yet Persistent) Effects When Other Determinants Are Controlled

Prepared for
Association of Social Work Boards (ASWB)

Exam Report No. 3

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Contents

Executive Summary

This report aims to investigate the determinants of the first-time ASWB Clinical exam passage and estimate the net effects of race/ethnicity on the exam outcome. This report — the third in the Exam Report Series — builds upon the second report, which reviewed the determinants of licensing exam disparities identified in other professions' literature. The **conceptual framework** developed from the literature review was empirically tested with the ASWB Clinical exam data (1) to assess whether the determinants of ASWB exam passage are consistent with those in other licensed professions' literature and (2) to estimate the net effects of race/ethnicity on the Clinical exam outcomes while holding the effects of other determinants constant. As the ASWB exam data provide only a limited number of variables on the examinees, the data were reinforced with zip code–level income data from the U.S. Census Bureau and institutional characteristics data from the U.S. Department of Education. The report begins with a closer look at the raw scores of Clinical examinees by race/ethnicity to better understand the disparate exam outcomes. **The analyses were confined to U.S. examinees who took the Clinical exam for the first time between 2018 and 2022**. Below are some of the key findings.

- ✓ First, the average score of all examinees was 110, and half of the examinees scored at least 111. When **raw scores** were compared to passing scores, Black examinees, on average, scored about four points below the passing scores. In comparison, examinees from other historically marginalized groups scored roughly three to six points above the passing scores.

- ✓ Second, exam outcomes were associated with race/ethnicity and most other demographic, institutional, and community characteristics examined in the analyses. Consistent with the existing evidence from other professions, Clinical exam pass rates varied significantly by **age group, gender, primary language, educational background, and employment experiences**. Those who began their postsecondary education with an associate's degree and majored in social work as undergraduates had lower pass rates than their counterparts. Examinees who waited longer to take the exam after earning an MSW and had more years of employment also had lower pass rates than those who waited for a shorter period or worked for fewer years. Examinees who did not hold direct service positions had a lower pass rate.

- ✓ Third, as the literature suggested, the first-time Clinical exam pass rate was associated with the **characteristics of educational institutions that the examinees attended**. Those who attended smaller MSW programs, as well as institutions that were less selective in admission and mainly served students from lower socioeconomic backgrounds, had a lower pass rate than their counterparts.

- ✓ Last, statistical analyses suggested that if examinees from historically marginalized groups had the same demographic, educational, and employment characteristics and lived in similar institutional and community environments as white examinees, the Black–white disparity in the Clinical exam outcomes could be reduced by about 20%, and the Hispanic/Latino–white disparity by around 28%. **Black examinees' exam outcomes were**

sensitive to institutional and community-level socioeconomic status and inequalities. On the other hand, the exam outcomes of Hispanic/Latino examinees were explained more by their demographic backgrounds.

Many professions have been challenged with racially disparate licensing exam outcomes. The prevalence suggests that the causes of disparities are deeply rooted in the fabric of our socioeconomic systems. In response to the disparities in exam outcomes, many take a reductionist approach by blaming the exams or advocating to remove competence assessment in the licensure system. While no licensing exam may be perfect as an assessment tool for professional competence in the complexity of real practice environments (Kane, 2005), group differences in exam outcomes do not necessarily indicate that the exams are biased. They instead reflect persistent inequalities and segregation in our schools, communities, and workplaces that disproportionately and adversely affect people from low-income and historically marginalized backgrounds (Hauser & Heubert, 1998).

The findings presented in this report should prompt many research questions and call for longer-term and more comprehensive empirical research that incorporates the crucial determinants of exam outcomes that this analysis could not incorporate due to data limitations. Assuming the causes of racially disparate exam outcomes are multifaceted, complex, and deeply rooted in our society, professional stakeholders must commit to collaborative research and strategic interventions to address the problem.

Background and Purpose

The *2022 ASWB Exam Pass Rate Analysis* revealed that racial/ethnic disparity in exam pass rates exists in the social work competence assessment. The analysis called for a further investigation to shed light on examinees' performance differences and, more importantly, the contributing factors. Having a deeper understanding of the level of disparity as well as its contributing factors is a critical first step toward developing effective interventions to reduce and eliminate the disparity. This Exam Report Series was conceived as a way to investigate the disparity and its determinants further.

The **first report** in the Exam Report Series presented the demographic, educational, and employment profiles of the most recent examinees of the Bachelors, Masters, and Clinical exams. The report highlighted that examinees from historically marginalized groups, particularly Black examinees, experienced delays in their social work education and training, which might have led them to take the licensing exams at older ages than others.

The **second report** provided a review of other licensed professions' literature. Other professions reported a similar level of disparate exam outcomes by race/ethnicity (e.g., Affrunti & Rossen, 2023; Rubright et al., 2019; Sharpless, 2021; Yeo et al., 2021). Empirical evidence from those professions supports that examinees' demographic and educational backgrounds, as well as the characteristics of their educational institutions and communities of residence, are the determinants of racially disparate exam outcomes (Espahbodi et al., 2023).

Applying the takeaways from other licensed professions' literature, **this third report shares findings from statistical analyses of the ASWB's Clinical exam data to answer the following research questions.**

1) First, how do the ASWB examinees' performance — measured in raw scores — differ by race/ethnicity? Although a licensing exam is designed to discern a professional candidate's competence through a pass/fail outcome, raw score analyses provide additional information as to how examinees' performances are different by race/ethnicity.
2) Second, what demographic, educational, and employment characteristics of examinees, as well as the characteristics of their educational institutions and communities, are significantly associated with their ASWB exam outcomes? What are the positive or negative predictors of ASWB exam passage? Are the factors of ASWB exam passage consistent with the determinants identified in other professions' literature reviewed in Exam Report No. 2?
3) Third, are the negative predictors of ASWB exam passage, such as delayed exam taking, more prevalent among examinees from historically marginalized backgrounds?
4) Last, what is the estimated net effect of race/ethnicity on ASWB exam passage, holding the effects of other factors constant? How does the effect of race/ethnicity decline when other determinants of exam outcomes are considered in the analyses?

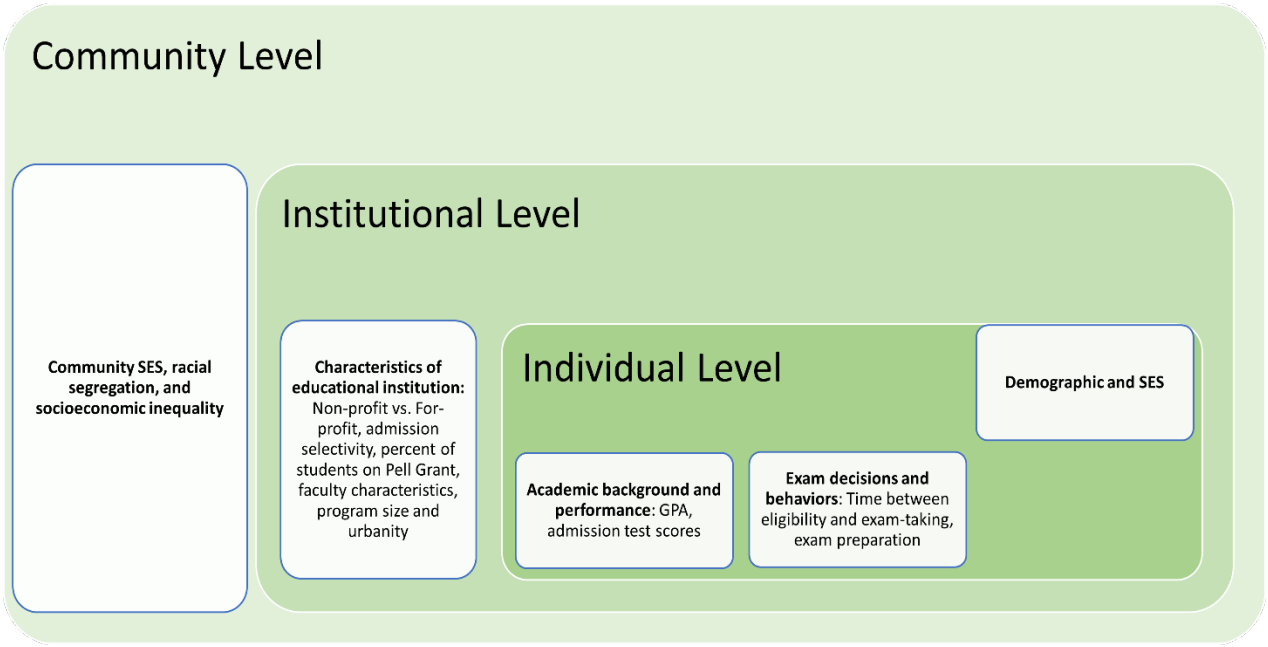
The following section discusses a conceptual framework and methodologies used to answer these four questions through statistical analyses.

Conceptual Framework

Figure 1 presents the determinants of licensing exam outcomes at individual, institutional, and community levels, as discussed in Exam Report No. 2. It serves as a conceptual framework that guides the empirical analyses of pass rate disparities. It depicts how examinees' exam outcomes are influenced not only by their demographic and socioeconomic backgrounds but also by the characteristics of their educational institutions and the broader socioeconomic opportunities and disadvantages in their communities.

Figure 1 also illustrates the data necessary to investigate licensing exam outcomes. To empirically test the framework depicted in the figure, one would need data that capture the examinees' socioeconomic status, detailed academic background and performance, and exam-related behaviors (such as how long after obtaining MSWs they took the exam, how they met the qualified supervision requirements, and how they prepared for the exam). Also necessary are data on the detailed characteristics of MSW programs that the examinees attended, such as admission selectivity, curriculum, faculty characteristics, and program size. Additionally, one would need data that measure the socioeconomic characteristics of the communities where the examinees lived, including household incomes and indicators of racial segregation and inequality.

Figure 1. Factors That Affect Licensing Exam Outcomes



As the next section discusses, only some of the necessary data were available in the ASWB exam data file for statistical analyses. The data limitation was a barrier to comprehensive statistical testing of the conceptual framework for social work.

Methods

Data and Sample

The primary data for this analysis came from the **Clinical exam data file** provided by ASWB. The sample was restricted to 88,678 first-time examinees in the United States between 2018 and 2022. Repeat examinees were excluded from the analysis as the examinees' performance is best described with the first-time scores and/or pass/fail outcomes (National Council on Teacher Quality, 2019). The year 2018 was chosen because it was the first year when the most recent exam blueprint was used. Because a single-year data file did not provide a sufficient number of Asian examinees, five years of data between 2018 and 2022 were pulled together to increase the sample size.

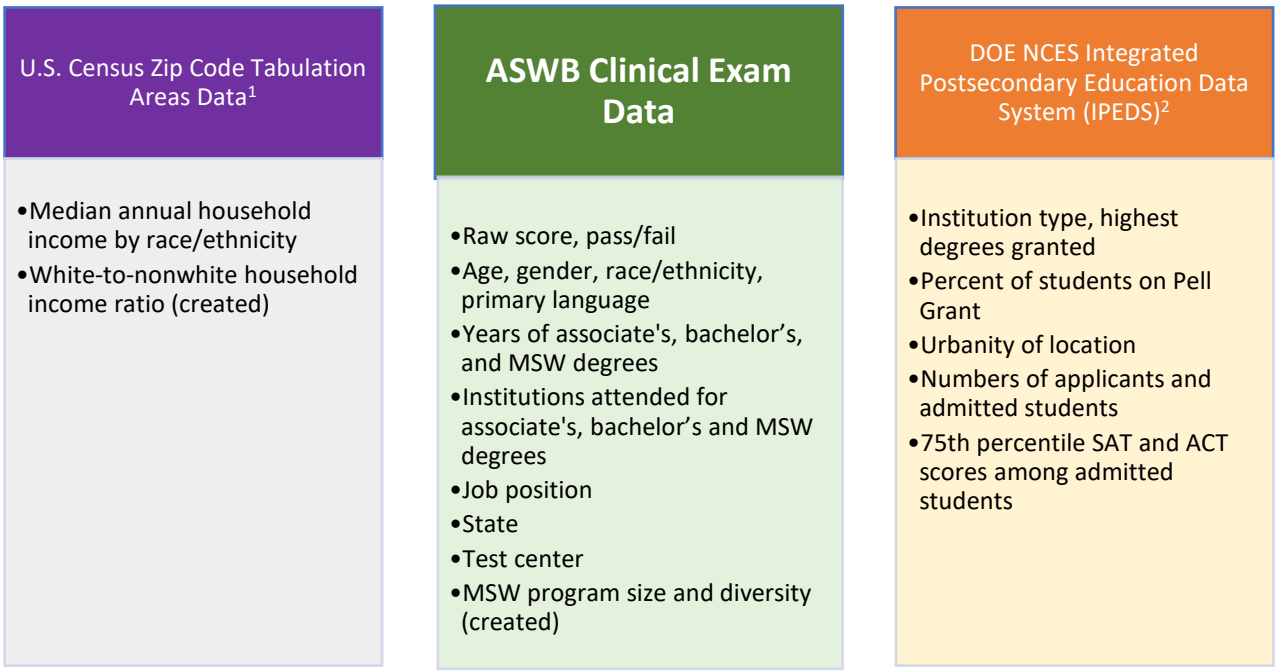
Social work licensing examinees' demographic data were collected when examinees registered for the exams. The available demographic characteristics of Clinical examinees were age, gender, race/ethnicity, English use as the primary language, and the state of residence. The available educational characteristics of the examinees were the years of associate's, bachelor's, and master's degrees and the identifiers and state locations of their educational institutions. Whether or not examinees had majored in social work as undergraduates was also available. Some of the examinees' employment characteristics, including years of employment and job positions, were available.

While these data can serve as important determinants of their exam passage, testing the conceptual framework depicted in Figure 1 required much more individual data as well as data for examinees' educational institutions and communities of residence. The necessary data include examinees' academic backgrounds and performance (e.g., GPAs in their academic programs and admission test scores), the characteristics of MSW programs that they attended (e.g., faculty characteristics, admission selectivity, curriculum, etc.), and the socioeconomic characteristics of the communities where the examinees grew up and lived (e.g., household incomes, racial/ethnic income inequality). **Unfortunately, the ASWB exam data file did not include any of them.**

To remedy these data limitations to the extent possible, the ASWB Clinical exam data were merged with data from the U.S. Census ZCTA tabulation areas and the U.S. Department of Education's National Center for Education Statistics (NCES) Integrated Postsecondary Education Data System (IPEDS) as shown in Figure 2. The Census data merge was to get **zip code–level household income data**, and the IPEDS data merge was to obtain public data about **institutions' characteristics.** The ASWB exam data contained two important variables to allow the data files

to merge: (1) the IDs of the test centers where exams took place and (2) the IDs of the educational institutions that the examinees had attended for graduate degrees. We received the test centers' zip codes from ASWB. We then obtained zip code–based median annual household incomes (between 2018 and 2022) by race/ethnicity from the U.S. Census. We merged the census data file with the exam data file, using the zip codes as the common denominator. Additionally, the IDs of the colleges or universities that the examinees had attended for their graduate degrees were identified in the institutional IDs of the 2018 NCES IPEDS data. Using the institutional IDs as the common denominator, the exam data file and the IPEDS data file were merged. Figure 2 summarizes the source files of all the variables included in the statistical analyses that will be discussed below.

Figure 2. Three Data Sources for This Analysis



1. https://data.census.gov/table
2. https://nces.ed.gov/ipeds/datacenter/InstitutionByName.aspx?goToReportId=5&sid=3fffcc66-2217-442c-b475-bfa5c5dcaa52&rtid=5

Variables and Measures

Examinees' Demographic, Educational, and Employment Characteristics

Clinical examinees' basic demographic characteristics were available in the ASWB exam data. The ***race/ethnicity*** variable recorded if examinees were Asian, Black, Hispanic/Latino, multiracial, Native American/Indigenous Peoples, or white. Note that some examinees (less than 2%) did not disclose their race/ethnicity and were categorized as 'unknown' in the analysis. In addition, the number of Native American/Indigenous Peoples examinees was too small for

analyses; data for that group was not used in this report. Using the age variable, the following four ***age categories*** were created: (1) age 29 or below, (2) between 30 and 34, (3) between 35 and 39, and (4) 40 or older. ***Gender*** was categorized as male or female. (Because less than 0.1% reported being a gender not listed, they could not be included in the analyses.) The examinees' ***English use*** was described as primary use or secondary use.

The exam data also documented whether the examinees held an ***associate's degree*** or not and had ***majored in social work*** for their undergraduate degrees. The exam data also contained the years when the examinees obtained their educational degrees. Using the years when they earned their master's degrees, we created a variable that measured the years between the examinees' master's degrees and their first Clinical exam attempt. The variable was labeled ***years since MSW*** and was categorized into the following five groups: (1) less than or equal to one year, (2) between one and two years, (3) between three and four years, (4) between five and six years, and (5) more than six years. Although Clinical exam candidates are required to complete postgraduate supervised clinical training hours that typically take a couple of years, some examinees with less than one-year post-MSW were shown in the exam data (In some states, early approval of the exam might have been available.) The exam data file also had a variable that described examinees' ***years of employment***, which was categorized into the following five groups: (1) less than or equal to one year, (2) between two and three years, (3) between four and five years, (4) between six and nine years, and (5) ten years or longer. The available ***job position*** variable measured if the examinees worked in direct service positions, administrative positions, other positions, or did not work (labeled as not applicable).

As discussed earlier, the exam data did not have more detailed information about the examinees' academic and socioeconomic backgrounds, such as examinees' GPAs in their academic programs, admission test scores, parents' education, and household incomes (e.g., Nettles, 2011, Rubright et al., 2019; Wightman, 1998). Lacking such important information limited the scope of our statistical analysis.

Characteristics of MSW Programs

The characteristics of MSW programs that the examinees had attended (e.g., faculty characteristics, admission selectivity, curriculum) are important determinants of their exam outcomes (e.g., Bline et al., 2016; Chaparro, 2020). However, the only relevant information available in the exam data file was the IDs of the institutions that the examinees had attended for their graduate degrees. To address this data limitation to the extent possible, we created two variables that could work as crude proxies of (1) the ***size of MSW programs*** and (2) the racial/ethnic ***diversity of student bodies***. Using the **five-year total number of Clinical examinees** by educational institution, we created a variable that could indicate the size of MSW programs in the following categories based on the percentile distribution of the variable: (1) fewer than 506 examinees (smallest program), (2) between 507 and 1,097 examinees, (3) between 1,098 and 1,934 examinees, and (4) 1,935 examinees or more (largest program). To estimate the racial/ethnic diversity of MSW programs, we created a ratio variable, "examinees of color-to-white examinees." The ratio variable was created using the number of

examinees from historically marginalized groups and the number of white examinees by the educational institution. It had four categories as follows: (1) less than 24% examinees from historically marginalized groups (least diverse), (2) between 24% and 33%, (3) between 33% and 48%, and (4) more than 48% (most diverse).

Characteristics of Educational Institutions

The NCES IPEDS data provided the following eight variables to describe the characteristics of educational institutions that the examinees had attended for their MSWs. Many previous studies identified them as contributing factors to licensing exam outcomes (e.g., Angelo et al., 2021; Espahbodi et al., 2023; Falcone, 2012; Trinkle et al., 2016; Mittlestaedt & Morris, 2017). First, the ***type of educational institutions*** measured if an institution was private for-profit, private not-for-profit, or public. Second, the ***highest degrees granted*** by an institution included the following four categories: (1) a master's, bachelor's, or associate's degree, (2) doctoral degrees including research, (3) doctoral degrees including professional practice, and (4) doctoral degrees including research and professional practice. Third, the ***urbanity of an institution*** described if an institution was located in a rural area, suburban area, small city, midsize city, or large city. Fourth, the ***percentage of undergraduate students on the Pell Grant*** was categorized into (1) less than 20%, (2) between 20% and 31%, (3) between 32% and 49%, and (4) greater than 49%. Fifth, the ***percentage of undergraduate applicants admitted*** to the institutions was categorized into (1) less than 46%, (2) between 46% and 63%, (3) between 64% and 75%, and (4) greater than 75%. Sixth, the 75th percentile ***SAT reading scores*** of admitted first-year undergraduate students were grouped into (1) less than 600, (2) between 600 and 639, (3) between 640 and 690, and (4) above 690. Seventh, the 75th percentile ***SAT math scores*** were grouped into (1) less than 590, (2) between 590 and 639, (3) between 640 and 710, and (4) greater than 710. Last, the 75th percentile ***ACT composite scores*** of admitted undergraduate students were recorded as (1) less than 25, (2) between 25 and 27, (3) between 28 and 31, and (4) above 31. Note that some examinees did not have these scores as their institutions did not report admitted undergraduate students' SAT and ACT scores. Furthermore, it is important to note that these broad institutional characteristics measured with undergraduate student bodies did not measure the school characteristics and admission standards of MSW programs attended by the Clinical examinees.

Community Characteristics

The socioeconomic characteristics of the communities where the examinees grew up and lived are important determinants of exam outcomes (Espahbodi et al., 2023), but the exam data file did not have any relevant variables. Again, to address the data limitation, the zip code–level median household incomes of test centers where the examinees took the exams were used as **crude proxies of their income backgrounds**. However, as there were only 270 test center locations for more than 88,000 examinees, it is important to acknowledge that using test centers as examinees' geographic locations is likely to reduce true variations in the examinees' socioeconomic statuses severely. Despite the concern, we proceeded with creating the variable due to the lack of any alternative. The zip code–level five-year average ***median annual***

household incomes were recorded as (1) less than $57,665, (2) between $57,665 and $72,133, (3) between $72,134 and $92,881, and (4) greater than $92,881 based on a percentile distribution of the data. In addition, using the zip code–level median annual household incomes by race/ethnicity, we created an "examinees of color-to-white examinees" income ratio to ***measure racial/ethnic income inequality*** by zip code. The income ratio was recorded as (1) less than 0.61 (most unequal), (2) between 0.61 and 0.76, (3) between 0.77 and 0.94, and (4) greater than 0.95 (about equal) based on a percentile distribution of the data.

The U.S. Census zip code data did not have income data for a multiracial group. In addition, income data for the examinees whose race/ethnicity was unknown could not be identified. Besides, not all zip codes had income data for Black, Hispanic/Latino, and Asian groups, as there were areas with insufficient residents from those groups. Therefore, some examinees' income and inequality variables were missing and could not be included in the statistical analyses presented below.

Furthermore, using the states that authorized their exam registration, we grouped the examinees by the nine ***regions of residence*** as follows: South Atlantic, East North Central, East South Central, West South Central, Middle Atlantic, Mountain, Pacific, New England, and West North Central regions.

Data Analyses

First, we present detailed analyses of exam scores and pass rates (which are presented in Table 1 and Chart 1). We also present descriptive statistics on the examinees to understand their demographic, educational, and employment characteristics as well as the characteristics of their educational institutions and communities. These descriptive statistics are presented in **Appendix Table A-1**.

Then, we proceeded to examine the **relationship** between demographic, institutional, and community determinants and exam passage. Tukey's multiple comparison tests were conducted in SAS 9.4 to determine which means amongst a set of means differ from the rest. These results are presented in Charts 2 through 22. In describing the relationships, we used the word *significant* to mean statistical significance at least at $p<0.05$, meaning that there is less than a 5% chance of obtaining the result by chance and more than a 95% chance that the result reflects a true relationship or difference in the population under study. Where possible, we connected the findings of our analyses to the literature of other professions to assess how our findings were congruent with the existing knowledge about licensing exam outcomes.

Finally, we ran a logistic regression analysis to examine **the net effect of race/ethnicity on exam failure** while controlling for other determinants/predictors of the exam outcome, including examinees' characteristics and the characteristics of their institutions and communities. A logistic regression is a statistical method designed to examine associations between predictor variables (e.g., the characteristics of examinees and their institutions and communities) and a dichotomously measured outcome variable of interest (e.g., exam

pass/fail). We chose to predict exam failure rather than passage because we intended to examine how the negative effects of being a member of a historically marginalized group could be **reduced** when other predictors were considered in the analyses. Predicting failure instead of passage made the narration of the findings easier. As stated earlier, because the multiracial and unknown race/ethnicity groups were missing household income and racial inequality variables, those two groups were excluded from the regression analyses. The findings of our logistic regression analyses are summarized in Table 2, and the detailed findings are presented in **Appendix Table A-2.**

In building the logistic regression models, only the variables significantly related to exam failure were included. Also, as many predictor variables were highly correlated with one another (e.g., correlations between the 75th percentile SAT reading and math scores, correlations between zip code–level incomes and racial income ratios), we used caution in building a model to avoid high correlations among the variables by including only the necessary predictors that generated the best model fit statistics. Most importantly, to observe how the effects of the race/ethnicity variable changed with the inclusion of other predictor variables, we first ran a base model with only the race/ethnicity variable and then added other demographic, educational, and employment characteristic variables to the model. In the final model, we added the institutional and zip code–level community variables to examine how the additions changed the effects of race/ethnicity on the likelihood of exam failure. Our focus was to examine if and to what extent the effect of race/ethnicity was reduced due to the added other determinants of exam outcomes.

When interpreting the findings of the regression analyses, it would be important to note that the relationships explored in the analyses were **not causal, but only correlational**.

Findings

A detailed raw score analysis of the Clinical exam data revealed that on average, Black examinees scored around four points below the passing scores, but examinees from other historically marginalized groups scored roughly three to six points above the passing scores.

Raw Scores

Before examining exam pass rates, raw scores and their distributions were examined to gain a more thorough understanding of the exam outcomes. Table 1 shows the average raw scores, scores at percentile ranks, maximum score, and standard deviation of the scores for all examinees and by race/ethnicity. The average score for all examinees was 110, with a minimum

score of 25 and a maximum score of 143. The median (the 50th percentile) score of 111 suggests that one-half of all examinees scored at least 111. The table also suggests that half of all examinees scored between 102 (the 25th percentile score) and 119 (the 75th percentile score). The 5th and 10th percentile scores of all examinees were 85 and 92, respectively.

The table shows significant racial/ethnic disparities in raw scores, particularly between Black and white examinees. **Black examinees' average raw score was 99, about 14 points — roughly equivalent to one standard deviation — below white examinees' average score, which was 113**. Hispanic/Latino examinees' average score was 106, about seven points below white examinees' score. The scores of Asian, multiracial, and unknown racial groups were similar to one another at around 108–109.

The raw scores at the percentile rank reveal more important details about how scores were distributed differently by race/ethnicity. White examinees' scores surpassed the scores of examinees from other racial/ethnic groups at each percentile rank reported in Table 1. Yet, the score differences were rather modest, particularly at the 90th percentile ranks, where examinees from all racial/ethnic groups scored above 120, except for Black examinees. Interestingly, the Black–white score difference was the greatest at every percentile rank. For example, for the lowest performing (1st percentile) group, the Black–white score difference was 60 versus 81, and for the highest performing (90th percentile) group, the difference was 116 versus 127.

Looking at the mean difference from a passing score by race/ethnicity, Black examinees were the only group with a difference of -3.79. This suggests that **Black examinees, on average, scored around four points below the passing scores, but examinees from other marginalized groups scored roughly three to six points above the passing scores.**

Table 1. Clinical Exam Raw Score by Race/Ethnicity (2018-2022)

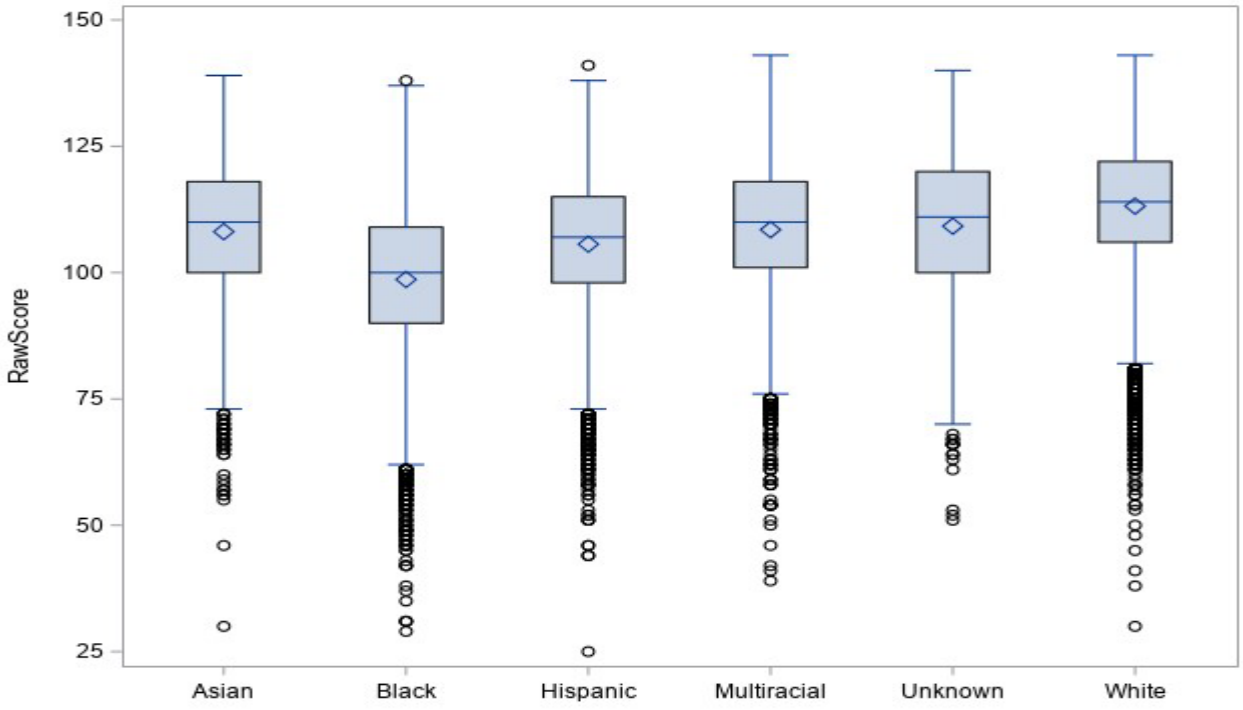
	All	Asian	Black	Hispanic/Latino	Multiracial	Unknown	White
N	88,678	3,146	12,530	10,572	4,714	1,373	56,343
Mean score	**110**	**108**	**99**	**106**	**108**	**109**	**113**
Score at percentile							
1st	72	69	60	69	70	68	81
5th	85	84	74	83	83	84	92
10th	92	90	80	89	91	91	97
25th	102	100	90	98	101	100	106
50th	111	110	100	107	110	111	114
75th	119	118	109	115	118	120	122
90th	126	124	116	121	125	126	127
Maximum score	143	139	138	141	143	140	143
Standard deviation	13.56	13.38	14.21	13.02	13.81	14.13	11.80

The mean difference from a passing score	7.31	5.67	-3.79	3.22	6.08	6.80	10.76

Chart 1 provides additional visualizations of the raw score distributions by race/ethnicity. Using the 25th and 75th percentile scores in Table 1, Chart 1 illustrates where 50% of the scores were found in the distributions and how the distribution differed by race/ethnicity. Please note that the horizontal lines that split the boxes in two indicate the median scores and the diamonds indicate the mean scores. Overall, Chart 1 confirms that racial/ethnic disparities exist in median and mean scores and that Black examinees' median and mean scores were the lowest of all groups.

In Chart 1, the upper line stretching outside each box indicates the 75th percentile score to the maximum raw score for each race/ethnicity. Conversely, the lower line outside each box marks the 25th percentile score to the minimum raw score for each race/ethnicity. According to the plot, **white examinees' scores were relatively tightly distributed above 80. The scores of examinees from other historically marginalized groups — particularly Black examinees' scores — were more dispersed to include scores even below 70.** In addition, the circles outside the minimum scores in Chart 1 suggest that many extremely low scores existed as potential outliers, especially among Black examinees.

Chart 1. Box Plot of Clinical Exam Raw Scores by Race/Ethnicity, 2018–2022



Pass Rate Disparities by Demographic Characteristics

Examinees from historically marginalized groups, older groups, men, and those who use English as a second language had lower pass rates than their counterparts. These demographic disparities were consistent with findings from other professions' licensing exams.

Race/Ethnicity and Age Group

Analyses suggested that Clinical exam pass rates were significantly lower for Asian, Black, Hispanic/Latino, and multiracial groups than for white examinees. Chart 2 depicts the pass rates by race/ethnicity. The rates for Asian (0.71), Black (0.44), Hispanic/Latino (0.64), multiracial (0.72), and examinees whose race/ethnicity was not reported (0.71) were lower than the rate for white examinees (0.83). This significant racial disparity in exam pass rate is consistent with the findings from other regulated professions (Nettles et al., 2011; Rubright et al., 2019; Wightman, 1998; Yeo et al., 2020).

Analyses also found that the pass rates differed significantly by age group. As shown in Chart 3, older examinees had lower pass rates than younger examinees. While 80% of examinees in their 20s passed the exam, 66% of examinees in their 40s passed the exam. Age disparities in licensing exam pass rates are well documented in the literature (Bline et al., 2016; Mittestaedt & Morris, 2017; Nayer & Grover Takahashi, 2017; Nguyen et al., 2021; Trinkle et al., 2016), and this finding is aligned with previous studies in other professions.

Chart 2. Pass Rate by Race/Ethnicity, 2018-2022

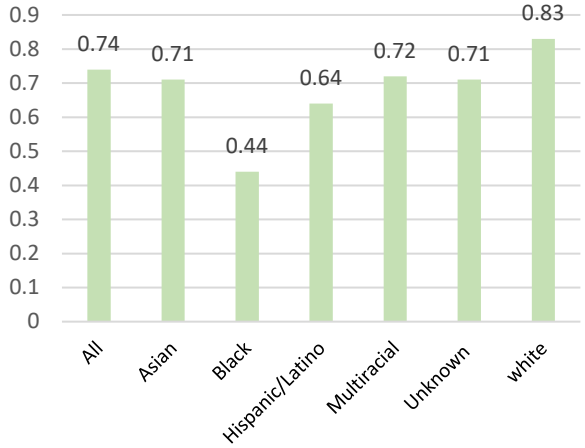
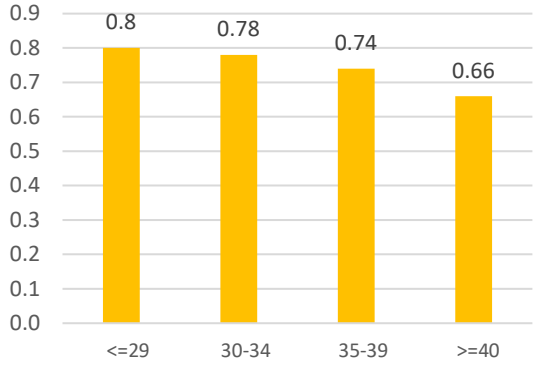


Chart 3. Pass Rate By Age Group, 2018-2022



The bivariate analyses showed that older examinees, particularly those in their 40s, were more likely to fail the exam. **Are examinees from historically marginalized groups significantly older than their white counterparts?** Findings presented in **Appendix Table A-1** show the distribution of age groups by race/ethnicity. The table suggests that a higher percentage of Black examinees (37.26%) and examinees in the unknown race/ethnicity group (38.97) were in their 40s than white examinees (28.87%). The findings suggest that historically marginalized groups are significantly older than white examinees among Clinical examinees.

Gender and Primary Language

As Chart 4 shows, the exam pass rates significantly varied by gender. Women had a higher pass rate than men (0.75 versus 0.72). Although previous studies have reported gender disparity in licensing exam pass rates (Trinkle et al., 2016; Yeo et al., 2020), the ASWB exam appears unique in that women, not men, had a higher pass rate.

Chart 5 shows pass rate disparity by English use. Examinees who used English as a second language had a significantly lower pass rate than those whose primary language was English (0.57 versus 0.75). The use of English as a secondary language typically signifies the examinees' immigration status from a non-English speaking country. The disparity is similar to findings from other licensed professions that investigated pass rate differences by domestic and international examinees (Eich & O'Neill, 2017).

Chart 4. Pass Rate by Gender, 2018-2022

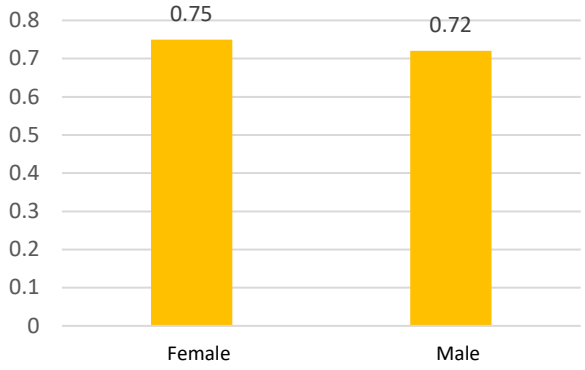
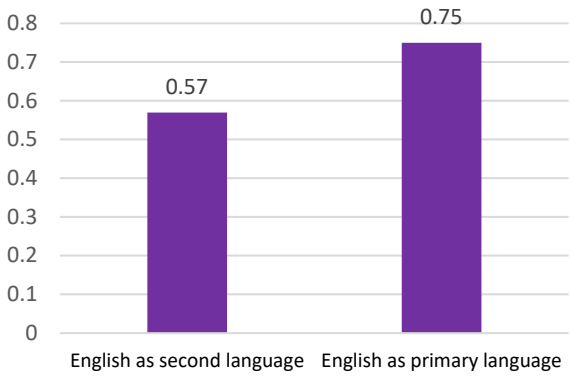


Chart 5. Pass Rate By Primary Langauge, 2018-2022



Are these negative predictors of exam outcomes more concentrated in historically marginalized groups of examinees? Interestingly, according to **Appendix Table A-1**, a higher percentage of the unknown race/ethnicity group than white examinees was male (18.94% versus 12.70%). In addition, nearly 33% of Asian and Hispanic/Latino examinees used English as a second language, compared to 3.63% of Black examinees or 1.36% of white examinees. Among multiracial and unknown race/ethnicity examinees, 9.44% and 6.26% used English as a second language. So, the negative predictors of exam outcome were more prevalent among members of historically marginalized groups.

Pass Rate Disparities by Educational and Employment Backgrounds

Clinical examinees who held an associate's degree and a BSW had lower pass rates. Those who waited longer to take the first Clinical exam after earning an MSW and had more years of employment had lower pass rates. Examinees who held non-direct service jobs also had lower pass rates.

Associate's Degree and a BSW

As Chart 6 shows, beginning postsecondary education with an associate's degree was negatively related to Clinical exam pass rates. Examinees with an associate's degree had a pass rate of 0.61, significantly lower than the rate of 0.78 for those who began their postsecondary education with a four-year degree. Undergraduate major was also related to exam pass rates. As shown in Chart 7, examinees who majored in social work for their undergraduate degrees had a pass rate of 0.66, significantly lower than 0.79 for those who had other undergraduate majors. This finding on the relationship between BSWs and Clinical exam pass rate seems counterintuitive. Yet, Nettles et al. (2011), who examined teacher licensing exam outcomes in Praxis I (Mathematics), reported the similar finding that education majors had a lower pass rate on the Praxis exam than non-education majors (Nettles et al., 2011).

Chart 6. Pass Rate by 'Having an Associate's Degree', 2018-2022

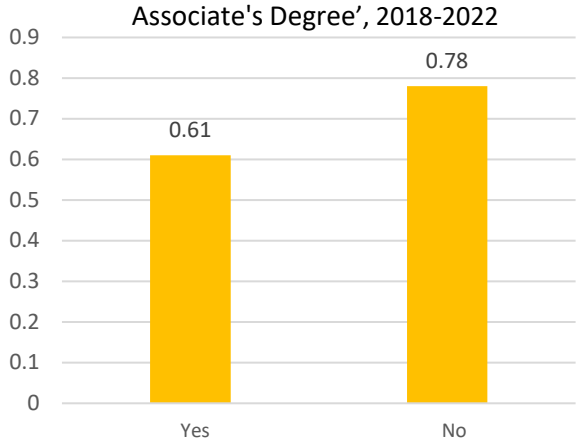
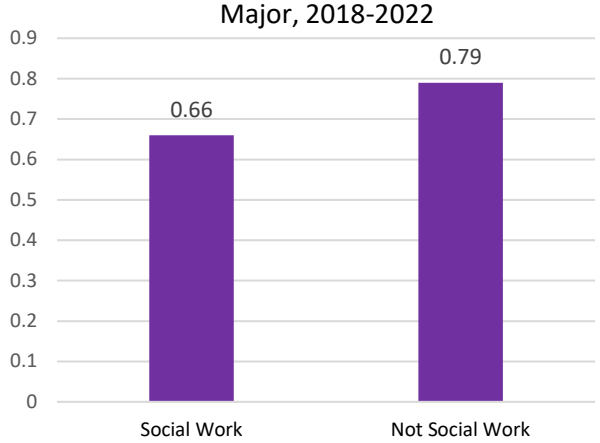


Chart 7. Pass Rate by Undergraduate Major, 2018-2022



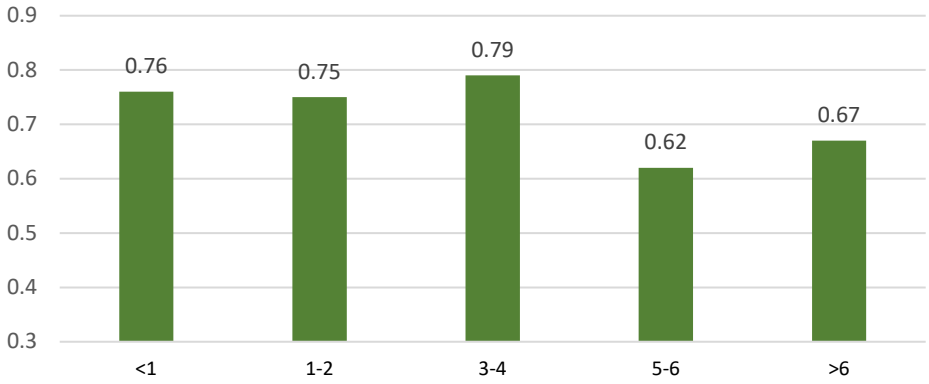
Beginning postsecondary education with an associate's degree and majoring in social work as an undergraduate were negatively related to Clinical exam passage. **Were these negative predictors of exam outcomes more prevalent among examinees from historically marginalized groups? Appendix Table A-1** presents that a significantly higher percentage of Hispanic/Latino (30.34%), multiracial (25.58%), and Black examinees (24.03%) began their postsecondary education with an associate's degree than white examinees (18.61%). At the same time, more than 40% of Black examinees were social work majors, compared to 33.27% of

white examinees. That is, a higher share of historically marginalized race/ethnic groups carried educational characteristics that were negatively associated with exam outcomes.

Timing of the Exam

Chart 8 shows that the exam pass rate was significantly related to the number of years between when examinees earned their MSWs and when they took their first exams. Examinees who took the Clinical exam for the first time more than five years after they obtained their MSWs had a significantly lower pass rate than those who did it within three to four years after their MSWs (0.62 versus 0.79). Previous studies similarly reported that delayed exam-taking is negatively related to exam passage (Eich & O'Neill, 2017; Espahbodi et al., 2023; Nettles et al, 2011).

Chart 8. Pass Rate by Years Since MSW, 2018-2022



As with other negative predictors of exam outcomes, delayed exam-taking was more prevalent among examinees from historically marginalized groups. **Appendix Table A-1** suggested that a much higher percentage of Black examinees (nearly 53%), compared to about 37% of white examinees, took their first Clinical exam at least five years after earning their MSWs. Examinees from other historically marginalized groups also showed delays in exam-taking relative to their white counterparts. The exam delays may be related to challenges in meeting the required clinical supervision hours and warrant further studies.

Years of Employment and Job Position

The exam pass rate was significantly associated with years of employment. As Chart 9 suggests, the pass rate was the highest at 0.80 among examinees who had about two to three years of employment, and the rate was the lowest at 0.66 among those with at least 10 years of employment or less than a year of employment.

Job position was also significantly related to the exam pass rates. Examinees with direct service positions had the highest pass rate of 0.79, compared to those holding administrative positions (0.70) or "other" positions (0.64). It is possible that having a direct service position,

relative to other positions, is more likely to facilitate the development of clinical social work competence. According to the NASW/ASWB's national guidelines for clinical social work supervision (NASW & ASWB, 2013), candidates for clinical social worker licensure should complete the required supervised training "in an appropriate setting" to be eligible for the Clinical exam. In addition, the ASWB policy manual on the examinations (2022) states that the Clinical exam is developed for candidates with two years of experience in "clinical settings." The exam data suggest that some examinees held positions that might not have been conducive to developing clinical social work competence compared to those who held a direct service position.

Chart 9. Pass Rate by Years of Employment, 2018-2022

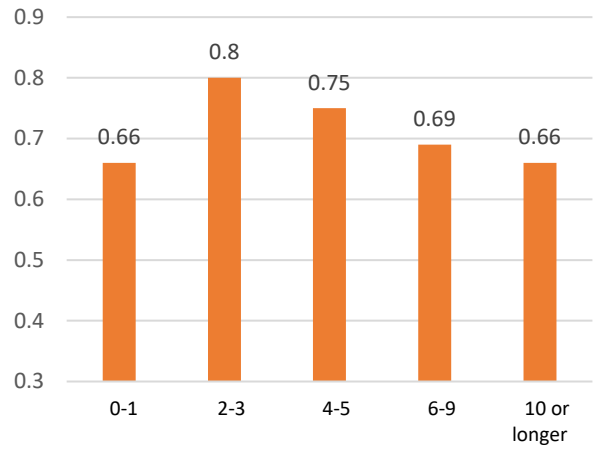
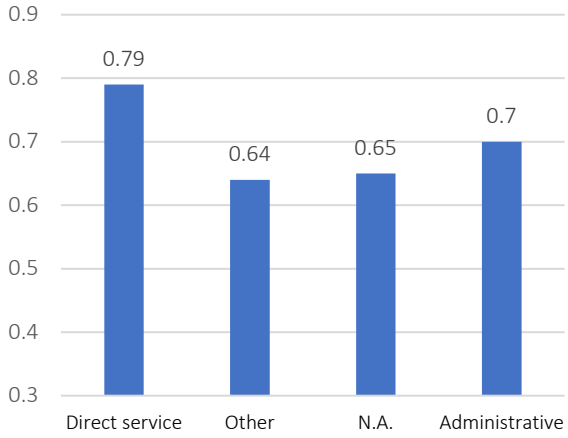


Chart 10. Pass Rate by Job Position, 2018-2022



Were these negative predictors of exam outcomes more prevalent among examinees from historically marginalized groups? Again, **Appendix Table A-1** suggests that relative to about 21% of white examinees who had more than six years of employment at their first exam attempt, nearly 32% of Black examinees had more than six years of employment. In addition, the lowest share of Black examinees (54%), compared to other racial/ethnic groups, had direct service positions. On the other hand, more than 65% of white examinees reported having a direct service position. The difference in job positions by race/ethnicity may indicate race/ethnicity-specific experiences in the social work labor market, which also warrants further studies.

Pass Rate Disparities by Institutional Characteristics

The ASWB Clinical exam pass rate was associated with the characteristics of MSW programs that the examinees attended. Those who graduated from large programs and programs with fewer students from historically marginalized groups had a higher pass rate than their counterparts.

The characteristics of educational institutions were related to exam outcomes. Clinical examinees who attended institutions that were less selective in admission and where more than half of students were Pell Grant recipients had a lower pass rate than their counterparts.

MSW Program Size and Diversity

As Chart 11 shows, examinees who graduated from the smallest programs (with less than 506 examinees) had the lowest pass rate of 0.69, and those who graduated from the largest (with at least 1,935 examinees) had the highest pass rate of 0.78. As indicated by the literature, the programs with a large number of Clinical examinees might have had more resources to aid examinees' preparation for the exam (Falcone, 2012).

Examinees who attended MSW programs in which up to a third (33%) of the students were from historically marginalized groups had a pass rate of around 0.80 but those who had attended programs in which nearly half of the students were from historically marginalized groups had the lowest pass rate of 0.65.

Chart 11. Pass Rate By Program Size, 2018-2022

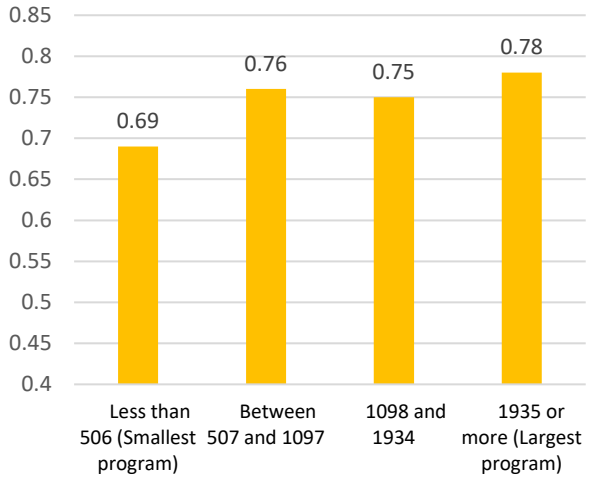
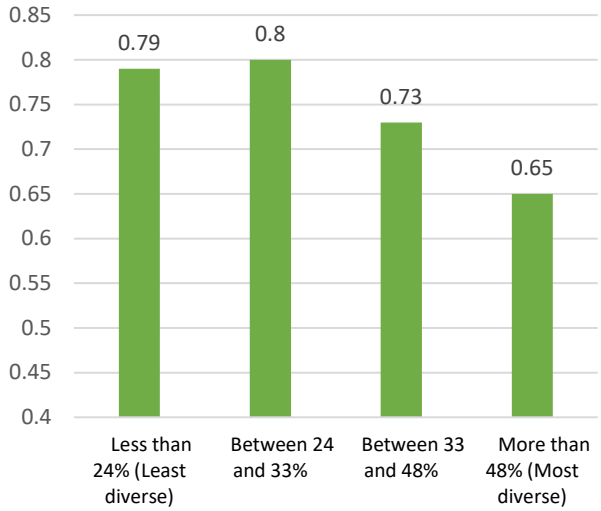


Chart 12. Pass Rate by Racial/Ethnic Diversity, 2018-2022



Findings presented in **Appendix Table A-1** suggest that **a higher share of examinees from historically marginalized groups earned their MSWs from institutions whose characteristics might have been negatively associated with Clinical exam outcomes**. For example, a higher share of Black examinees (31.48%) than white examinees (23.97%) obtained their MSWs from a program with the smallest number of Clinical examinees. At the same time, large percentages of Hispanic, Asian, and Black examinees earned their MSWs from institutions where nearly half of the examinees were from historically marginalized groups. Only about 15% of white examinees earned their MSWs from such an institution.

Type of Educational Institutions

Chart 13 shows that the type of educational institution that examinees attended was associated with exam pass rates. Examinees who attended private, for-profit institutions had a pass rate as low as 0.49. This low pass rate for examinees from private, for-profit institutions was consistently documented in the literature (Espahbodi et al., 2023; Mittelstaedt & Morris, 2017; Spector et al., 2020). The finding confirms that the same pass rate disparity by educational institution type exists in social work.

Chart 14 presents a related finding that examinees who attended doctorate-granting institutions had a higher pass rate than those who attended master's-granting institutions (0.75 versus 0.70).

Chart 13. Pass Rate by Type of Institution, 2018-2022

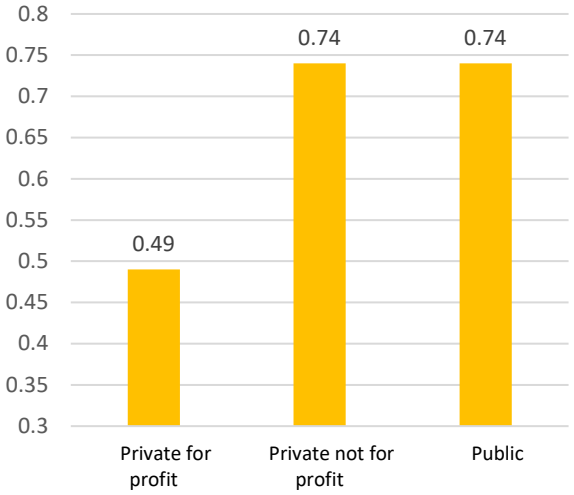
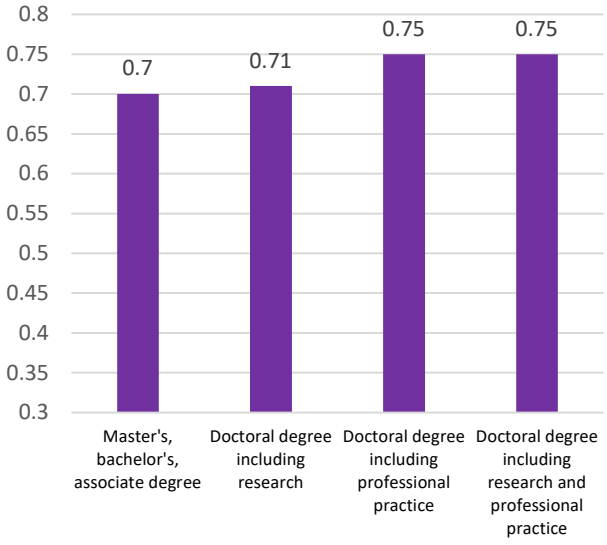


Chart 14. Pass Rate by Institutions' Highest Degrees Granted, 2018-2022



How were these predictors of exam outcomes distributed across the examinees' racial/ethnic groups? According to **Appendix Table A-1,** only 0.56 % of all examinees had earned their MSWs from private, for-profit institutions (There were only two private, for-profit institutions that housed accredited MSW programs.) About 0.5% of white examinees, 1.17% of

Black examinees, and 0.80% of examinees from unknown race/ethnic groups were graduates of private, for-profit programs. In addition, approximately 70% of all examinees, across most racial/ethnic groups, earned their MSWs from doctorate-granting institutions. The race/ethnicity differences in the types of institutions were not as clear as those in other predictors of exam outcomes.

Institution's Location and Undergraduate Students' Socioeconomic Status

Chart 15 shows that the exam pass rates significantly differed by the urbanity of institutions' locations. Examinees from institutions located in mid-size or large-size urban areas passed the exam at a higher rate than those from institutions in rural or suburban areas (0.76 versus 0.71) (Angelo et al., 2021). As previous evidence reported, examinees who graduated from institutions with a higher share of students in poverty had a lower pass rate than their counterparts (Espahbodi et al., 2023). According to Chart 16, examinees who had attended institutions where at least half of the undergraduate students were Pell Grant recipients had a pass rate of 0.64, far lower than the pass rate of 0.80 for the examinees whose institutions had less than 20% of students on Pell Grant.

Chart 15. Pass Rate by Urbanity of Institution's Location, 2018-2022

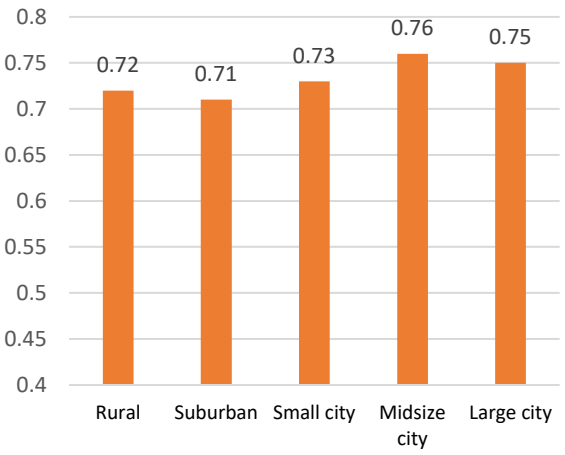
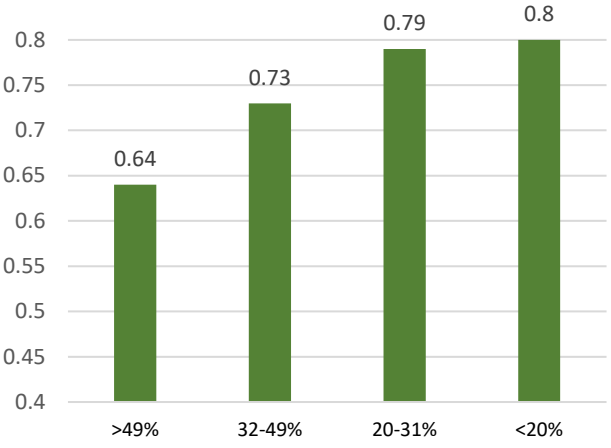


Chart 16. Pass Rate by Percent of Students on Pell Grant, 2018-2022



Appendix Table A-1 presents the locations of educational institutions by examinees' race/ethnicity. The finding suggests no significant patterns in the institutions' locations by racial/ethnic groups. However, **significantly greater shares of Black (35.91%) and Hispanic/Latino (36.26%) examinees, compared to 15.62% of white counterparts, had attended institutions where at least half of undergraduate students were Pell Grant recipients**.

Institution's Undergraduate Admission Selectivity

Chart 17 presents another well-established relationship in the literature between the selectivity of educational institutions and students' licensing exam outcomes (Chaparro, 2020; Espahbodi et al., 2023; Wightman, 1998). The chart demonstrates that examinees from more selective institutions (in terms of the percentage of applicants admitted) had a higher pass rate than examinees from less selective institutions. Examinees whose institutions accepted less than half of the undergraduate applicants had a pass rate of 0.79, but those whose institutions accepted somewhere between 67 and 79% of the applicants had a pass rate of 0.70.

Interestingly, **Appendix Table A-1** shows that nearly 41% of Asian and 34% of Hispanic/Latino examinees, compared to 22% of white examinees, had earned their MSWs from more selective institutions (i.e., with less than a 45% acceptance rate for undergraduate admission). White examinees had the lowest percentage of attendance at more selective institutions among all racial/ethnic groups.

Chart 17. Pass Rate by Percent Admitted Among Applicants, 2018-2022

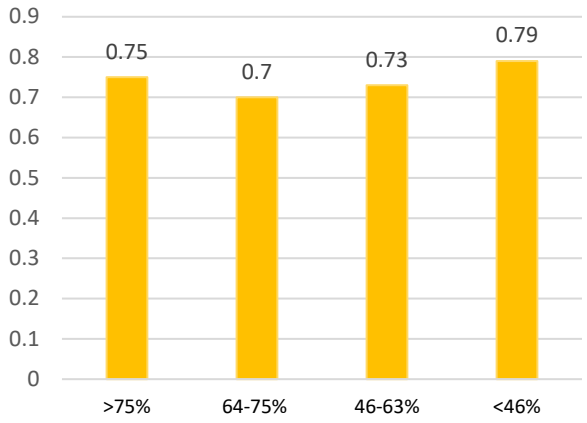
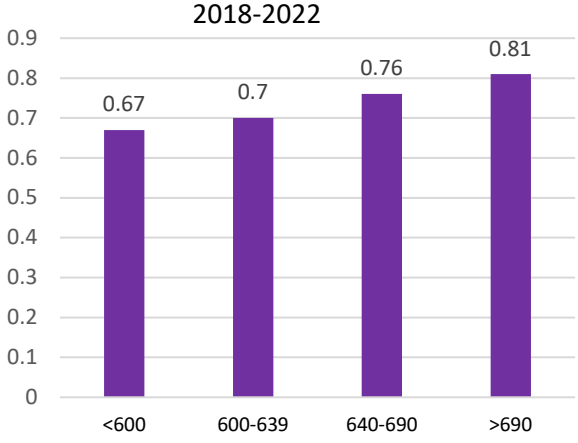


Chart 18. Pass Rate by the 75th Percentile SAT Reading Score, 2018-2022



As previous studies have reported (Chaparro, 2020; Espahbodi et al., 2023; Wightman, 1998), Charts 18, 19, and 20 show that success on the exam was associated with the admission selectivities of the educational institutions that examinees had attended. For example, the examinees who attended institutions where the 75th percentile SAT reading score for admitted first-year students was above 690 had a pass rate of 0.81, significantly higher than the pass rate of 0.67 for those from institutions where the score was below 600.

Charts 19 and 20 present similar pass rate gradients by undergraduate admission selectivity using the 75th percentile SAT math and ACT composite scores. Examinees from institutions where the 75th percentile ACT composite score was higher than 31 had a pass rate of 0.81. This was significantly higher than the pass rate of 0.64 for examinees who had attended institutions whose 75th percentile score was lower than 25.

Chart 19. Pass Rate by the 75th Percentile SAT Math Score, 2018-2022

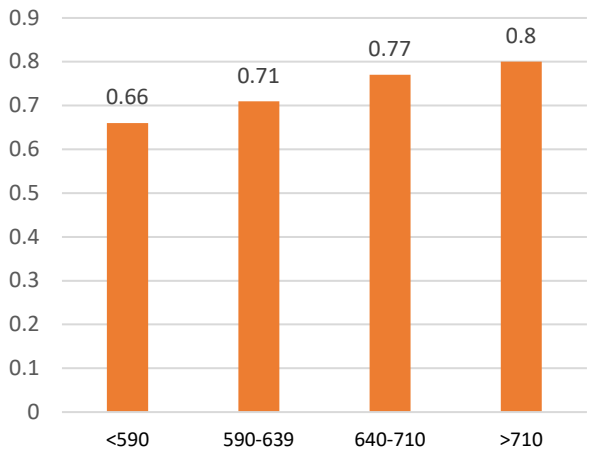
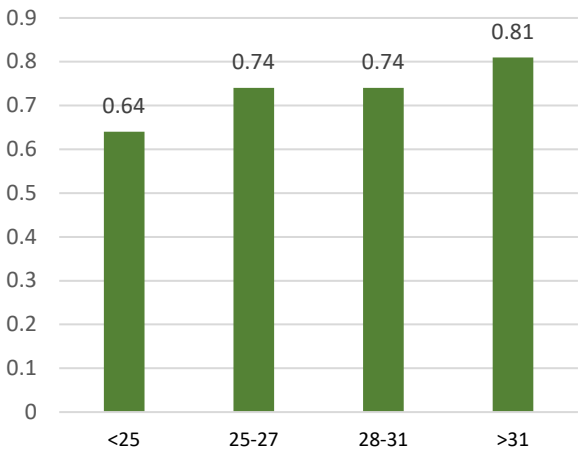


Chart 20. Pass Rate by the 75th Percentile ACT Score, 2018-2022



According to **Appendix Table A-1**, **the highest shares of Black and Hispanic students were from institutions with the lowest 75th percentile SAT scores (both reading and math) and ACT composite scores.** For example, while 16.22% of white examinees had attended institutions with below 600 for the 75th percentile SAT reading score, 23.85% of Black examinees and 23.12% of Hispanic/Latino examinees attended such institutions. These findings indicate that higher percentages of examinees from historically marginalized groups had attended institutions whose characteristics might have been negatively related to exam passage.

Pass Rate Disparities by Community Characteristics and Region

Consistent with the empirical studies of other licensing exams, success on the ASWB Clinical exam was significantly associated with community-level household incomes and racial income inequalities.

Examinees in high-income areas and areas with racial/ethnic income equality had a higher pass rate than those from less privileged areas. Pass rates also varied significantly by region of residence.

Household Income and Racial Income Inequality

As Chart 21 shows, examinees from low-income zip code areas had a significantly lower pass rate than examinees from high-income areas. Examinees in low-income areas (with annual

median household incomes less than $57,665) had a pass rate of 0.63, but those in high-income areas (with incomes more than $92,881) had a pass rate of 0.83.

Chart 21. Pass Rate by Zip Code Level Median Household Incomes, 2018-2022

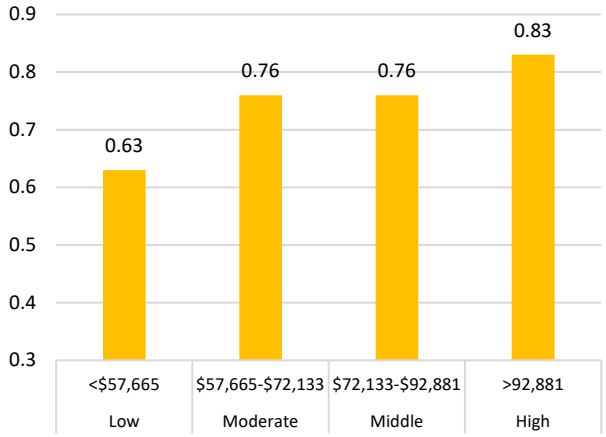


Chart 22. Pass Rate by Zip Code-Level Racial Income Inequality, 2018-2022
(for Asian, Black and Hispanic examinees only)

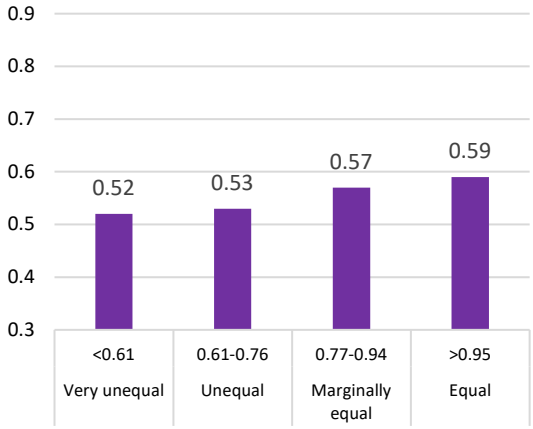


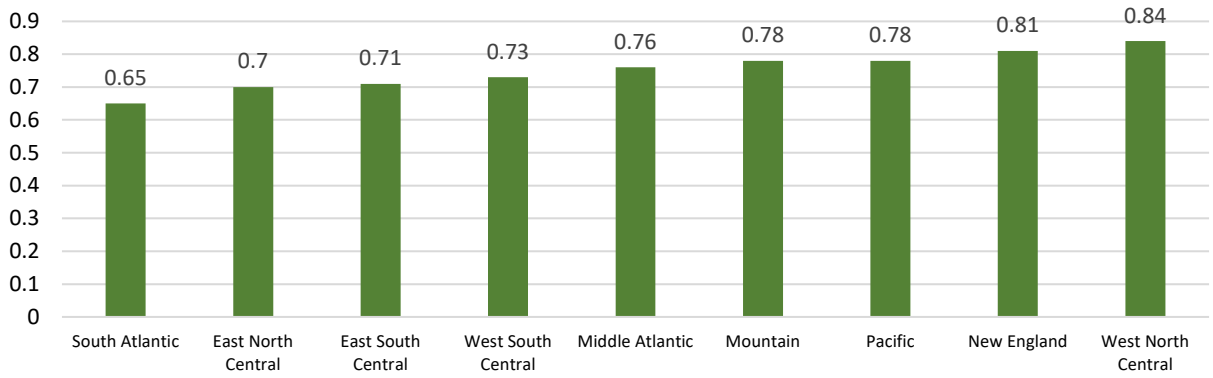
Chart 22 similarly demonstrates that examinees from areas with a high level of racial/ethnic income inequality were less likely to pass the exam than those from areas without such inequality. Asian, Black, and Hispanic/Latino examinees in zip code areas where their incomes were less than 61% of the incomes of white residents had a pass rate of 0.52. In the areas where the marginalized groups had at least 95% of the incomes of their white counterparts, the pass rate was 0.59. These findings were consistent with those reported for the CPA exam (Espahbodi et al., 2023).

Appendix Table A-1 presents an interesting finding about the zip code–level median annual household incomes for each racial/ethnic group. While nearly 47% of Asian and 29% of white examinees appeared to reside in zip code areas with an annual median income of at least $93,000, only 6.6% of Black and 13.99% of Hispanic/Latino examinees did so. On the other hand, **more than 58% of Black examinees lived in the lowest income areas** (with an annual median household income below $57,665). Only about 13% of Asian and 16% of white examinees lived in the lowest-income areas. About 26% of Hispanic/Latino examinees resided in the lowest income areas. Furthermore, Black examinees lived in areas with the highest level of racial income inequality. Appendix Table A-1 demonstrates that nearly 35% of Black examinees, compared to about 12% of Asian and 16% of Hispanic/Latino examinees, lived in zip code areas where Black residents' incomes were less than 61% of white residents' incomes. Only around 18% of Black examinees lived in areas where their incomes were at least about 95% of their white counterparts' incomes. These findings suggest that **a much higher share of Black examinees lived in economically segregated areas** than examinees from other historically marginalized groups**.** This means that higher percentages of Black examinees lived in communities with characteristics that may have had a negative effect on their exam performance.

Region of Residence

Chart 23 shows that Clinical exam pass rates significantly differed by examinees' region of residence. Examinees living in the South Atlantic region (DE, DC, FL, GA, MD, NC, SC, VA, WV) had the lowest pass rate of 0.65, much lower than the highest rate of 0.84 for those in the West North Central area (IA, KS, MN, MO, NE, SD, ND). Interestingly, there is a clear regional gradient in the pass rates, as shown in Chart 23. Although previous studies from other regulated professions (e.g., Falcone & Hamad, 2012) also presented a regional disparity in exam pass rates, the literature does not yet provide any theoretical explanations as to why such a regional disparity is observed.

Chart 23. Pass Rate by Region of Residence, 2018-2022



According to **Appendix Table A-1**, **racial/ethnic groups were not evenly distributed across the nine regions.** As high as 37% of Black examinees lived in the South Atlantic region, and nearly 46% of Asian and 42% of Hispanic/Latino examinees lived in the Pacific region. Although white examinees were most evenly distributed across the country, nearly 20% were from the East North Central area.

Net Effect of Race/Ethnicity on the Odds of Exam Failure

Logistic regression analyses suggested that if examinees from historically marginalized groups had the same demographic, educational, and employment characteristics and lived in similar institutional and community environments as white examinees, the Black–white disparity in the Clinical exam outcome could be reduced by about 20%, and the Hispanic/Latino–white disparity by around 28%.

Black examinees' exam outcomes were sensitive to institutional and community-level socioeconomic status and inequalities. On the other hand, Hispanic/Latino examinees' exam outcomes were explained more by their individual backgrounds.

As discussed earlier, a logistic regression analysis was conducted to understand the effects of race/ethnicity on the likelihood of failing first-attempt Clinical exams while taking the effects of demographic, institutional, and community characteristics into consideration. As shown in Table 2, the first race/ethnicity–only model (Model 1) included only race/ethnicity variables in the analyses. The second model (Model 2) added examinees' other demographic (other than race/ethnicity), educational, and employment characteristics to the first model. The last, full model (Model 3) added institutional and community-level variables to the second model. The goal was to observe how the odds ratios of the race/ethnicity variables declined between the models. **Appendix Table A-2** provides the full findings of the three regression models, including the odds ratios of variables other than race/ethnicity. Also, as discussed previously, the regression analyses did not include multiracial examinees or examinees whose race/ethnicity was unknown. Please note that due to high correlations between multiple variables (e.g., age groups and years of employment; SAT scores and percent of students on Pell Grant), the logistic regression models include only the necessary interrelated predictors of pass/fail outcome.

Table 2 presents the major findings in odds ratios of the race/ethnicity variables. The last two columns of the table show the percent reductions in the effect of race/ethnicity due to the added individual, institutional, and community-level variables. A comparison of the three regression models suggests that the effect of race/ethnicity remains large and significant, but the effect was reduced when other predictors were included in the model to explain exam failure, as discussed below.

Table 2. The Effects of Race/Ethnicity on First-Time Clinical Exam Failure, 2018-2022

	Model 1 (M1)		**Model 2 (M2)**		**Model 3 (M3)**		**Percent (%) reduction in Odds Ratio between models**	
	Race/Ethnicity only		Demographic, educational, and employment characteristics		Demographic, educational, employment, institutional, and community characteristics			
	O.R.	*p*	O.R.	*p*	O.R.	*p*	M1 vs. M2	M1 vs. M3
Asian	2.055	***	1.868	***	1.879	***	9.10	8.56
Black	6.483	***	6.019	***	5.193	***	7.16	19.90
Hispanic/Latino	2.771	***	2.199	***	2.009	***	23.53	27.50
(White)								

Notes: (1) O.R.: Odds Ratio; (2) *** $p<0.001$; (3) Reference group is in parenthesis

According to the findings of the race/ethnicity–only model (Model 1), the odds of exam failure for Asian examinees were 2.055 times higher than the odds for white examinees. The odds of exam failure were 6.483 times higher for Black examinees and 2.771 times higher for Hispanic/Latino examinees than the odds for their white counterparts. In the individual characteristics model (Model 2), the odds ratios of all race/ethnic groups were reduced when examinees' demographic, educational, and employment characteristics were controlled for. For example, the odds of exam failure for Black examinees were **reduced by 7.16%** from 6.483 to 6.019 (0.0716= [6.483-6.019]/6.483), and the odds of exam failure for Hispanic/Latino examinees were **reduced by 23.53%** from 2.771 to 2.199 (0.2353= [2.771-2.119]/2.771).

When the full model (Model 3) added institutional and community-level variables to the logistic regression, **the odds of exam failure for Black examinees** — relative to the odds of white examinees' — **were reduced by 19.90%** from 6.483 to 5.193. **For Hispanic/Latino examinees, the odds of failure declined by 27.50%** from 2.771 to 2.009. **As suggested by the large reduction in the odds ratios between Model 1 and Model 3, Black examinees' exam outcomes appear to be sensitive to institutional and community-level socioeconomic status and inequalities**. This finding was closely in line with the finding reported by Espahbodi et al. (2023). On the other hand, **Hispanic/Latino examinees' exam failure was explained more by their individual backgrounds as indicated by the large reduction in the odds ratios between Model 1 and Model 2.** Asian examinees' odds of failure were reduced by about 9%, regardless of the inclusion of institutional and community-level determinants. This finding was not surprising because Asian examinees' overall characteristics were not as markedly different from white examinees as Black or Hispanic/Latino examinees' characteristics were.

Many additional regression analyses were conducted, although their findings were not presented in this report. For example, **when the same regression model was run with examinees in the South region only, the Black–white disparity in the exam failure rate was**

reduced by nearly 30% (from an odds ratio of 6.345 in the race/ethnicity–only model to 4.444 in the full model). This finding suggests that the included predictors had more explanatory power with a geographically homogenous sample of examinees. Likewise, when the regression analysis was conducted with examinees from private, nonprofit educational institutions, the included predictor variables reduced the Black–white disparity in the failure rate by 26%, from the odds of 6.415 in the base model to 4.747 in the full model.

Overall, the models explained relatively moderate levels of variance in the exam outcome, as shown in the pseudo-R^2 in **Appendix Table A-2**. It may be that variability in the exam data was high and that the full model did not include determinants that are critical to the exam outcome. As discussed earlier, many crucial predictor variables presented in Chart 1 were not available for this analysis. In addition, the institutional and zip code–level variables from the U.S. Census and NCES IPEDS data were, at best, only partial and crude proxies of the individual-level variables needed to test the conceptual framework depicted in Chart 1. The findings of this analysis should be interpreted with these limitations in mind.

Discussion

Summary

This study set out to shed light on the racial/ethnic disparities in the ASWB Clinical exam outcome. We tested the statistical significance of the individual, institutional, and community-level determinants of licensing exam outcomes identified in other licensed professions' literature with the ASWB Clinical exam data. The findings of our analyses are closely aligned with the extant literature. Older ages, gender, English use as a second language, beginning postsecondary education with an associate's degree, holding a BSW, delays in taking the licensing exam, and working in non-direct service positions were negatively associated with exam passage. Smaller MSW programs and institutions that largely served students from lower socioeconomic backgrounds were also negatively related to exam passage. Additionally, living in low-income communities was a significant predictor of exam failure. Our analyses showed that these negative predictors of exam outcomes were, in general, more prevalent among examinees from historically marginalized groups, indicating that race/ethnicity serves as a marker of socioeconomic disadvantages.

Our regression analyses tried to separate the net effect of race/ethnicity from the effects of correlated socioeconomic disadvantages in explaining exam outcomes. The findings showed that the effect of race/ethnicity declined considerably (by around 20–30% in the odds of failure) when the associated effects of socioeconomic disadvantages were controlled for. Nevertheless, race/ethnicity remained the most influential determinant of the ASWB Clinical exam outcome. These findings were not surprising given the limited predictor variables available in the ASWB exam data. As discussed earlier, our analyses could not incorporate the number of crucial predictors of exam outcomes identified in the conceptual framework. Despite the data

limitations, our overall findings on the determinants of the exam outcomes were consistent with the existing evidence in other professions' literature. The data limitations, however, should spur many further research questions, as discussed below.

Further Studies for Potential Interventions

The findings of this study may prompt many research questions. First and foremost, our analyses could not investigate the relationship between **examinees' academic backgrounds and performance** and their ASWB Clinical exam outcomes because we did not have access to such data. Some of the most comprehensive studies in bar and medical licensing exams revealed that racially disparate exam outcomes were primarily explained by examinees' GPAs in the academic programs and admission test scores (Rubright et al., 2019; Wightman, 1998). It would be important for the social work profession to replicate such studies to identify the factors contributing to the large racial disparities in the ASWB exam outcomes. Obtaining the examinees' academic backgrounds and performance data and linking them to the ASWB exam outcomes would require long-term collaboration between MSW programs and ASWB. Such partnerships may enable more comprehensive empirical research that can allow investigation of the relationship between the **characteristics of MSW programs** (e.g., faculty characteristics, curriculum, admission criteria, etc.) and ASWB exam outcomes. Because our analysis could not include any of these important predictors, further studies are necessary to unveil what was hidden in the relationships. **Collaboration between ASWB and MSW programs** will be critical in making the necessary data available for such studies.

Relatedly, collaborative research between ASWB and MSW programs can bring additional insights into program- and institution-level determinants of exam outcomes. Although social work candidates take Clinical exams many years after they graduate from MSW programs, the development of their clinical competence begins with MSW education and training. Our data analyses showed that some MSW programs did an excellent job of graduating Black and Hispanic/Latino candidates who would later succeed on the Clinical exam on their first attempts. A few examples of such MSW programs were at San Diego State University; the University of California, Berkeley; and the University of Texas at Austin. Black and Hispanic graduates of these programs passed the Clinical exams at around 80 to 90% on their first attempts. Given these exemplary programs, it may be fruitful to **investigate what sets those programs and their graduates apart from others**. Suppose there are common features in their student bodies, curricular contents, clinical training, or faculty qualifications that may be relevant to their graduates' later success on the Clinical exams. In that case, they may inform ideas for feasible and replicable interventions for other MSW programs or institutions.

Last, the findings of this study raised another question about **the labor market experiences of social work candidates, particularly Black candidates**. Little is known about how MSW graduates navigate the social work job market to secure employment in a clinical setting to gain the required postgraduate clinical supervision and if their experiences significantly differ by race/ethnicity. It is difficult to explain why a smaller share of Black MSW graduates held a direct service position and took many more years to attempt their first Clinical exams than

examinees from other racial/ethnic groups. It will be important to study if experiences of postgraduate clinical training are racially patterned and create barriers for Black candidates to develop clinical competence in a reasonable timeframe. States' regulatory rules and practices governing social work candidates' supervised training and ASWB exam registrations may also be an important topic for investigation. States vary in terms of requiring a specified amount of time to accrue supervision hours and take the ASWB Clinical exam. Therefore, it will be worthwhile to explore if there are any regulatory rules and practices that affect social work candidates' acquisition of the required postgraduate supervision.

Implications

Licensing exams play a critical role in verifying candidates' competence in a uniform and efficient way (Kane, 2005). For the public, a licensing exam certifies professional candidates' minimum competence to protect the public. For educational institutions, a licensing exam can help institutions externally validate student outcomes. For individuals, the assessment can provide useful feedback about areas for additional knowledge and skill development. As Kane (2005) explained, a high level of achievement on a licensing exam does not ensure success in practice, but a lack of adequate mastery of competencies may put clients at risk. Evidence from the legal and medical professions suggests significant relationships between exam outcomes and the indicators of public safety (Anderson & Muller, 2019; Cuddy et al., 2017; Tamblyn et al., 2007).

As with other professions' licensing exams, the ASWB exams follow strict test development standards, set by the American Psychological Association, the Joint Commission on Standards for Educational and Psychological Testing, the American Educational Research Association, and the National Council on Measurement in Education. Questions on the ASWB exams are reviewed for signs of potential bias at each step in the exam development process. Any questions identified as potentially biased, as well as those failing to accurately test candidates' knowledge, are not included on the exams. However, as with many licensed professions reviewed in the Exam Report Series, the social work profession has been challenged with racially disparate licensing exam outcomes.

The prevalence of racial disparities across many professions' licensing exams indicates that the causes of disparities are deeply rooted in the fabric of our socioeconomic systems. In response to the disparities in exam outcomes, many take a reductionist approach by blaming the exams or advocating to remove competence assessment in the licensure system. While no licensing exam may be perfect as an assessment tool for professional competence in the complexity of real practice environments (Kane, 2005), group differences in exam outcomes do not necessarily indicate that the exams are biased. They instead reflect persistent inequalities and segregation in our schools, communities, and workplaces that disproportionately and adversely affect people from low-income and historically marginalized backgrounds (Hauser & Heubert, 1998).

To maintain the integrity of the licensure system while not reinforcing and perpetuating the inequalities that continue to penalize people from historically marginalized groups, major professional stakeholders must come together to determine what further research is necessary and what interventions may be feasible and effective to address the problem. Doing this would be more challenging, yet more effective in narrowing the disparities than simply discarding the exam or the licensure system. When we can locate the sources of the disparities and know how to intervene strategically, we can reduce and even eliminate them in the long run, as they were socially created and not inherent in the demographic groups.

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Appendix Tables

Table A-1. Percentage Distributions of First-Time Clinical Examinees' Individual, Institutional, and Community Characteristics (N=88,678)

	All	Asian	Black	Hispanic	Multi	Unknown	White
	100.00	3.55	14.13	11.92	5.32	1.55	63.54
Age group							
<=29	25.59	24.00	18.87	22.13	23.57	12.75	28.30
30–34	28.56	33.82	26.09	34.10	28.21	26.37	27.85
35–39	16.28	18.88	17.77	19.32	17.54	21.92	14.98
>=40	29.58	23.30	37.26	24.44	30.67	38.97	28.87
Male	12.94	14.88	12.00	13.64	13.73	18.94	12.70
English as a secondary language	7.12	32.77	3.63	33.36	9.44	6.26	1.36
Holding an associate's degree	21.10	15.61	24.03	30.34	25.58	22.21	18.61
BSW	33.64	24.73	40.47	32.09	31.08	27.17	33.27
Years since MSW							
Less than 1	3.81	2.16	1.72	2.36	4.52	2.99	4.60
1–2	16.70	10.81	14.64	11.38	15.44	12.38	18.70
3–4	38.65	41.32	30.93	42.43	37.87	36.56	39.63
5–6	18.00	20.22	20.48	22.12	20.03	20.10	16.32
More than 6	22.84	25.49	32.23	21.71	22.15	27.97	20.76
Years of employment							
<=1	13.82	10.33	15.79	11.27	14.91	12.31	14.01
2–3	40.63	40.08	29.15	39.12	38.23	37.22	43.77
4–5	22.39	24.92	23.22	26.09	24.52	22.65	21.19
6–9	12.98	14.27	17.22	14.83	13.22	15.88	11.53
>=10	10.18	10.39	14.62	8.69	9.12	11.94	9.50
Job position							
Direct service	62.30	61.92	53.95	57.32	61.09	57.68	65.33
Other	20.59	23.27	24.74	26.46	22.19	23.82	18.21
Not applicable	5.98	5.12	5.97	6.03	5.88	8.74	5.97
Administrative work	11.12	9.69	15.34	10.19	10.84	9.76	10.49
Size of graduate program							
Less than 506	25.68	25.05	31.48	28.25	25.90	23.60	23.97
Between 507 and 1097	28.70	29.78	23.97	29.97	29.53	29.50	29.37
1098 and 1934	23.76	14.94	24.61	14.36	19.88	21.34	26.21
1935 or more	21.86	30.23	19.93	27.42	24.69	25.56	20.45
Diversity of graduate student body							
Less than 24%	23.97	8.68	11.47	7.36	15.93	17.41	31.55
Between 24 and 33%	25.17	22.35	17.65	15.49	23.38	22.80	29.03
Between 33 and 48%	24.71	25.52	29.55	21.37	25.60	26.44	24.09
(More than 48%)	26.15	43.45	41.33	55.78	35.09	33.36	15.33

Type of institution							
Missing	1.55	2.73	1.36	0.81	1.46	1.97	1.66
Private, for-profit	0.56	0.19	1.17	0.28	0.36	0.80	0.51
Private, nonprofit	33.79	38.40	31.55	35.66	34.79	39.26	33.46
Public	64.10	58.68	65.92	63.24	63.39	57.98	64.37
Highest degree granted by the institution							
Missing	4.55	8.68	3.62	7.60	4.71	6.12	3.90
Master's, bachelor's, associate's	7.05	4.35	6.67	7.35	7.85	7.79	7.14
Doctoral, w/ research	11.43	6.68	13.96	9.74	11.33	10.85	11.48
Doctoral, w/professional practice	6.94	7.15	6.36	7.28	7.02	5.54	7.02
Doctoral, w/ research and professional practice	70.03	73.14	69.39	68.02	69.09	69.7	70.46
Urbanity of institution							
Missing	1.55	2.73	1.36	0.81	1.46	1.97	1.66
Town or rural	4.62	2.10	3.97	3.67	4.65	4.73	5.08
Suburban	19.40	13.83	19.15	19.31	18.65	19.52	19.84
Small city	14.75	8.04	13.35	8.88	11.39	10.71	16.91
Midsize city	13.22	10.33	15.14	9.36	13.39	12.24	13.69
Large city	46.45	62.97	47.02	57.96	50.47	50.84	42.80
Percent of students on Pell Grant							
Missing	3.56	3.91	4.14	1.95	3.78	3.50	3.69
(Less than 20%)	24.02	30.48	18.69	23.37	25.52	26.07	24.79
Between 20–31%	27.57	26.61	18.99	19.09	26.01	26.07	31.30
Between 32–49%	22.96	15.26	22.27	19.33	19.60	19.45	24.59
Greater than 49%	21.88	23.74	35.91	36.26	25.10	24.91	15.62
Admission selectivity							
Missing	7.77	6.23	9.51	5.92	8.70	6.92	7.76
>75% accepted	23.96	15.16	20.61	16.35	21.21	20.98	26.93
64–75% accepted	20.69	17.42	22.36	15.30	18.07	18.43	21.79
46–63% accepted	22.82	20.44	23.91	28.49	22.59	22.29	21.68
<46% accepted	24.76	40.75	23.62	33.94	29.42	31.39	21.84
75th PCTL SAT Reading score							
Missing	13.78	12.11	16.52	12.05	13.62	12.96	13.61
<600	18.17	14.24	23.85	23.12	18.10	17.84	16.22
600–639	20.00	20.53	19.31	22.18	20.64	20.32	19.65
640–690	23.44	14.69	21.76	15.98	19.9	20.83	26.05
>690	24.62	38.43	18.55	26.67	27.75	28.04	24.46
75th PCTL SAT Math score							
Missing	13.78	12.11	16.52	12.05	13.62	12.96	13.61
<590	16.40	12.02	22.35	21.00	16.76	15.95	14.44
590–639	20.33	20.41	18.40	21.04	19.50	20.17	20.69
640–710	23.18	15.48	22.49	17.18	20.00	20.32	25.22

>710	26.32	39.99	20.23	28.74	30.12	30.59	26.03
75th PCTL ACT score							
Missing	14.30	14.34	16.07	14.43	15.70	14.79	13.76
<25	14.06	13.22	22.87	21.34	15.19	13.91	10.68
25–27	25.20	21.61	20.72	23.57	22.42	22.72	27.00
28–31	18.26	10.11	18.38	11.53	15.76	17.26	20.19
>31	28.17	40.72	21.96	29.12	30.93	31.32	28.37
Zip code–level median household incomes by race							
Missing	10.18	3.02	5.28	2.70	-	-	3.37
< $57,665	22.22	12.71	58.18	26.17	-	-	16.41
$57,665–$72,133	22.73	22.47	15.82	36.06	-	-	24.23
$72,134–$92,881	22.42	15.10	14.13	21.08	-	-	27.35
(> $92,881)	22.45	46.69	6.60	13.99	-	-	28.63
Racial income ratio group							
Missing	-	3.02	5.28	2.70			
<0.61	-	12.30	34.63	16.37	-	-	-
0.61–0.76	-	6.68	26.12	28.31	-	-	-
0.76–0.95	-	26.51	16.10	32.33	-	-	-
> 0.95	-	54.51	17.88	20.29	-	-	-
Region of residence							
New England	8.18	4.55	4.28	4.61	6.62	9.47	10.02
Middle Atlantic	14.49	14.84	11.85	12.13	13.85	18.06	15.47
East North Central	17.14	10.52	16.33	8.50	12.86	12.38	19.79
West North Central	6.16	4.29	2.43	1.76	4.26	3.86	8.13
South Atlantic	17.68	9.47	36.99	12.53	17.42	17.99	14.83
East South Central	3.34	0.45	5.27	0.47	1.48	1.97	3.81
West South Central	6.76	4.90	10.09	8.56	6.22	5.75	5.86
Mountain	8.93	5.28	2.35	9.58	10.61	7.87	10.36
Pacific	17.31	45.71	10.42	41.86	26.69	22.65	11.74

Note: - denotes that data are not available.

Table A-2. Logistic Regression of First-Time Clinical Exam Failure

	Model 1		Model 2		Model 3	
	O.R.	*p*	O.R.	*p*	O.R.	*p*
Race						
Asian	2.055	***	1.868	***	1.879	***
Black	6.483	***	6.019	***	5.193	***
Hispanic	2.771	***	2.199	***	2.009	***
(White)						
Male			1.321	***	1.315	***
English as a secondary language			1.621	***	1.614	***
Holding an associate's degree			1.908	***	1.825	***
BSW			1.774	***	1.708	***
Years since MSW						
Less than 1			1.090		1.151	**
1–2			1.289	***	1.276	***
(3–4)						
5–6			1.332	***	1.313	***
More than 6			1.616	***	1.582	***
Job position						
Other			2.006	***	1.963	***
Not applicable			2.118	***	2.104	***
Administrative work			1.396	***	1.388	***
(Direct service position)						
Size of graduate program						
Less than 506					1.159	***
Between 507 and 1097					1.057	+
1098 and 1934					1.220	***
(1935 or more)						
Diversity of student body						
(Less than 24%)						
Between 24 and 33%					0.936	*
Between 33 and 48%					1.106	***
More than 48%					1.147	***
Percent of students on Pell Grant						
Missing					1.278	***
Greater than 51%					1.300	***
Between 39–51%					1.228	***
Between 27–38%					1.001	
(Less than 27%)						
Zip code–level median household incomes by race						
Missing					1.154	**
< $57,665					1.252	***

$57,665 and $72,133					1.100	***
$72,134 and $92,881					1.153	***
(> $92,881)						
Exam Year						
2018	1.0986	***	1.228	***	1.222	**
2019	1.0422		1.146	***	1.143	**
2020	0.9622		1.018		1.014	
2021	0.9844		1.002		1.003	
(2022)						
Model Statistics						
Cox-Snell R^2	0.0976		0.1465		0.1516	
Nagelkerke R^2	0.1436		0.2155		0.2230	
Likelihood Ratio Test: Chi-square (*df*)	8479 (7)	***	13082 (18)	***	13576 (32)	***
N	82591		82591		82591	

Note: The multiracial group and examinees with no race/ethnicity information were excluded from the logistic regression analysis. Reference groups are in parentheses.

+ p <.10; *p <.05; **p <.01; ***p <.001

Virginia Department of
Health Professions
Board of Social Work

Staff Discipline Report

Jun 8, 2024 - Sep 13, 2024

NEW CASES RECEIVED BY BOARD Jun 8, 2024 - Sep 13, 2024
36

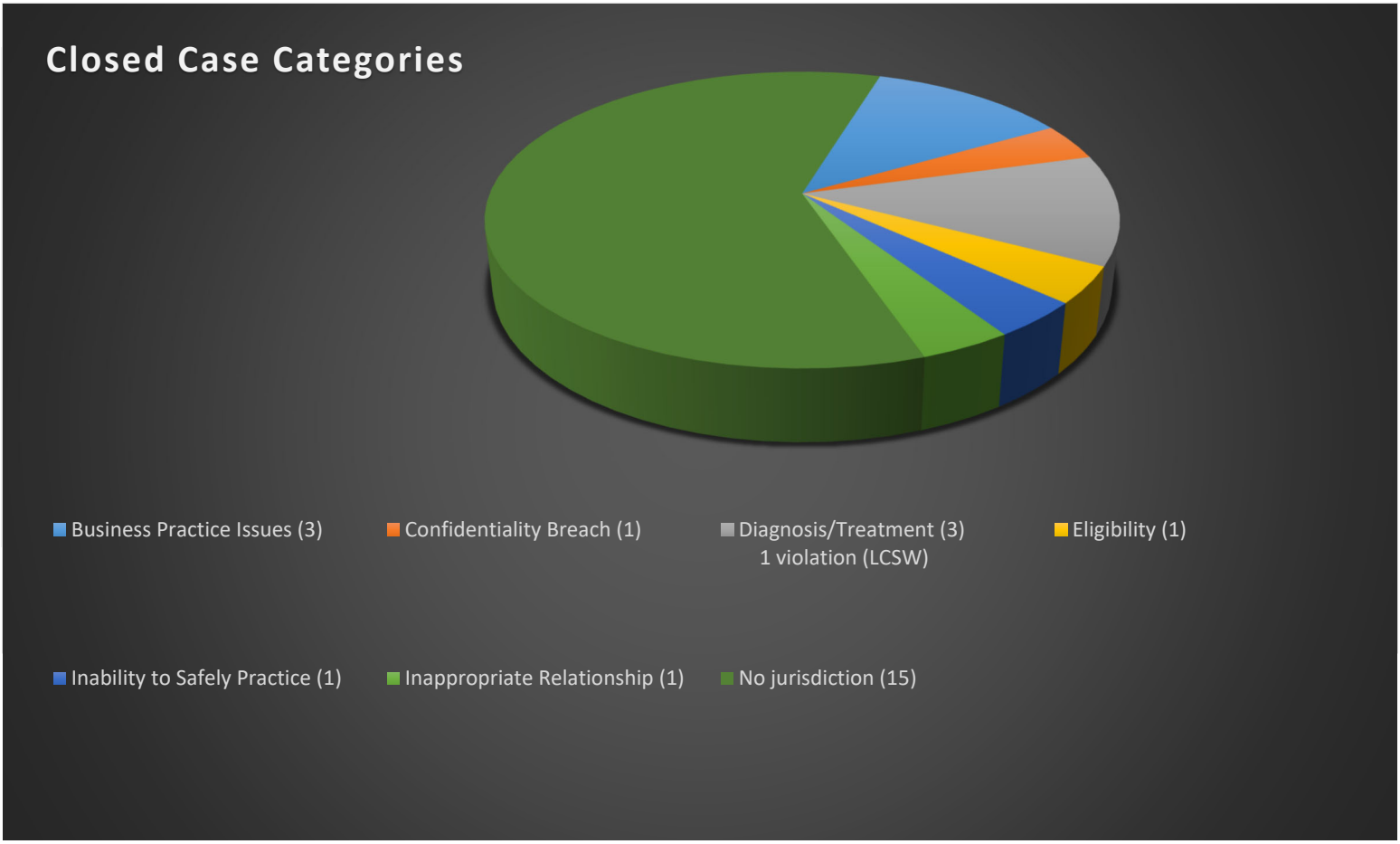
TOTAL OPEN INVESTIGATIONS (ENFORCEMENT)
43

OPEN CASE STAGES as of Sep 13, 2024	
Probable Cause Review	171
Scheduled for Informal Conferences	2
Scheduled for Formal Hearings	15
Other (pending CCA, PHCO, hold, etc.)	4
Cases with APD for processing (IFC, FH, Consent Order)	1
TOTAL CASES AT BOARD LEVEL	**193**

CONFERENCES AND HEARINGS			
Informal Conferences			
Conferences Held:	Jun 21, 2024	Aug 30, 2024	
Scheduled Conferences:	Dec 6, 2024		
	Feb 7, 2025	May 2, 2025	Aug 1, 2025
Formal Hearings			
Hearings Held:	n/a		
Scheduled Hearings:	Sep 27, 2024		

CASES CLOSED Jun 8, 2024 - Sep 13, 2024		
Closed – **No violation**		21
Closed – **Undetermined**		2
Closed – **Violation**		1
Conference/Hearing held	0	
Consent Order	1	
Confidential Consent Agreement	0	
Mandatory Suspension	0	
Summary Suspension	0	
Credentials/Reinstatement		
Application Denied	0	
Application Approved	0	
Credentials/Reinstatement – **Withdrawn**		1
TOTAL CASES CLOSED		**25**

Virginia Department of
Health Professions
Board of Social Work



AVERAGE CASE PROCESSING TIMES (counted on closed cases)	
Average time for case closures	**202**
Avg. time in Enforcement (investigations)	48
Avg. time in APD (IFC/FH preparation)	56
Avg. time in Board (includes hearings, reviews, etc).	149

Virginia Department of
Health Professions
Board of Social Work

Discipline Staff for Behavioral Science Boards

Jennifer Lang, Deputy Executive Director
Christy Evans, Discipline and Compliance Case Specialist
(Vacant), Discipline and Compliance Case Specialist
Discipline Reviewer, Board of Counseling (part-time)
Discipline Reviewer, Board of Psychology (part-time)
Discipline Reviewer, Board of Social Work (part-time)

CASES RECEIVED YEAR-TO-DATE PER BOARD Jan 1, 2024 – Sep 13, 2024	
Board of Counseling	343
Board of Psychology	143
Board of Social Work	**128**
TOTAL CASES RECEIVED	614

CURRENT OPEN CASES PER BOARD as of Sep 13, 2024	
Board of Counseling	194
Board of Psychology	151
Board of Social Work	**193**
TOTAL CASES WITH BOARD STAFF	538

Recent Orders entered by the Board of Social Work

*For informational purposes only.
Board action is not required.

BEFORE THE VIRGINIA BOARD OF SOCIAL WORK

IN RE: KATHLEEN E. HANAGAN, L.C.S.W.
License Number: 0904-002139
Case Number: 222520

CONSENT ORDER

JURISDICTION AND PROCEDURAL HISTORY

The Virginia Board of Social Work ("Board") and Kathleen E. Hanagan, L.C.S.W., as evidenced by their signatures hereto, in lieu of proceeding to an informal conference, enter into the following Consent Order affecting Ms. Hanagan's license to practice clinical social work in the Commonwealth of Virginia.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. Kathleen E. Hanagan, L.C.S.W., was issued License Number 0904-002139 to practice clinical social work on January 20, 1993, which is scheduled to expire on June 30, 2024.

2. Ms. Hanagan violated 18 VAC 140-20-150(B)(1) and (3) and 18 VAC 140-20-160(3), (5), (6), and (8) of the Regulations Governing the Practice of Social Work ("Regulations"), in that between in or about February 2018 and March 2020, Ms. Hanagan served as a couples counselor for Client A and his spouse, and during that time, Ms. Hanagan encouraged Client A and his spouse to use illegal hallucinogens, i.e., mushrooms. Ms. Hanagan sent Client A and his spouse an email on October 18, 2018, in which she provided them a link to buy the "magic mushrooms." Ms. Hanagan stated that she wanted to have the experience herself and then they would "talk about a time to use them." Client A told a subsequent therapist that Ms. Hanagan used the mushrooms as a psychedelic aid to therapy and she encouraged them to use the mushrooms, which his spouse did, but he was very troubled and upset by Ms. Hanagan's approach.

3. Ms. Hanagan violated 18 VAC 140-20-150(C)(1) and (5) of the Regulations in that she did not maintain written or electronic clinical records for clients that she treated separately and together from

in or about 2017 through in or about March 2020. Specifically, Ms. Hanagan treated Client A's spouse beginning in early 2017 and then served as a couple's counselor for Client A and his spouse for approximately two years, until in or about March 2020. The Department of Health Professions investigator requested the clients' records from Ms. Hanagan, but Ms. Hanagan did not produce the records, maintaining that she did not have the clients' records due to a computer crash.

CONSENT

Kathleen E. Hanagan, L.C.S.W., by affixing her signature to this Consent Order, agrees to the following:

1. I have been advised to seek advice of counsel prior to signing this document and am represented by Katherine Skilling Larkin, Esq.;

2. I am fully aware that without my consent, no legal action can be taken against me or my license except pursuant to the Virginia Administrative Process Act, Virginia Code § 2.2-4000 *et seq.*;

3. I acknowledge that I have the following rights, among others: the right to an informal fact-finding conference before the Board; and the right to representation by counsel;

4. I waive my right to an informal conference;

5. I neither admit nor deny the Findings of Fact and Conclusions of Law contained herein but waive my right to contest such Findings of Fact and Conclusions of Law and any sanction imposed hereunder in any future judicial or administrative proceeding in which the Board is a party;

6. I consent to the entry of the following Order affecting my license to practice clinical social work in the Commonwealth of Virginia.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, the Virginia Board of Social Work hereby accepts the VOLUNTARY SURRENDER of Kathleen E. Hanagan's license to practice

clinical social work in the Commonwealth of Virginia IN LIEU OF FURTHER DISCIPLINARY ACTION. The license of Ms. Hanagan will be recorded as SURRENDERED IN LIEU OF DISCIPLINARY ACTION.

Pursuant to Virginia Code §§ 2.2-4023 and 54.1-2400.2, the signed original of this Order shall remain in the custody of the Department of Health Professions as a public record and shall be made available for public inspection and copying upon request.

FOR THE BOARD

DocuSigned by:
Jaime Hoyle
E858AEB08A9F4A4...

Jaime Hoyle, J.D.
Executive Director
Virginia Board of Social Work

ENTERED: 7/1/2024

SEEN AND AGREED TO:

DocuSigned by:
Kathleen Hanagan
A8ED70258D454CB...

Kathleen E. Hanagan, L.C.S.W.

Date signed: 6/29/2024

LICENSING REPORT

Satisfaction Survey Results	
2024 4th Quarter (April 1 – July 31, 2024)	**99.3%**
2024 3rd Quarter (January 1 – March 31, 2024)	**95.4%**

Total as of September 19, 2024*

Current Active Licenses/Registrations	
Associate Social Worker	1
Licensed Baccalaureate Social Worker	54
Licensed Clinical Social Work	11,307
Licensed Master's Social Worker	1,305
Registered Social Worker	4
Supervisees in Social Work	3,545
Total	**16,216**

*Unofficial numbers (for informational purposes only)

Licenses and Registrations Issued

Licenses and Registrations Issued	April 2024	May 2024	June 2024	July 2024	August 2024
Licensed Baccalaureate Social Worker (LBSW)	2	0	1	2	2
Licensed Clinical Social Worker (LCSW)	134	141	153	120	173
Licensed Master's Social Worker (LMSW)	26	29	34	34	36
Supervisees in Social Work	64	106	139	119	98
Total	**226**	**276**	**327**	**275**	**309**

Applications Received

Licenses and Registrations Issued	April 2024*	May 2024*	June 2024*	July 2024*	August 2024*
Licensed Baccalaureate Social Worker (LBSW)	4	7	5	2	5
Licensed Clinical Social Worker (LCSW)	151	159	127	181	162
Licensed Master's Social Worker (LMSW)	44	48	54	31	43
Supervisees in Social Work	77	134	150	127	124
Total	**276**	**348**	**336**	**341**	**334**

*Unofficial numbers (for informational purposes only)

Additional Information:

- **Board of Social Work Staffing Information:**

  - The Board currently has two full-time, and one part-time staff members to answer phone calls, emails and to process applications across all license types.
    - Licensing Staff:
      - Sharniece Vaughan – Licensing Supervisor (Full-Time)
      - Vacant – Licensing Specialist (Full-Time)
      - Gabriella Smith – Licensing Administration Assistant (Part-Time)
      - Vacant - Licensing Administration Assistant (Part-Time)

- **Business Process Updates**

  - Effective October 1, 2024, the Verification of Clinical Supervision Form will need to be notarized.
  - Supervisor Registry updated July 1, 2024 (includes public address of supervisors)
  - Updated Licensure Process Handbooks:
    - Licensed Clinical Social Worker (LCSW)
    - Licensed Master Social Worker (LMSW)
    - Licensed Baccalaureate Social Worker (LBSW)
  - Developed individual website pages that provide information on which application to select, step-by-step process instructions and direct links to information and forms.
  - Updated all forms and applications.
  - Updated all compliance forms.
  - Updated all internal application face sheets.
  - Updated wording to all automated emails.
  - Updated all online checklist items.
  - Updated online applications screens.
  - Created new license verification page.