Behavioral Health Sub-Report

Social Work

Overview

The practice of social work is regulated in all 50 states. In Utah, the regulation of social work is overseen by the Division of Professional Licensing, Department of Commerce. Current license types include Licensed Clinical Social Worker (LCSW), Certified Social Worker (CSW), and Social Service Worker (SSW).

License Type	Scope	Authority	Education	Experience	Exam
LCSW	Mental Health Therapist	Independent	Master's Degree	✓	✓
CSW	Mental Health Therapist	Supervised	Master's Degree	-	-
SSW	Non-Mental Health Therapist	Supervised	Bachelor's Degree	✓	-

Fee Structure

	Initial Licensing Fee		Annualized Renewal Fee	
License Type	Utah Fee	US Median	Utah Fee	US Median
LCSW	$120	$148	$47	$61
CSW	$120	$125	$47	$47
SSW	$85	$115	$39	$39

Complaints

During the past 5 years (2018-2022), an average of **152** complaints were filed annually against an average of **104** Utah social workers–or **1.3%** of active licensees in any given year. On average, **49** of those complaints were found to be substantiated (32%).[87] Common types of substantiated complaints among behavioral health licensees include violations of ethical standards, incompetence and/or negligence, sexual misconduct, criminal conduct, substance use, unauthorized practice, and failure to release records.

[87] OPLR Analysis of DOPL Substantiated Complaint Data

Wait Times and Active Licensees

On average, Utah social workers report that at their primary practice location there is a **~30 day wait time** for those seeking care. This is lower than the **~37 day** average across Utah's behavioral health care field, but is still substantially higher than the **10 day CMS** guideline.[88,89]

Name	# Active Licensees	Annualized 5-Year Growth Rate[90]
LCSW	5,881	9.16%
CSW	2,061	8.53%
SSW	1,885	-1.33%
All	9,835[91]	6.15%

Recommendations

Relevant Recommendations from OPLR's Periodic Review

The following recommendations from OPLR's periodic review of the regulation of the behavioral health care workforce are relevant for social work (see final report for additional information):

- 1a. Supervisor Requirements
- 1b. Supervision Hours
- 1c. Continuing Education
- 2a. Exam Alternate Path
- 2b. Interstate Compacts
- 3a. Recovery Assistance (UPHP)
- 3b. Safety Checks & Disclosures
- 5a. Multi-Profession Board

Additional Recommendations

In addition to the relevant recommendations listed above, OPLR recommends that Utah policymakers enact the following change to the regulation of behavior analysts.

- **SSW Scope Expansion.** Expand social service worker (SSW) scope of practice to include, under the supervision of a mental health therapist, authorization to collaborate in treatment planning and to conduct a wider range of low-intensity treatment interventions. *(58-60-202)*
- **SSW Supervision Authority Clarifications.** Update SSWs' scope of practice to explicitly allow SSWs with two years of post-licensure experience to supervise BSW/bachelor's-level interns. *(58-60-202)*
- **Designated Examiner Clarifications.** Include language in the Mental Health Professional Practice Act (58-60) and the Psychologist Licensing Act (58-61) clarifying which licensees may act as designated examiners according to DHHS standards. (*58-60, 58-61)*

[88] OPLR Behavioral Health Care Workforce Survey (CPMDS)
[89] Centers for Medicare & Medicaid Services Center for Consumer Information and Insurance Oversight (2022). 2023 Letter to Issuers in the Federally-facilitated Exchanges. [online] U.S. Department of Health and Human Services. Available at: https://www.cms.gov/files/document/2023-draft-letter-issuers-508.pdf
[90] OPLR Analysis of DOPL Licensing Data; five-year growth rate
[91] The number of licensed clinical social workers, certified social workers, and social service workers do not sum to the total number of active social work licensees due to holders of license subtypes not listed above (e.g., interns).

SSW Scope Expansion

Summary of Recommendation

Expand social service worker (SSW) scope of practice to include, under the supervision of a mental health therapist, authorization to collaborate in treatment planning and to conduct a wider range of low-intensity treatment interventions. *(58-60-202)*

Status Quo. Practice as a social service worker (SSW) is currently defined as: "(i) conducting: (A) a non-clinical psychosocial assessment; or (B) a home study; (ii) collaborative planning and goal setting; (iii) ongoing case management; (iv) progress monitoring; (v) supportive counseling; (vi) information gathering; (vii) making referrals; and (viii) engaging in advocacy." Additionally, statute establishes that practice as a social service worker does not include: "(i) diagnosing or treating mental illness; or (ii) providing psychotherapeutic services to an individual, couple, family, group, or community."[92]

Existing Approaches.

- Practice as an advanced substance use disorder counselor (ASUDC) in Utah includes "treatment planning for substance use disorders, including initial planning [and] ongoing intervention," as well as "cofacilitating group therapy with a licensed mental health therapist…"[93] A-SUDCs, like SSWs, must complete at least a bachelor's degree and a period of supervised practice to qualify for licensure.
- Under Maryland law, non-therapist social workers are allowed to deliver modified evidence-based treatments (EBTs) under the supervision of a mental health therapist, consistent with their scope of practice to perform "counseling activities."[94]
- Internationally, the United Kingdom allows non-therapists to deliver or co-facilitate low-intensity behavioral health interventions, including guided self-help based on cognitive behavioral therapy (CBT), and group-based psychoeducation, cognitive behavioral therapy, behavior activation, mindfulness and meditation, and activity-based therapeutic programs.[95,96] Further, Ontario Canada's "controlled acts" framework restricts the use of psychotherapy only in treating serious behavioral health-related disorders, meaning that the

[92] UCA 58-60-202
[93] UCA 58-60-502
[94] Hooley, C., Graaf, G. and Gopalan, G. (2021). Scaling up Evidence-based Treatments in Youth Behavioral Healthcare: Social Work Licensing Influences on Task-shifting Opportunities. *Human Service Organizations: Management, Leadership & Governance*, 45(5), pp.1–14. doi:https://doi.org/10.1080/23303131.2021.1970069.
[95] National Collaborating Centre for Mental Health (2023). *The Improving Access to Psychological Therapies Manual.* [online] United Kingdom: National Health Service. Available at: https://www.england.nhs.uk/wp-content/uploads/2018/06/the-nhs-talking-therapies-manual-v6.pdf.
[96] *NICE Guideline 222 1.5 Treatment for a new episode of less severe depression.* (2022). [online] United Kingdom: National Institute for Health and Care Excellence. Available at: https://www.nice.org.uk/guidance/ng222/chapter/Recommendations.

treatment of mild to moderate conditions with psychotherapy is not restricted as part of this framework.[97]

Rationale. In order to extend the reach of clinicians, OPLR recommends granting a limited scope expansion to SSWs in two key areas of practice: 1) treatment planning and 2) low-intensity interventions. In both instances, we recommend that these areas of practice are not automatically open to any licensee, but rather granted at the discretion of the employer as an individual SSW demonstrates competence–a supervisor (most often a mental health therapist) would remain ultimately responsible.

First, OPLR recommends granting SSWs limited authority, in collaboration with a mental health therapist, to draft, review, and update treatment plans, under the following conditions:

- In the treatment of mild to moderate behavioral health conditions
- With prior authorization from a licensed health facility or human service program
- Under the supervision of a mental health therapist, who must both:
    - Sign off on the plan before treatment begins; and
    - Be available to consult with the client before treatment begins

Treatment planning is part of the practice of mental health therapy as defined in statute, and involves "prescribing a plan for the prevention or treatment of a condition of mental illness or emotional disorder."[98] In other words, a treatment plan outlines the interventions that will be used in treating a patient—drawing a connection from an assessment or diagnosis of a client's condition, to what methods will be used to improve it. In a third party payor environment, treatment planning helps to establish medical necessity and the ongoing need for clinical treatments such as psychotherapy. The authority to independently engage in treatment planning is appropriately reserved for mental health therapists, who have training and expertise not only in assessing and diagnosing behavioral health conditions, but also in prescribing treatments to address those conditions.

As currently defined, however, the limits of SSWs' scope of practice may result in operational inefficiencies that reduce Utahns' access to behavioral health care. Employers reported to OPLR that mental health therapists' time is often burdened by paperwork and documentation requirements (including drafting, reviewing, and updating treatment plans), much of which could be effectively managed by lower-level providers.[99] Because the SSW scope does not currently include the authority to draft initial treatment plans or to review and update treatment plans (at any level of complexity), a mental health therapist is required to perform these activities on their own.This diverts mental health therapists' time away from practicing at the top of their scope in delivering psychotherapy and other intensive forms of treatment, thereby reducing capacity and ultimately Utahns' access to these services. By expanding SSWs' scope to include collaborating in drafting

[97] Safriet, B.J. (2002). Closing the Gap Between Can and May in Health-Care Providers' Scopes of Practice: A Primer for Policymakers. *Yale Journal on Regulation*, 19(2), p.2.
[98] UCA 58-60-102
[99] OPLR Listening & Vetting Tour

treatment plans, within the guardrails outlined above, the burden on mental health therapists could be reduced and their time preserved for top-of-scope, client care activities.

In cases where a client's behavioral health symptoms are only mild to moderate in severity, where additional facility-level oversight is in place, and where clinician supervision is preserved, SSWs may be able to valuably contribute to this work. In cases of mild to moderate symptoms and disorders, appropriate treatment options are typically less intensive (e.g., involving interventions like case management, care navigation, supportive counseling, or psychoeducation) and the path forward is likely to be less complex and lower risk than for clients with more severe symptoms or disorders. As frontline practitioners who have frequent opportunities to interact with clients and gather information, SSWs can meaningfully participate in the treatment planning process, in collaboration with mental health therapists. Further, by requiring that clinicians sign off on treatment plans and make themselves available for client consultation before treatment begins, this limited scope expansion still provides needed oversight—similar to existing state laws that ensure patients' immediate access to consultation with a dispensing medical practitioner (i.e., pharmacist) before taking a new prescription medication, but that also allow patients to forgo this consultation.[100]

Further, OPLR is only proposing that SSWs be allowed to engage in treatment planning for clients with mild to moderate BH conditions. This model of differentiating scope of practice based on the severity of the condition being treated is already being used in Canada and the UK to safely improve the efficiency and flexibility of systems of care. For instance, Canada, which operates under a "controlled acts" framework, only protects the act of treating severe mental health disorders, allowing extenders and BH providers other than clinical therapists to participate in the treatment of mild and moderate conditions.[101] Similarly, the UK differentiates BH providers' scopes of practice based on their performance of high- or low-intensity interventions.[102] Thus, while this change would not authorize SSWs to independently engage in treatment planning, it could help therapists to spend more of their time practicing at the top of their scope by shifting some lower-risk, less complex treatment planning activities to SSWs.

Second, OPLR recommends granting SSWs limited authority to provide low-intensity interventions aimed at treating behavioral health symptoms and disorders as directed by a supervisor with authority to diagnose (e.g., a mental health therapist). The practice of mental health therapy includes "engaging in the conduct of professional intervention, including psychotherapy by the application of established methods and procedures generally recognized in the professions of mental health therapy." Still, many non-therapist providers across the behavioral health system—including SSWs—play an important role in providing lower-intensity interventions such as case management, care navigation, wellness coaching, supportive counseling, and psychosocial education. OPLR recommends that SSWs' scope of practice be amended to specifically include

[100] UCA 58-17b-803(4)(c)
[101] Safriet, B.J. (2002). Closing the Gap Between Can and May in Health-Care Providers' Scopes of Practice: A Primer for Policymakers. *Yale Journal on Regulation*, 19(2), p.2.
[102] National Collaborating Centre for Mental Health (2023). *The Improving Access to Psychological Therapies Manual.* [online] United Kingdom: National Health Service. Available at: https://www.england.nhs.uk/wp-content/uploads/2018/06/the-nhs-talking-therapies-manual-v6.pdf.

several additional types of care, under the supervision of a mental health therapist, in addition to the "supportive counseling" and "case management" they are already specifically authorized to perform. These additional types of care would include the delivery of evidence-based manualized therapeutic interventions that have been modified for use by non-therapist providers, and co-facilitation of group therapy.

- *Evidence-based manualized therapeutic interventions* employ elements of evidence-based therapies (EBTs) in a structured, standardized format, lowering both the need for practitioner discretion and the chances of practitioner error. Many of these interventions may be modified and standardized such that they can be safely delivered by a non-clinically trained provider.[103] For example, guided self-help based on the principles of CBT.[104]
- *Group therapy* is a form of psychotherapy conducted with multiple participants and one or more behavioral health professionals who act as group facilitators to guide discussion—including at least one mental health therapist.[105]

The current SSW scope inhibits employers from deploying "task-shifting" models that could utilize SSWs to deliver interventions that are within their capabilities and training. Task-shifting, in which "specific tasks are moved, where appropriate, to health workers with shorter training and fewer qualifications"[106] is an established approach that healthcare delivery systems implement to address large-scale public health crises and resource-constrained environments. Updates to regulation may be needed to actualize these task-shifting efforts, and to enable Utah's laws to remain relevant in addressing current needs and evolving best practices.[107]

Although only mental health therapists are authorized to independently provide psychotherapy, SSWs may be able to provide less intensive, more standardized, and co-facilitated interventions, thereby further extending the work of mental health therapists as they work to treat their clients. This utilization of SSWs is also consistent with the commonly used "stepped care" model of mental health care delivery, in which low-intensity, cost-effective interventions are delivered as first-line treatments before progressing as needed to higher-intensity, more costly treatments that require the care of a therapist or prescriber.[108] Intensive clinical treatments (such as individual

[103] For example, one research team "modified a behavioral parenting EBT with stakeholder and treatment developer feedback such that it could be delivered in a CW service setting by non-clinically licensed caseworkers (Gopalan et al., 2019)." From Hooley et al. 2021
[104] National Collaborating Centre for Mental Health (2023). *The Improving Access to Psychological Therapies Manual.* [online] United Kingdom: National Health Service. Available at: https://www.england.nhs.uk/wp-content/uploads/2018/06/the-nhs-talking-therapies-manual-v6.pdf.
[105] American Psychological Association (2018). Group therapy. In: *APA Dictionary of Psychology.* [online] Available at: https://dictionary.apa.org/group-therapy.
[106] The Joint United Nations Programme on HIV/AIDS and U.S. President's Emergency Plan for AIDS Relief (2007). *Task Shifting: Global Recommendations and Guidelines.* World Health Organization, p.https://www.unaids.org/sites/default/files/media_asset/ttr_taskshifting_en_0.pdf.
[107] Hooley, C., Graaf, G. and Gopalan, G. (2021). Scaling up Evidence-based Treatments in Youth Behavioral Healthcare: Social Work Licensing Influences on Task-shifting Opportunities. *Human Service Organizations: Management, Leadership & Governance*, 45(5), pp.1–14. doi:https://doi.org/10.1080/23303131.2021.1970069.
[108] Ho, F.Y.-Y., Yeung, W.-F., Ng, T.H.-Y. and Chan, C.S. (2016). The Efficacy and Cost-Effectiveness of Stepped Care Prevention and Treatment for Depressive and/or Anxiety Disorders: A Systematic Review and Meta-Analysis. *Scientific Reports*, 6(1). doi:https://doi.org/10.1038/srep29281.

psychotherapy) are a core part of the service mix for treating behavioral health disorders and the authority to perform psychotherapy is appropriately reserved for those with advanced clinical training. However, these intensive treatments are often not sufficiently scalable to reach all Utahns who are in need of some type of behavioral health intervention. SSWs (and other bachelor's-level practitioners like SUDCs) can fill these service gaps by providing and assisting in lower-intensity interventions, which can be effective and more easily delivered at scale.

Evidence-based, manualized therapeutic interventions are an example of tasks that can be safely shifted from mental health therapists to extenders such as SSWs: therapeutic methods are modified and standardized, and non-clinical providers can be trained and supervised in the delivery of some of those services.[109] The nature of evidence-based manualized interventions provides a strong foundation for safe delivery—manualized interventions are by definition evidence-based, targeted to the effective treatment of a specific diagnosis, and when appropriately modified, can be performed without the need for the nuanced clinical decision-making that remains the purview of trained mental health therapists. By enabling employers to utilize SSWs this way, Utah's systems of care can better reach the many Utah youth and adults who are not currently accessing behavioral health care services.[110,111] A growing body of research shows that entry-level BH practitioners and community health workers are capable of effectively delivering certain manualized therapeutic interventions and evidence-based treatments in a range of contexts. Hooley et al. (2021) report the following findings on the outcomes and efficacy of this task-shifting approach:[112]

> "Task-shifted workers in Low- and Middle-Income (LMIC) countries have effectively treated conditions like **anxiety, depression, trauma, and schizophrenia** (Deimling Johns et al., 2018). Similarly, researchers in High-Income countries (HIC) have effectively used task-shifting to treat conditions like **depression, stress, eating disorders, and substance use** (Barnett, Gonzalez, et al., 2018; Hoeft et al., 2018; Kilpela et al., 2014). Reviews of task-shifting report it to be **effective** (Deimling Johns et al., 2018; Hoeft et al., 2018; Singla et al., 2017), to be a viable option for **system cost savings** (Seidman & Atun, 2017), and to be a means for **addressing inequities** in service delivery (Barnett, Gonzalez, et al., 2018)." [emphasis added]

Evidence from within Utah itself also shows that bachelor's-level extenders can safely co-facilitate group therapy. The scope of practice for substance use disorder counselors explicitly allows them

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[109] Gopalan, G. (2016). Feasibility of improving child behavioral health using task-shifting to implement the 4Rs and 2Ss program for strengthening families in child welfare. Pilot and Feasibility Studies, 2(1). doi:https://doi.org/10.1186/s40814-016-0062-2.

[110] Substance Abuse and Mental Health Services Administration (2023). *2021 NSDUH: Model-Based Estimated Prevalence for States*. [online] www.samhsa.gov. Available at: https://www.samhsa.gov/data/report/2021-nsduh-state-prevalence-estimates.

[111] Data Resource Center for Child & Adolescent Health (2021). *NSCH 2020 21: NOM 18: Percent of children with a mental/behavioral condition who receive treatment or counseling, Utah*. [online] www.childhealthdata.org. Available at: https://www.childhealthdata.org/browse/survey/results?q=9615&r=1

[112] Hooley, C., Graaf, G. and Gopalan, G. (2021). Scaling up Evidence-based Treatments in Youth Behavioral Healthcare: Social Work Licensing Influences on Task-shifting Opportunities. *Human Service Organizations: Management, Leadership & Governance*, 45(5), pp.1–14. doi:https://doi.org/10.1080/23303131.2021.1970069.

to co-facilitate group therapy,[113] all under the supervision of a mental health therapist. DOPL data shows that SUDCs have a below-average rate of substantiated complaints related to practicing outside their scope, incompetence or negligence, or unauthorized practice, as compared to other BH professions.[114] Based on these findings, it logically follows that SSWs, who have equivalent or higher levels of training than SUDCs, would likely be just as safe to co-facilitate group therapy, where a mental health therapist is always present to supervise and intervene as necessary. As long as the state maintains appropriate guardrails around SSWs' delivery of manualized treatment interventions and group therapy co-facilitation, safety can be maintained while significantly expanding access to care.

[113] UCA 58-60-502
[114] OPLR Analysis of DOPL Substantiated Complaint Data

SSW Supervision Authority Clarifications

Summary of Recommendation

Update SSWs' scope of practice to explicitly allow SSWs with two years of post-licensure experience to supervise bachelor's-level social work interns. *(58-60-202)*

Status Quo. Currently, Utah statute does not specify whether the scope of practice of a social service worker (SSW) includes the authority to supervise bachelor-level student interns.

Existing Approaches. Among the U.S. jurisdictions that license bachelor's-level social workers, OPLR found that at least eight jurisdictions (AL, AR, ME, MA, MO, NM, WV, N. Mariana Islands) explicitly grant licensees the authority to supervise or train licensees at the bachelor's, associate's, or provisional level, and/or unlicensed social work interns.[115]

Rationale. Training institutions and employers may not be utilizing their full capacity to offer bachelor's-level social work internship positions due to the current ambiguity in the statutory definition of SSWs' scope of practice. Reports from training providers and employers suggest that because SSWs' authority to supervise interns is neither explicitly allowed nor prohibited in statute, organizations have been taking a conservative approach to complying with supervision regulations and have not allowed bachelor's-level interns to work under the supervision of even very experienced SSWs.[116] This approach has effectively constrained the number of available bachelor's-level social work internship positions (already a critical workforce constraint) to the number that can be supervised by LCSWs, CSWs, or other high-demand licensed mental health therapists. By updating the definition of SSWs' scope of practice in the statute to explicitly grant them authority to supervise bachelor's-level interns, this will remove ambiguity for training institutions and providers, and enable them to expand internship capacity by resolving concerns about legal supervision authority.

There is already precedent within Utah's behavioral health licensing structure for allowing experienced bachelor's-level, non-clinician practitioners to supervise interns or those practicing at a less advanced level of licensure. Licensed advanced substance use disorder counselors (LA-SUDCs) are explicitly allowed to supervise all lower levels of SUDC licensees and interns, given that they have at least two years of experience practicing as an LA-SUDC.[117] This proposed statutory change to the SSW scope of practice language has the potential not only to expand internship capacity as described above, but also to improve consistency between bachelor's-level BH practitioners' scopes of practice and their level of training.

[115] OPLR Law Review
[116] OPLR Listening & Vetting Tour
[117] UCA 58-60-508

Designated Examiner Clarifications

Summary of Recommendation

Include language in the Mental Health Professional Practice Act (58-60) and the Psychologist Licensing Act (58-61) clarifying which licensees may act as designated examiners according to DHHS standards. (*58-60, 58-61)*

Status Quo. Designated examiners conduct evaluations of individuals' mental conditions as part of various types of legal proceedings, as laid out in the Utah Rules of Civil Procedure.[118] Utah's Health and Human Services Code[119] allows both licensed physicians and licensed mental health professionals with specific training, experience, and qualifications to serve as designated examiners. Qualified individuals can become certified as a designated examiner through the DHHS Office of Substance Use and Mental Health.[120,121] Based on these guidelines, LCSWs can become designated examiners, while CSWs and SSWs cannot. As currently written, the Mental Health Professional Practice Act (58-60) and Psychologist Licensing Act (58-61) do not include references to these laws and procedures, and DOPL reports receiving frequent inquiries from social work and other practitioners who are unclear as to whether their scope of practice includes this type of participation in legal proceedings.

Rationale. This recommendation is primarily intended to give BH practitioners better clarity on their eligibility to serve as a designated examiner. The language added to Chapters 58-60 and 58-61 would not change current scopes of practice or designated examiner qualifications as already established in law–rather, it would simply clarify the current requirements and refer interested parties to the appropriate statutes. This update will not only better enable DOPL to respond to practitioners' questions, but also help practitioners feel confident that they are acting lawfully and ethically when asked to participate in legal proceedings.

Key Considerations. In addition to the updated statute language, a brief explanation of designated examiner requirements and links to the appropriate DHHS and Utah Courts statutes, rules, and resources should also be posted to DOPL's website.

[118] URCP Rule 35. Physical and mental examination of persons.
[119] UCA 26B-5-301
[120] R523-7
[121] Utah Department of Health and Human Services (2023). *Designated Examiner Information*. [online] Available at: https://sumh.utah.gov/education/certification/designated-examiner.