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Pursuing Legislative Authority for Clinical Social Workers to Provide Private Independent
Mental Health Services: What is the Status and What are the Issues?

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Abstract

The scope of clinical social work practice differs among the various US states as defined by legislative codes. Understanding these differences is challenging because legislative codes are difficult to read, sometimes requires advanced knowledge to interpret, or do not provide the sufficient breadth and/or depth of information to enable a full understanding of practice limits. The study utilized an electronic survey and asked social workers throughout the US five questions about providing private independent mental health services. These questions addressed the ability of licensed clinical social workers (LCSWs) to (1) provide diagnosis, (2) create treatment plans, (3) bill third party insurance, (4) bill Medicaid, and (5) bill Medicare. Results indicated that LCSWs in at least 32 states reported ability to provide all five services independently and privately; 17 states whose respondents reported conflictual or uncertain ability to provide one or more of the services; and two states whose respondents reported inability to provide one or more of the services. Fortunately, respondents from no states reported inability to provide all the services. The conflictual or uncertain responses likely arise from complications or restrictions in scope of practice in some states and in understanding evolving definitions of private and independent practice.

Pursuing Legislative Authority for Clinical Social Workers to Provide Private Independent Mental Health Services: What is the Status and What are the Issues?

Across the United States, every state has a legislative code that defines the parameters of practice for social workers; however, these parameters differ significantly across states. Dyeson (2004) provides a rather concise explanation of the history and evolution of social work licensure and the complexities within and among the states.

Specific professional standards for licensure that are consistent across the states include:

Level of education from Council on Social Work Education (CSWE) accredited programs. All states require that social workers applying for licensure have completed social work education from a CSWE accredited program. CSWE regulates standards for both bachelors and masters levels of social work education in the Education and Policies and Educational Standards (EPAS) (CSWE EPAS, 2008).

Examination. The Association of Social Work Boards (ASWB) administers three levels of national standardized exams to assure that individuals preparing to practice social work demonstrate evidence of competence. All states accept the ASWB determined passing score for each exam. States determine the level of exam required for practice.

Post education supervision. All states require post education supervision; however, there is variance in the required number of hours, who is eligible to provide the supervision, content of the supervision, the work related experience that qualifies for supervision, and the number of hours of work experience.

Ethics. All states require that social workers agree to comply with the National Association of Social Worker's Code of Ethics (NASW Code, 2008) as part of licensure requirements.

Requirement for ongoing continuing education. All states require that licensed social workers engage in continuing education.

Variation in licensure requirements exists in the details, however, such as categories of licensure, requirements to attain each specialization of licensure, titles of licenses, required number of hours of supervision and continuing education, and most notably, the definitions of specific types of practice and the degree of independence with which functions (as defined within the state code) can be performed. (Dyeson, 2004).

A review of the literature reveals very few publications specific to *independent* and *private* provision of mental health services by master's level licensed clinical social workers (LCSWs); however, the General Accounting Office (GAO; 1986) stated that "... persons performing clinical social work in independent practice who meet the established criteria for clinical social workers must be accepted as alternative providers of mental health services under policies providing mental health coverage" (p.7). They further defined independent clinical social workers as "those not employed by physicians, clinics, or hospitals" (p. 1). While not specifically included in the definition, the report also refers to state recognition of insurance reimbursement and the requirements of a medical doctor to supervise the social worker as part of independent practice. Since 1986, new definitions of *independent* have emerged. For example, the Model Social Work Practice Act currently defines *independent* as, "practice of social work outside of an organized setting, such as a social, medical, or governmental agency, in which the social worker assumes responsibility and accountability

for services provided” (ASWB, 2012, p. 10). This definition is not limited to *clinical* social workers or to the provision of mental health service delivery. The Model Social Work Practice Act defines *private* practice, a term that was not used in the 1986 report, as “the provision of clinical social work services by a LCSW who assumes responsibility and accountability for the nature and quality of the services provided to the client in exchange for direct payment or third-party reimbursement” (p. 10). Given the emergence of these different terms, it is necessary to use them jointly to sustain the meaning and context for this study.

The signature item of research related to private and independent practice of licensed clinical social work, as referenced above, was produced by the GAO at the request of Senator Daniel Inouye and provided an overview of the independent practice of clinical social work in 1986. Of the 50 states, 32 had developed a licensing structure, 19 of which required a license to independently practice clinical social work. Twelve states, none of which required supervision of the clinical social worker, established that independent practicing clinical social workers could provide mental health services for insurance billing purposes. Five of the twelve states allowed the clinical social worker to bill directly for services (rather than billing through a medical doctor or clinic). Notably, no state recognized independent practitioners of clinical social work as being eligible for Medicaid reimbursement (GAO, 1986).

Despite the substantive changes that have occurred regarding the independent practice of clinical social work since the release of the GAO’s (1986) report, no other published studies have examined the limits of private practice for social workers. As such, it is vital that new research examine the extent to which individual states have modified legislation related to the independent provision of mental health services by LCSWs and to explore the private and independent practice of such services.

For example, Indiana provides the following definition of clinical social work within the state's legislative code:

Sec. 6. (a) "Practice of clinical social work" means professional services that are designed to help individuals, marriages, couples, families, groups, and communities to enhance or restore their capacity for functioning by:

(1) assisting in the obtaining or improving of tangible social and health services;

(2) providing psychosocial evaluations using accepted classifications, including classifications from the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) as amended and supplemented, but only to the extent of the counselor's education, training, experience, and scope of practice as established by this article;

(3) using appraisal instruments as an aid in treatment planning that the clinical social worker is qualified to employ by virtue of the counselor's education, training, and experience; and

(4) counseling and psychotherapeutic techniques, casework social work advocacy, and treatment in a variety of settings that include mental and physical health facilities, child and family service agencies, or private practice.

(b) The term does not include diagnosis (as defined in IC 25-22.5-1-1.1(c)).

(Indiana Code: IC 25-23.6-1-6)

As a practical matter, LCSWs in Indiana may provide mental health services privately and, to some degree, independently; however, the legislative code limits the ability to diagnose. If an LCSW references a diagnosis, a supervising psychologist or physician must cosign, or authorize, the diagnosis.

Comparatively, the Code of Virginia defines clinical social worker as:

A social worker who, by education and experience, is professionally qualified at the autonomous practice level to provide direct diagnostic, preventive and treatment services where functioning is threatened or affected by social and psychological stress or health impairment (Code of Virginia: § 54.1-3700, p. 2).

Thus, LCSWs in Virginia can perform private and independent mental health services within the scope of practice and training and co-signatures are not required for diagnosis, treatment planning or billing insurance.

Simple comparison of the codes of Indiana and Virginia indicate distinctive differences in scope of social work services. Notably, the Code of Virginia aligns much more closely to definitions created and supported within the social work profession. For example, Barker (2003, p. 76) has defined clinical social work as “the professional application of social work theory and methods to the treatment and prevention of psychosocial dysfunction, disability, or impairment, including emotional and mental disorders.” Grant (2008) used the definition of the National Association of Social Workers (NASW; 1999, p. 318):

Clinical social work shares with all social work practice the goals of enhancement and maintenance of psychosocial functioning of individuals, families and small groups.

Clinical social work practice is the professional application of social work theory and methods to the treatment and prevention of psychosocial dysfunction, disability, or impairment, including emotional and mental disorder. It is based on one or more theories of human development within a psychosocial context. Clinical social work services consist of assessment,

diagnosis, treatment including psychotherapy and counseling, client-centered advocacy, consultation, and evaluation. The process of clinical social work is undertaken within the objectives of social work and the principles and values contained in the NASW Code of Ethics .

However, the current definition of clinical social work used in the NASW Standards for Clinical Social Work in Social Work Practice cited Barker's 2003 definition (NASW, 2005, p. 9). While Barker's work may present a somewhat cohesive definition of clinical social work, clearly it does not consistently carry into definitions used in state legislation.

Although it is not necessary for all states to use identical terminology to define the profession's practice within legislative code, the variance in terminology within various legislative codes clearly creates differences within the scope of social work practice. At the present time, the extent of these differences remains unknown.

As noted above, no studies have examined LCSW's ability to independently provide mental health services since the GAO report of 1986 LCSWs. The concept of private practice, in particular, has not been examined or debated. That states vary in the use of the terms *independent* and *private* perhaps leads to some differences in legislative code among the states, as these definitions have changed over time.

The precise number of states that restrict the authority of LCSWs to practice independently remains unclear since, as previously noted, state codes can be difficult to read and often require advanced knowledge or more information than is readily attainable to interpret. However, the GAO (1986) report identified twelve states that authorized LCSWs to independently provide mental health services, but only five in which LCSWs were given the authority to independently bill insurance companies. Most likely, the number has increased

over the years, yet questions remain as to the margin of change.

It is also important to frame the value of this research within and outside of the social work profession. Within the social work profession, some believe that providing private and independent mental health services draws social workers away from the altruistic ideals of the profession, from serving the poor and underserved, and away from efforts to address large-scale societal problems (Barker, 1991; Lord et al., 2012; Seiz, 2000; Specht 1991). It has been argued that attention given to the needs of the “worried well” changes the profession’s goals (Barker, 1991; Lord et al., 2012). Criticisms of clinical social workers pursuing private and independent practice include arguments of being in it for the money (Barker, 1991; Jayaratne et al., 1991; Specht, 1991), having decreased involvement in political and social action (Barker, 1991), that private practice draws social workers out of agencies and leaves a shortage of social workers to serve those in real need (Barker, 1991; Seiz, 2000), and that social workers in private and independent practice discriminate by accepting only clients who can afford to pay or have insurance (Barker, 1991). Borenzweig (1981) adds that agency-based clinical social workers are more likely to use community resources than those in private practice. Furthermore, some social workers, as well as members from other professions providing mental health services, argue that the masters in social work education does not adequately prepare professionals for private practice and that curriculum changes are necessary to do so (Brown & Barker, 1995; Eppler, 2007; Lord et al., 2012). Interestingly, Specht (1991) notes that there are only two primary differences between private practice and agency based social work: payment and nature of service, noting that educational preparation need not differ based on desired future practice setting.

Conversely, clinical social workers favoring private and independent mental health

services cite reasons such as the opportunity to do direct work with clients without the frustration of bureaucracy (Barker, 1991; Jayaratne et al., 1991; Seiz, 2000). Some cite the benefit of being able to do direct service with clients without pressure to assume administrative roles (Barker, 1991), and others acknowledge a desire to have control over working conditions which reduces stress (Jayaratne et al., 1991; Seiz, 2000). Clinical social workers providing services privately and independently often serve the community in other ways, such as on boards or through volunteerism, and offer some mental health services within the private setting based on sliding scale fees or pro bono (Barker, 1991). Biggerstaff (2000) notes that providing private and independent mental health services aligns with the NASW Code of Ethics as a component of comprehensive services available from clinical social workers and that such provision allows social workers to be held to the highest standards of service. Many clinical social workers in private practice use social work theory, adhere to ethical guidelines, and remain true to the profession while providing mental health services (Biggerstaff 2000; Borenzweig, 1981). Others acknowledge that mental health services provided by clinical social workers adds to the quality of mental health services available because such services are different from those provided by other professions (Chesney et al., 1983; Epple, 2007).

The literature review for this study included perspectives of other professions regarding belief that licensed clinical social workers should (or should not) provide mental health services, but yielded no substantive results. For the purposes of the current study clinical social work is defined as social work practice that can only be performed by a social worker who has earned a master's degree in social work from a CSWE-accredited program and is licensed at the clinical level in their respective state. Furthermore, the study is limited to

the independent and private provision of mental health services by master's level LCSWs. For the sake of brevity of expression, the term "independent" is used to mean both "independent" and "private."

The primary objective of the current study was to identify the states within the United States whose legislative code allows clinical social workers to privately and independently diagnose, write a treatment plan, bill third party insurance, bill Medicaid, and bill Medicare.

Methods

The goal of the study was to develop a snapshot of the status of licensed clinical social work, specific to independent and private practice, across the United States (US). The study surveyed social workers across the US to identify the components of mental health services they can and cannot provide. Participants were queried with regard to their ability to (1) assign diagnoses, (2) create treatment plans, (3) bill private insurance, (4) bill Medicaid, and (5) bill Medicare.

Potential participants for the study included social workers registered with the Association of Baccalaureate Social Work Program Directors (BPD) listserv. The Association of Baccalaureate Social Work Program Directors maintains the listserv of approximately 1,500 members who are focused on providing quality BSW education and consist of directors, faculty, administrators, publishers, researchers, doctoral students, and many others (BPD, 2015).

The survey was administered electronically through Qualtrics; a link to the survey was sent to the BPD listserv on two occasions between March 2014 and March 2015. Using a snowballing technique, participants were asked to forward the survey link to any social workers

that may have interest in the study. Responses were analyzed for frequency by state, per answer to each question.

Participants were asked to verify that they were a social worker and informed consent was obtained to use their responses for a potential publication. Demographic information was collected, including primary state of licensed practice, gender, highest earned social work degree, title of license, and years of social work practice. Participants were also asked whether their state allows social workers with masters degrees that are licensed at the clinical level to provide private independent clinical social work services.

Sample

There were 217 responses to the survey. Five responses were excluded, as one participant was not a qualified social worker and four did not provide any responses to the survey; partial responses were included in the results. Of the participants whose data was included (N=212), there were 187 (88%) females and 25 (12%) males. The substantial majority (n=181, 86%) of the sample reported a master's degree in social work from a CSWE accredited program as their highest degree, trailed by those who earned a doctorate in social work (n=26, 12%) and those who earned a bachelor's degree in social work (n=5, 2%). The sample was very experienced in providing social work service; 102 (47%) of the participants indicated experience of providing social work services for more than twenty years. Among the remaining participants, 28 reported having 16-20 years of experience, 28 reported 11-15 years, 29 reported 6-10 years, 24 reported 5 or less years, and 1 reported having no experience.

Results

From the 212 valid responses to the survey, 48 states and the District of Columbia were represented. Information from the two unrepresented states, North Carolina and Wyoming, was

collected by reviewing the state legislative codes and the state Medicaid guidelines which provided enough information to determine answers to each of the research questions. Results are provided in Table 1.

A summary of the answers to each question, per state, are color coded. A response of Yes is coded in green; No is coded in red; I don't know (IDK) is coded in blue (when IDK is the only response); and questions for which there is an undeterminable answer are not color coded. If IDK is combined with another response, then the color code is given to the other response. There were 32 (63%) states whose respondents reported the ability to independently provide all five of the services ; 17 (33%) states whose respondents gave conflicting responses with regard to their ability to provide one or more of the services; and two (4%) states whose respondents reported inability (response of no) to provide one or more of the services. Fortunately, there were no states whose respondents reported inability to provide all of the five services independently and privately.

With regard to ability to independently assign diagnoses, respondents from 41 (80%) states indicated an ability to do so while respondents from only one (2%) state indicated an inability to do so. Respondents from nine (18%) states gave conflicting responses.

Respondents from 46 (90%) states indicated the ability to independently write treatment plans, whereas respondents from five (10%) states gave conflicting responses.

Respondents from 42 (82%) states reported the ability to independently bill third party insurance, whereas respondents from one (2%) state reported the inability to do so. Respondents from eight (16%) states gave conflicting responses.

Respondents from 36 (71%) states indicated the ability to independently bill Medicaid with respondents from one (2%) state indicating an inability to do so. Respondents from 14 (27%) states gave conflicting responses.

The ability to independently bill Medicare was reported by respondents from 39 (76%) states. Respondents from one (2%) state reported an inability to do so and respondents from eleven (22%) states gave conflicting responses.

Finally, all respondents were asked if legislation allows masters degreed social workers licensed at the clinical level to provide private and independent clinical social work. Of the 212 respondents, 209 (99%) indicated yes, whereas three respondents reported being unsure. No respondents indicated an inability to do so.

Discussion

Clearly, the ability of LCSWs to provide mental health services independently and privately has come a long way since 1986. Most notably, at least 36 states now allow LCSWs to provide services and bill Medicaid directly, a service in that was not authorized by any state in 1986. The question of LCSWs billing Medicare was not even examined in 1986; thus, it is notable that the ability to engage in this activity has grown tremendously, as respondents reported that LCSWs in 39 states could now do so.

Advances have occurred in other areas of service provision by LCSWs in many states since 1986. Recall that at that time only twelve states' (CA, KS, LA, ME, MD, MA, NH, NY, OK, OR, UT, and VA) statutes allowed clinical social workers to practice independently and bill third party insurance when providing mental health services. Present results indicate that LCSWs in 42 states can now do so., with respondents from three states (CA, NY, and VA) provided conflicting answers or IDK, thus, categorizing them 'unclear' for the purposes of this

study. However, it is noted that each of these states were included among the original 12; assuming that these states have maintained the status of clinical social workers serving independently as mental health providers who can bill third party insurance, the current total is likely 45 state. Given that respondents from only one state (Arkansas) indicated that the state does not allow LCSWs to provide and bill for mental health services independently, there are potentially five more (the unclear) states where this may be possible. Again, the results represent an amazing transformation of autonomy in clinical social work practice since 1986.

The other two questions in the survey address the ability to diagnose and create treatment plans by LCSWs when providing mental health services. Respondents indicated that LCSWs in at least 41 states can independently assign diagnoses and can create treatment plans in at least 46 states. A respondent from only one state (Alabama) indicated the inability to diagnose. These two questions were not defined in the 1986 GAO report, so there is no information for which to base a comparison, however, it is important to note the current status of legislative authority.

One of the most interesting results in the survey comes from the final question which asked whether legislation in the respondent's state allows master's-degreed social workers licensed at the clinical level to provide private independent clinical social work. Of the respondents to the survey, 99% indicated the ability to provide independent clinical social work services and no one indicated inability to do so. The responses to the other questions in the survey suggest that there should have been at least some variation among the answers to this question with some indication of inability to do so. Perhaps some explanation lies in the varying and changing definitions of independent and private practice. In other words, one can do "independently" what one is allowed to do.

Lastly, emphasis is given to the fact that the respondents of the survey, social workers, provided the data used in the study. Information about two states (North Carolina and Wyoming) was collected from review of statutes and other sources rather than survey respondents in order to have representation in responses from all states in the US and Washington DC. This methodology was used because practicing social workers were likely to be informed about their abilities and limitations to practice. While this was the chosen methodology for the study, it is important to recognize the results as interpretations of social workers about their abilities and limitations to practice and not fact.

Knowing that the survey data are based on social worker responses raises another discussion point. Responses to every question on the survey produced some conflicting results. For example, in California, of the 20 responses to the question about ability to diagnose, 16 respondents indicated ability to diagnose independently, one respondent indicated ability to diagnose with a cosigner, and two respondents noted inability to diagnose. Yet in the 1986 GAO report, social workers in California could provide mental health services independently. Another example is Indiana where there were five respondents to the question about ability to diagnose; three indicated ability to diagnose, one indicated inability to diagnose and one responded IDK. As demarcated in the white sections of Table 1, there were several questions for which this confusion was apparent. Perhaps social workers are not as informed of their scope of practice as originally thought; or are they?

Confusion likely arises with the perceptions of social workers when there are additional aspects of practice that may not be so clear. A good example is the question of ability to diagnose in Indiana. Section 6b in Indiana Code states that LCSWs may not diagnose (Indiana Code: IC 25-23.6-1-6). In the reality of clinical social work practice, clinicians might actually

form a diagnostic impression in order to serve a client and bill third party insurance, which is within the provision of clinical social work service. However, when providing services to a client who has Medicaid, the diagnosis must come from a psychologist or MD; thus, in many cases the psychologist or MD may cosign the diagnostic impression assigned by the clinical social worker.

Limitations

A significant limitation of the current study is the assumption that LCSWs would be able to clearly articulate their abilities and limitations of practice within the home state. It remains likely that results are accurate for some states with legislative codes that more clearly define scope of practice and delineate more defined abilities for LCSWs. The results of the study highlight the states in which there are likely some confounding circumstances that affect scope of practice, similar to the examples of California and Indiana.

Another limitation in the study is the sample. Most, but not all, of the sample were LCSWs. Most of the social workers in the sample were educators with more than twenty years of experience; however, the survey did not ask about years of *clinical* practice experience. While it was assumed that experienced, well-educated social workers would know about scope of clinical practice in the state, it would have been beneficial to access more practicing LCSWs.

Recommendation for future study

Given the substantial shortage of publications related to this study, it is recommended that further research be conducted and published in the areas of state regulation of social work practice, scope of clinical social work practice, and independent and private practice. It is recognized that ASWB is an excellent resource for licensure related information; however, research and publications were significantly underrepresented in this literature review and can

serve to help advance the scope of clinical practice in the profession, serve as historic record of the profession's advancement of clinical social work, and can identify areas that need more advanced study.

As authors, we acknowledge that there is value in the broader perspective of services that social workers provide and emphasize need for research in all aspects of social work services to advance the profession as a whole. We simply choose to focus research on clinical social work services provided privately and independently and recognize the contribution as a piece of the whole. Social workers with interest in other aspects of social work are encouraged to do the same, thus, creating a more holistic advancement for the profession.

It is assumed that perspectives of other professions play at least some (if not a substantial) role in how legislative codes are written as related to LCSWs providing private and independent mental health services. Future studies are encouraged to gain further insight into how this affects legislation.

Summary

There are two obvious beneficial points from this study. First, clinical social work practice overall, as well as specific to private and independent practice, has evolved tremendously since 1986. Most notably, LCSWs in at least 36 states now have the ability to provide mental health services and bill directly through Medicaid and can bill Medicare in at least 39 states. Further, respondents indicated that LCSWs in at least 32 states can perform all of the identified services independently and privately; this statistic indicates substantial progress since the 1986 report indicating that LCSWs from 12 states could provide mental health services independently and privately. While the study had notable limitations, these points clearly represent transformation of the profession. Second, the study demonstrates need to continue to

work in evolving the scope of licensed clinical social work practice toward some consistency.

The current status allows for substantial confusion among social workers about services that can and cannot be provided in any given state. For benefit to social workers, but more importantly consumers, consistency and clarity in scope of clinical social work practice is important. A more consistent scope of clinical social work practice is necessary from the perspective of clients (as recipients of service) as well as social workers; it is not only an aspect of best practice, but aligns with the purpose of licensure (protection of clients).

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