7. Social work in the United States of America

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Introduction

Social work practice in the United States is based in unique history, population, culture, and values. This article will discuss the diverse influences on social work practice in the United States through the following: introduction, social work definition and values, social work education, qualifications: licensure, the role of clinical social work among other helping professions, social work workforce, and future practice for American social workers.

A federal republic, the United States consists of 50 states, the federal district of Washington, Dc (the nation's capital), and several territories in the Pacific and in the Caribbean (Adams, Strother-Adams, Pearlie, 2001). Forty-eight states and Washington, Dc are connected and located in North America between Canada and Mexico. The other two states are located far from the lower 48 states: Alaska is located in the north-

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west of North America, just west of Canada, and Hawaii is located in the Pacific ocean.

The United States is comparatively large geographically, spanning approximately 9.8 million square kilometers (The world factbook, 2013). In total land area and population, the Us is the third largest country. One of the world's most ethnically and culturally diverse nations, the United States contains approximately 316 million people, a vast majority of whom live in urban or suburban areas (The world factbook, 2013). Large waves of immigration from many countries have contributed to the vast multicultural landscape of the United States, while the physical landscape reflects a similar diversity. Geography and climate varies within the country, ranging from arid deserts to plains, fertile prairies, and coasts, to forests, mountains, and tundra, playing host to a wide variety of plant and animal species (The world factbook, 2013).

According to the 2010 national census, the people of the United States are 73% white, 13% Black, 5% Asian, 1% American Indian, 3% multiracial, and 16% Hispanic or Latino. The country is near evenly split with regard to gender, as it is 51% female and 49% male (Us census bureau, 2011). Undocumented immigrants represent 11 million people (Camarota, Jensenius, 2008). Although the country has no official language, 80% of its residents speak english exclusively (The world factbook, 2013). The country has no official religious affiliation, and even specifies a separation of church and state within its constitution (The pew forum on religion & public life, 2008). However, many of the nation's founders were protestant Christians, and a large percentage of its current residents today identify as Christian, with 51% of Americans identifying as Protestant and 23.9% identifying as Catholic (The pew forum on religion & public life, 2008). Approximately 3.8% of Americans identify as gay, lesbian, or bisexual (Gates, 2011).

Primary issues for social work in the United States include the persistence of poverty, violence, mental illness and addiction, inadequate housing, health care, chronic illness, particularly hiv/aids, educational inequalities, immigration, and the aging of the population. Many of these issues are interconnected, a concept which has been critical to the practice of social work in the Us.

Despite having many of the highest incomes in the world, poverty persists as an important social problem in the United States. Moreover, issues related to poverty are intricately tied to gender and race, both separately and in combination. According to the most recent census data, 16% of Americans, or 48.5 million people, live in poverty – an increase of 3% since 2008 (Us census bureau, 2010). Children are overrepresented in America's poor, as 22% of children live in poverty. Poverty rates include 14% of those ages 18 to 64 and 9% of those 65 and older. Non-hispanic whites have lower poverty rates than any other racial group, comprising 10% of those in poverty. While 14% of males live in poverty, 16% of females have been shown to live in poverty (Us census bureau, 2010). World governments use either relative or absolute measures to determine poverty among their populations. Relative measures, employed by many European nations, measure poverty in relation to the standard of living within a particular country. In contrast, the United States uses an absolute measure that sets the poverty line at a fixed amount of income. In both scenarios, individuals falling below a pre-determined poverty line qualify for public assistance programs (Couch, Pirog, 2010). In 1996, the Clinton administration ushered in dramatic reforms to the welfare (public assistance) system in America with the passing of the Personal responsibility and work opportunity reconciliation act, or Prwora. This act was designed to motivate individuals and families away from public assistance and, instead, toward work, providing a system of incentives in combination with strict requirements for welfare recipients. Within this legislation are separate programs designed to provide services to individuals and are grouped as either means-tested or social insurance programs. Means-tested programs require that participants meet certain income or other resource-related qualifications. Examples of means-tested programs would be Temporary assistance to needy families (Tanf) and Supplemental nutrition assistance program (Snap). Tanf is a program providing cash benefits to very poor families with children as well as resources to help adult recipients gain and maintain employment. Provisions of this program are more stringent than in the past programs as recipients can only receive federal benefits for 60 or less months in their lifetime. The Snap program has recently become the nation's largest income support program (Klerman, Danielson, 2011). Snap provides support to families

via a debit card that can be used to purchase food at participating stores. This program was designed to provide families with children access to necessary living provisions. In addition to the aforementioned programs, there are many other income-based programs that provide assistance to families and individuals within the United States. Such examples would be the Women, infant, and children (Wic) program and the School breakfast and lunch program. Social insurance programs are not means tested and were created to smooth income over the life cycle, for example during times of disability or unemployment through no fault of the individual. Social security is the nation's largest social insurance program, accounting for 29 percent of federal government revenues and 20 percent of expenditures (Aaron, 2011). The Social security program provides cash benefits to individuals that are retired, disabled, or survivors after the death of a qualifying family member. The program has come under fire in recent years for the threat of insolvency and disincentive for work among recipients. Despite massive overhaul of the Prwora legislation, along with the work of social workers, legislators, and the general public, poverty remains a significant issue in America. Poverty continues to disproportionately affect women and persons of color in the United States, and income inequalities are still growing.

Violence also presents a significant issue for social work in America. Though violent crime had decreased 4% since 2010, 386 violent crimes had still been reported per 100,000 people in 2011. Aggravated assault was most common among these violent crimes, representing 62% of the violent crime in 2011, followed by robbery (29%), rape (7%), and murder (1.2%). Though murder represented only 1.2% of violent crimes in the United States, homicide represented the leading cause of death and injury in young people aged 10-24 (Fbi, 2012).

In all categories of violent crime, firearm use was high, though also down from the previous year. Given the role that firearms plays in violent crimes in America, gun ownership and use remains a controversial topic in the United States. Current estimated totals for civilian gun ownership in the United States, both legal and illicit, range from approximately 270 to 310 million, which, as of 2012, are distributed among 34.4% of American households. While many Americans oppose firearms or favor stricter measures of gun control, others cite the im-

portance of the second amendment to the Us constitution, or what is commonly known as «The right to bear arms» (Cornell university law school, 2013). Like many other policies in the United States, state-by-state legislation further complicates this issue. While local, state, and federal legislation places restrictions on gun ownership through factors such as age and history of domestic violence, along with varying background checks to hold a gun license, these restrictions vary by jurisdiction. This remains an important issue that not only influences social work in violent communities, but also continues to be an important debate in American politics as a whole.

Hiv/aids also remains a health problem of significant concern for the United States. While the United States has made great strides to address issues related to hiv/aids since the 1980s, as of 2010, more than 1.1 million Americans were estimated to have been living with hiv, with approximately 56,000 new infections occurring each year (White house, 2010). Widespread awareness of information regarding prevention, diagnosis, and treatment in America has driven the decline of transmission rates as well as public perception of the problem's urgency, yet 43% of Americans reported in 2009 that they know someone living with hiv (White house, 2010). Moreover, much like other social issues in the United States, hiv disproportionately affects some groups more than others, often only furthering stigma associated with the disease. The «National hiv/aids strategy for the United States», a policy initiative put forth by the Obama administration, reports that hiv/aids is of particular interest in communities such as: «gay and bisexual men of all races and ethnicities, Black men and women, Latinos and Latinas, people struggling with addiction, including injection drug users, and people in geographic hot spots, including the United States south and northeast, as well as Puerto Rico and the Us Virgin islands» (White house, 2010).

Mental illness and addiction also represents an important, yet also stigmatized, issue in the United States. With the passing of the Paul Wellstone and Pete Domenici Mental health parity and addiction equity Act in 2008, and subsequent release of rules for implementation in 2013, Us federal law officially recognized mental illness and substance use disorders as equal to physical illnesses. However, there is still much more work to be done. Only 13% of Americans received inpatient, out-

patient and/or medication treatment for mental or emotional problems. Of those with a serious mental illness, 40% do not receive treatment. Meanwhile, about half (50%) of children with mental disorders do not receive treatment. Though the reasons for these gaps in treatment are several and complex, part of the issue likely stems from the issue of health care in the United States.

Healthcare in the Us is provided by a mix of private and public organizations and payers. Recent issues include rapidly rising costs and challenges across the population with access to needed healthcare. Total expenditures on health have been estimated at 17.9% of gdp and $8,608 per capita in 2011 (World health organization, 2014). Costs are among the most expensive in the world, and yet the United States does not yield the best outcomes. One of the most significant drivers of these costs, representing 75% of expenditures, is chronic illness, due to longer life spans and lifestyle choices. Administrative costs also play a role in expenditures, including the costs of a fragmented system, such as duplicated services, gaps in quality and safety, and profits, for example. Technology and prescription drugs also drive these costs. Moreover, 26% of Americans reported in 2010 to have experienced at least 1 month without health insurance coverage. Largely in response to these high costs and gaps in coverage, healthcare reform became a critical issue in the United States in recent years. The Affordable care act of 2010 (Aca) sought to address these issues through legislation that mandated health insurance coverage for all Americans, among other health care provisions. This piece of legislature contained the most significant changes to the Us health care system since the establishment of Medicare in 1965. The goal of the Aca was to expand insurance access to more than 32 million uninsured Americans, increase consumer protections, emphasize prevention and wellness, and improve both quality and performance of health care systems (Ncsl, 2011). As of January 1, 2014, the Aca required most Americans to have some form of health insurance. Citizens could access and acquire health insurance through newly created state-based American health benefit exchanges. These exchanges offered insurance plans based on income levels and provided premium and cost-sharing benefits to individuals/families with incomes between 133-400% of the federal poverty level (the poverty level was $19,350 for a family of three in 2013). Citizens that failed to purchase

health coverage were required to pay a tax penalty of the greater of $695 per year up to a maximum of three times that amount ($2,085) per family or 2.5% of household income (Kff, 2013). In addition to expanding access to insurance, the Aca also expanded Medicaid to all non-medicare individuals under age 65 with incomes up to 133% of the federal poverty level. All the newly eligible individuals would be guaranteed a benefit package that would meet the essential health coverage requirements of the Aca. The most widely spread debate about the Aca involved the role of government in the execution of the program. Many politicians questioned the constitutionality of the bill and argued that the federal government did not have the right to require health care coverage for Americans. On June 28, 2012 the Supreme court of the United States upheld the Aca stating that its requirement that most Americans obtain insurance was authorized by congress's power to levy taxes. Additionally, the Supreme court agreed that congress has exceeded its constitutional authority in the expansion of the Medicaid program (Liptak, 2012). Individual states were now in charge of deciding if the Medicaid expansion would be offered to their citizens.

Social workers confront many other issues and problems that affect disenfranchised populations in the Us. Many of these issues are increasingly global and require global solutions, such as poverty, environmental degradation, and unemployment caused by downsizing/relocation. Within the Us as elsewhere, social issues are defined as problems whose solutions reflect the context of American culture and ideology, which is securely rooted in democracy, capitalism, and individual responsibility. While family is important to many Americans, extended family is typically considered less important than the immediate family. That said, many Americans still look toward the individual or the immediate family as the primary providers of help rather than the government.

Hard work is highly revered and is seen as a critical part of achievement of the American dream. Hard work cannot be underestimated in the American ethos: there is no legal mandate for vacation time in the United States, and 23% of Americans have no paid vacation or sick days (Ray, Sanes, Schmitt, 2013). Independence and autonomy are seen as major strengths, and as a result, hard work represents a highly valued way to retain one's freedom. In contrast, government assistance, commonly known as «welfare», is often viewed as demoraliz-

ing, creating unwanted dependency and defying the American values of independence and hard work. Many of these beliefs originated in the Elizabethan era, and by extension, American colonial poor laws. These early poor laws shaped the values of America, which, in turn contributed to the moral foundations of American social work. Many of these poor laws were designed to uphold the responsibility of the individual and to differentiate the deserving poor from the undeserving poor, which still persists in much of American social policy today.

For example, although most Americans are covered by private insurance through their employers or purchased on the individual market, many have health plans through the assistance of the government. Medicare is one such program, which is a social insurance program that provides assistance to adults who previously made contributions during their working years (e.g., older adults). Medicare consists of four parts, each covering different benefits. Part A, also known as the Hospital insurance (Hi) program, covers inpatient hospital services, skilled nursing facility, home health, and hospice care. It is funded by a tax of 2.9 percent of earning paid by employers and workers. Part B, the Supplementary medical insurance (Smi) program, helps pay for physician, outpatient, home health, and preventative care. Part B is funded by general revenues and beneficiary premiums. Part C, known as the Medicare advantage program, allows beneficiaries to enroll in a private plan, such as health maintenance organization, preferred provider organization, or private fee-for-service plan, as an alternative to the tradition fee-for-service program. Lastly, Part D, the outpatient prescription drug benefit, was created by the Medicare modernization act of 2003, and launched in 2006. Individuals who sign up for a Part D plan typically pay a monthly premium. Part D is funded by general revenues, beneficiary premiums, and state payments (Kff, 2010). In contrast, Medicaid is a program for the poor and, as a result, is means tested. Medicare recipients are often seen as «deserving» of the benefit as everyone who paid into the program during their working years receives the benefit. No moral judgment or stigma is attached to these benefits, as older adults are often viewed as having worked hard their whole lives and worthy of benefits. By contrast, Medicaid, considered a public assistance programs, remains more controversial. Since it is for the poor, Medicaid is means tested, and only available to individuals who quali-

fy. Medicaid provides health care insurance coverage to low-income people, especially those with complex health needs, women, and children. Funding for Medicaid is shared between federal and state governments. Enrollment requirements vary between states but the federal government requires certain core groups always receive coverage. The federal core groups that states must cover are pregnant women, children, parents, elderly individuals, and individuals with disabilities, with income below specified minimum levels. As of 2013, Medicaid covered an estimated 62 million Americans and was the largest source of health insurance for children (Kff, 2013). In contrast to Medicare, Medicaid assistance comes with a great deal of stigma, as its recipients are often viewed as undeserving, criticized by many in the American public as not working hard enough. In this case, many Americans compare Medicaid recipients to themselves, citing the ethos of upward mobility as a basis of criticism, regardless of their comparative social privilege.

Increasingly, the United States maintains a neo-liberal world view that is known as «conservative individualism». This is highly predicated on the privatization of services and the importance of personal choice, valuing the private market as more efficient and suggesting that less government is better. For the most part, individuals in America utilize a free market system in which they can select and purchase services. This, in turn, creates a market-driven commodification of services, producing an increase in the for-profit sector. Subsequently, Americans favor a decrease in regulation, which supports a decrease in taxes paid by the American public.

American social workers are employed in both private and public sectors, and as a result, are subject to the effects of individualism, a free market system, and the American approach to public aid. American social work practice is strongly predicated on these systems and ideologies, while also being influenced by the unique geographical and multicultural landscape of its people and the problems they face.

1. Social work definition and values

Social work in the United States mirrors the diversity of its geography and people, offering a wide range of possibilities for practice uni-

fied by a shared adherence to a set of professional values, principles, and techniques with the purposes of helping individuals, groups, and communities. Social workers utilize a number of pathways toward this goal, connecting clients to services, providing psychotherapy and counseling, and taking part in processes of legislation (Nasw, 2013). In order to perform these functions, social workers in the United States need to have an integrated knowledge base in the areas of human development, human behavior, and institutional systems at social, economic, and cultural levels (Nasw, 2013). Thus, social workers in the United States must not only be able to work with people but also are trained to identify systems of accountability. This wide scope of professional roles and duties, however, only further complicates the problem in creating a clear definition for American social work. Not only is it a challenge to define a singular social work practice, but no agreed-upon definition of social work exists in the United States (Nasw, 2013).

Despite these challenges, the United States maintains the largest primary social work practice organization in the world: the National association of social workers, or Nasw. According to the Nasw, this organization, «…works to enhance the professional growth and development of its members, to create and maintain professional standards, and to advance sound social policies» (Nasw, 2013). Created in 1955, the Nasw supports all domains of practice through a body of 145,000 members who are organized at the local level through state chapters. Primary functions of the organization include maintenance of the integrity of the profession, political advocacy, and a code of ethics that sets ethical practice standards. The Nasw supports these goals by recognizing the value of social work and its licensure, providing brand protection, offering malpractice insurance for independent practitioners, taking a stand on issues, and supporting professional education. By working together with the government through policy and program development, the Nasw also provides opportunities, improves social conditions, and targets injustice.

From its inception, Us social work as a profession has been grounded in concepts of social values, which have grown and changed throughout its 100+ year history. As a part of this commitment to ethics, the Nasw identifies six core values of social work in its code of ethics: service, social justice, dignity and worth of the person, importance

of human relationships, integrity, and competence (Nasw, 1999). Residual concepts such as «morality» and «character», though they may sound antiquated, remain a key feature of social work practice today. This is most notable in terms of licensure standards, but can also be seen within many social policies which are a manifestation of collective national values.

Social work values in the United States, both explicit and implicit, reflect the unique changing socio-historical climates that have shaped them. Several sources point to large-scale early 20th century social movements in the United States as major influences on the profession (Murdach, 2010, Pozzuto, Arnd-Caddigan, 2008). During the early years of social work, progressive era ideals shaped the belief that society was able to change for the better (Pozzuto, Arnd-Caddigan, 2008, Murdach, 2010), while temperance movement values suggested a moral focus (Murdach, 2009; Murdach, 2010). As a result, major tenets of these early 20th century movements had a profound effect on the development of social work as a profession. Not only did social work embrace the concept of change during its early years, but its principles were also guided by ethical standards with some function of social control (Murdach, 2010).

Much to their credit, early social work groups offered novel, much-needed scientific and creative interventions for America's quickly-expanding urban communities; however, these organizations often also approached these interventions through a moral lens (Murdach, 2010). Aligned with the rapidly growing health and sanitation needs of the time, particularly as a result of overcrowded, poor urban environments, progressive-era organizations approached need from a perspective of «mental hygiene» Though moralistic in tone, mental hygiene interventions did acknowledge the impact of the environment on the individual, laying some of the groundwork of future social work practice that continues today, while the concept of metal hygiene itself persisted well into the middle of the 20th century, and many of its moralistic undertones are consistent with social work practice values today.

As the progressive era came to a close and the first world war began, changing social values began to seek solutions founded in the growing scientific understanding. The publication of the Flexner report in 1915

was a key turning point for social work and other health providers of the time, spurring social work to create a more professional identity, revealing the need for social work to create and define its own distinct knowledge base (Pozzuto, Arnd-Caddigan, 2008). In it, dr. Abraham Flexner, a professional educator, performed a study of medical education in the United States, and claimed social work was not a true profession, citing a lack of a theoretical knowledge base and scientific method (Pozzuto, Arnd-Caddigan, 2008). This, in turn, inspired many in the field to substantiate their practices through scientific evidence, seeking to legitimize social work – an influence which has maintained a longstanding legacy within the field since that time (Pozzuto, Arnd-Caddigan, 2008; Wheeler, Gibbons, 1992).

Shortly after the Flexner report's release, Mary Richmond, an early charitable organization society member, published her revolutionary text, Social diagnosis, ushering in a new, diagnostic paradigm of social justice, geared toward fixing individual ills through more research-based methods (Danto, 2009). With these influences, social work interventions became predominantly oriented toward the practice of psychoanalysis and diagnosis into the 1920s and beyond (Danto, 2009; Goldstein, 2009). These early defining moments of American social work ushered in a greater emphasis on the professional application of social work theory and methods to the diagnosis, treatment, and prevention of psychosocial dysfunction, disability, or impairment, including emotional, mental, and behavioral disorders.

With this ethically-guided base and attention to the environment, coupled with the influence of more scientific methods, diagnosis, and treatment, social work was among the first to address a broad base of human needs (Danto, 2009). Not only do social workers offer support for a variety of issues, such as mental disorders, behavioral disturbances, and life transitions, but they also do so for many different client types, such as individuals, families, couples, and groups. Moreover, since its inception, the social work profession has tempered this approach to individuals by providing services to environments, communities, and other social systems, utilizing what has since been described as an ecological or systems framework and person-in-environment perspective (Bronfenbrenner, 1979; Goldstein, 2009; Karls, Wandrei, 1992). Today, while a large portion of social work practice in the

United States focuses upon counseling and psychotherapeutic services, it also addresses a number of other components, such as the role of the community, other environmental or systemic impact on individuals and groups, goals of social justice, policy, and leadership-oriented interventions (Whitaker, Weismiller, Clark, 2006). An emphasis on the person's reciprocal relationship to the environment is a critical feature of social work practice on all levels. Although this person-in-environment perspective is growing within other similar fields, such as counseling psychology or psychiatry, its role within social work practice is a particularly distinguishing feature of the profession.

Social work in the United States maintains a holistic, client-centered approach, and offers practitioners a number of routes through which to intervene. The client, which can be an individual, group, or community, is always considered in the context of their environment at all stages of the therapeutic relationship. Treatment planning also includes ongoing assessment of risk and protective factors, such as client vulnerability, strength, and resilience. Social workers are known to address mental, behavioral, or emotional health through crisis intervention and brief or long-term psychotherapy, but they may also fulfill a role of advocacy, evaluation, or consulting. Social workers are found in a number of settings in the United States, including but not limited to: hospitals, schools, health and mental health care centers, private practices, non-profit organizations, employee assistance settings, colleges and universities, centers for specific populations (e.g older adults, Lgbtq, survivors of various trauma), government and child welfare agencies, and substance use treatment centers. Though social work maintains a particular emphasis on helping disadvantaged and vulnerable groups, such as children, the poor, and the homeless, social work practice is performed among all ages and socio-economic groups.

Along with other helping professionals, clinical social workers in the United States can provide differential diagnosis and are often among the first to intervene (Nasw, 2005). This is largely due to the fact that licensed clinical social workers comprise the largest group of mental health service providers in the United States (Pozzuto, Arnd-Caddigan, 2008). The professional application of social work goals, ethics, and principles with individuals, groups, couples, and families is typically described as «clinical social work», a term which emerged in the 1960s

as the profession began to establish and individuate itself by its unique training and education as well as its newly-developed state licensing standards. In contrast to its early title of «psychiatric social work,» the term «clinical social work» speaks to the nature of the profession, which incorporates an understanding of larger systems which affect smaller groups and individuals (Nasw, 2005; Pozzuto, Arnd-Caddigan, 2008; Whitaker *et al*., 2006). As a result, clinical social work practice primarily focuses upon mental, emotional, and behavioral health interventions, but does not necessarily always indicate direct therapeutic practice.

Drawing from several sources, Eda Goldstein identifies several specific features of social work practice that are critical to the definition of clinical social work. Though Goldstein acknowledges not all practitioners may implement all of these features, she suggests that, together, these methods together comprise the core practices of clinical social work: «the importance of person-in-situation in assessment; an emphasis on genuineness and realness in relationship and the use of the clinician's self as core to the treatment process; being where the client is; respect for the client's self determination; the need for self-awareness about the impact of the clinician's personality, values, and background on the treatment process; engagement and treatment as a collaborative process; the importance of reaching out to «hard to reach» or so-called «difficult» patients; respect for cultural and other types of diversity; a commitment to working with those who are the targets of discrimination and oppression; the mobilization of a client's strengths, the development of insight, the creation of reparative experiences, and the fostering of new learning and behavioral change; an appreciation of the impact of and work with the social environment, including advocacy; a commitment to social justice» (Goldstein, 2009).

With this essential role in so many different sectors of the workforce, clinical social workers follow a set of twelve professional standards as defined by the Nasw (Nasw, 2005): ethics and values, specialized practice skills and intervention, referrals, accessibility to clients, privacy and confidentiality, supervision and consultation, professional environment and procedures, documentation, independent practice, cultural competence, professional development, and technology.

2. Social work education

Formal social work education began first at a summer training course at Columbia University given by the Charity organization society of New York in 1888, but a formal accrediting body for social work education was not established until 1952 (Feldman, Kamerman, 2001; Haynes, 1999). Professional social work education takes place in colleges in universities, accredited by one of six regional accrediting agencies, representing all of Us higher education: public/private, faith based, urban/rural, historically black colleges and universities, and Hispanic research institutions. Only one organization, the Council on social work education, or Cswe, serves as the accrediting body for social work education in the United States, as recognized by the Council for higher education accreditation (Cswe, 2012). The Cswe consists of a partnership between educational and professional institutions, social welfare agencies, and private citizens and is a nonprofit national organization (Cswe, 2012). Since its foundation in 1952, the Cswe has grown to represent 2,500 individuals and 685 undergraduate and graduate social work education programs (Cswe, 2012). Not only does the Cswe set forth accreditation standards for programs at the baccalaureate and master's levels, but it also ensures these standards and social work values are upheld and fostered (Cswe, 2012).

The Cswe maintains a competency-based approach toward its standards to best prepare social workers entering the field to be proficient practitioners. Social work education has a longstanding history dedicated to the integration of social work values in keeping with the goal that social work professionals would internalize these values prior to entering the field (Haynes, 1999). The 2008 Educational policy and accreditation standards published by Cswe outlined ten key competencies for social work curricula that included knowledge, values, and skills necessary for effective social work practice (Cswe, 2012). These core competencies are stated as: 1) «identify as a professional social worker and conduct oneself accordingly»; 2) «apply social work ethical principles to guide professional practice»; 3) «apply critical thinking to inform and communicate professional judgments»; 4) «engage diversity and difference in practice»; 5) «advance human rights and social and economic justice»; 6) «engage in research-informed practice and practice-informed re-

search»; 7) «apply knowledge of human behavior and the social environment»; 8) «engage in policy practice to advance social and economic well-being and to deliver effective social work services»; 9) «respond to contexts that shape practice», and 10) «engage, assess, intervene, and evaluate with individuals, families, groups, organizations, and communities» (Cswe, 2012).

With these competencies in place, social work education promotes a unique skillset and knowledge base. In doing so, social work education maintains foundational values of the profession, such as social justice, while continuing to be responsive to current political and social climates. Particularly in light of recent trends toward a more globalized community, the Cswe is also working to develop standards to maintain and establish proficiencies among United States social workers within the international arena (Cswe, 2012).

As a national nonprofit organization, the Cswe offers professional development of social work faculty, research, advocacy, and international collaboration, and also hosts a wide range of individuals and institutions in its membership (Cswe, 2012). In addition to setting accreditation standards, the Cswe also continues to review its current standards and the programs that follow them through its commission on accreditation (Cswe, 2012). An additional body within the Cswe, the Commission on educational policy (Coep), reviews and adapts social work education policy every 7 years, which, in turn, affects accreditation standards (Cswe, 2012). In this way, social work education is not only designed to uphold the original mission set forth by the Cswe, but since its inception, has strived to remain socially relevant and responsible in response to trends in the workforce and needs of the field (Cswe, 2012).

While social work values and its code of ethics provide a seemingly clear framework for social work practice, and presumably social work education, some aspects of social work education have received criticism regarding their adherence to these values and ethics. For example, though the origins of social work practice hold firm roots in the alleviation of poverty, and subsequently, social work ethics deliberately emphasize providing aid to the poor, very few schools in the United States offer formal coursework dedicated to this topic (Krumer-Nevo, Weiss-Gal, Monnickendam, 2009). Meanwhile, other studies cite concerns

such as self-compassion (Ying, 2009), student anxiety (Deal, Hyde, 2004), and multicultural knowledge (Deal, Hyde, 2004) as important, yet oft-overlooked, indicators of student competencies. Though formal social work education standards have been in place in the United States for over half a century, the development of standards that best address the evolving needs of the profession continues to grow (Cswe, 2012). Moreover, professional competencies that guide these standards are also evolving, as they vary from state to state and work together with the qualifications required for social work licensure.

3. Qualifications: licensure

Many regulations within the United States are determined at the state level, largely to offer power to the states and diminish federal control. In the United States, individual states offer professional licensing to set standards and define the scope of practice for various professional fields, to include social work, law, medicine, and real estate brokerage. Like these professions, licensure qualifications for social work practice are determined at the state level (Whitaker *et al*., 2006). All 50 states have standards for licensure. Though these standards are often somewhat similar, they are each determined state by state. Because of this, licensure qualifications vary nationwide, and ultimately result in a lack of consistent national standards (Whitaker *et al*., 2006). Due in part to this lack of consistency, an organization known as the Association of social work boards (Aswb) was established to protect the interests of the public who use social work services. Incorporated in 1979, this organization is comprised of jurisdictional boards that regulate the practice of social work. The Aswb also provides policy and licensing exam guidance to state licensure boards.

Many state licensing standards make some distinction between a licensed social worker and a licensed clinical social worker, most notably between the lengths of time spent working professionally in the field with supervision (Whitaker *et al*., 2006). Again, this qualification varies from state to state. Even the licensure titles vary as well; the more basic licensed title is typically «licensed social worker», and usually requires, at minimum, a graduate degree in social work or some

number of years of professional experience (often three years). The more advanced licensed title is denoted by the words clinical, independent, or independent clinical, such as in licensed clinical social worker, or licensed independent social worker, or even licensed independent clinical social worker. Though a licensed social worker can indicate anything from a baccalaureate level social worker to a master's level graduation, the primary difference between a licensed social worker and the same title with the addition of clinical and/or independent is the ability to practice privately or independently.

Again, the qualifications for these independent or clinical licenses vary by state. For example, in Illinois, a licensed social worker must have a minimum of 3,000 hours of supervised clinical professional experience (approximately two years) prior to applying to become a licensed clinical social worker (Nasw, 2005). Some states, such as New York state, Colorado, and Pennsylvania, require even more hours, ranging from 3,360 hours (Colorado) (Naswco, 2013), up to about three years (New York and Pennsylvania) (Naswnys, 2013; Pscsw, 2013). Other requirements include specific coursework or continued education, age requirements, or specialized training, such as child abuse identification training. In addition, most states maintain an emphasis on «good moral character», which is seldom clearly defined, but presumably indicative of the historical moralistic roots of the profession, combined with the ethical standards set forth by the Nasw and Cswe. All states in the United States require at least a bachelor's or master's degree in social work from a program accredited by the Cswe (Whitaker *et al*., 2006).

In addition to these requirements, candidates for licensure must also take a licensing exam specific to the state in which they hope to practice and receive a passing score. Typically, a social worker can apply for licensure in another state if they have achieved the requirements; that is, a social worker in one state is not prohibited from obtaining licensure in another state if they did not complete their clinical hours within that state. Many Americans relocate from one state to another, often to follow better job opportunities or return to their home state after completing their degree in another region of the country.

Independent or clinical social work licensure allows Us social workers to provide services without physician or psychologist oversight, and

also allows them to bill to third-party payers, which, in the United States, are typically insurance companies (Pozzuto, Arnd-Caddigan, 2008). Non-clinical or direct service social workers are found practicing in varied work environments throughout the United States. These practitioners handle connecting clients with services, intake and initial screening, and limited counseling. The majority of direct service social workers have experience providing medication to clients, consulting on case management, and aiding in daily living goals. Limited in the ability to counsel, direct service social workers are not allowed to perform psychotherapy or conduct counseling with patients that have a diagnosable mental condition (Swl, 2014). Social work practice is largely private in the United States, in so far as that most social workers do not work in government settings. This reflects the American ideological focus on the individual, who is often determined as self-responsible even with regard to their utilization of services. This further demonstrates a general attitude of tolerance toward high income inequality and narrow government accountability for the good of the public in the United States (Pozzuto, Arnd-Caddigan, 2008).

4. The role of clinical social work among other helping professions

According to a recent nationwide study by the Nasw, a majority of Us social workers overwhelmingly identify mental health as their primary area of practice (Whitaker, Weismiller, Clark, 2006). Though this represents a current trend within social work practice, the evolution of this practice focus requires further exploration, particularly in comparison and contrast with the roots of social work practice and many of its macro or community level (as opposed to micro or individual level) origins (Murdach, 2010). In addition, some authors argue that social work practice has also begun to trend toward a bias of service provision to more middle-class and urban populations, leaving a gap within lower socioeconomic status and rural communities (Whitaker *et al.*, 2006).

Also, despite some difference in history or explicitly stated professional values, the distinction between social work practice and other similar fields can be difficult to ascertain at face level. Because licensed clinical social workers can practice independently, bill to insur-

ance payers, and represent the largest group of mental health providers in the nation, it can be very difficult for the general public to distinguish between a social worker who provides psychotherapy and a psychiatrist or counseling psychologist. Typically, psychiatry treats organic illness (pathology) with medication and intrapersonal and internal dynamics, while psychology focuses on the mind and individual behavior. Both of these professions have firm roots in the scientific method as well, which social work began to adapt in the early and mid-20th century as medical and diagnostic models gained prominence.

Despite the benefits of aligning social work with medical practices – particularly with regard to insurance systems in the United States that provide much-needed payers for social work practice – this approach has come under fire for a couple reasons. First, the medical model does not share the same person-in-environment foundational principles upon which social work was established (Goldstein, 2009). Second, some authors cite the drive to «legitimize» social work practice as misguided; after all, social work practice maintains a distinct and rich century-long history that, though acknowledging of its interaction with other systems, easily stands on its own (Goldstein, 2009). This struggle is mirrored in the current trend toward what is called evidence-based or research-based practices, largely in response to billing requirements dictated by insurance billing and Medicaid public funding requirements, but also in an effort to remain relevant in the mental health field alongside clinical psychology (Pozzuto, Arnd-Caddigan, 2008; Morago, 2006).

Moreover, colloquial conceptions of the role of the social worker means that this title is often also extended (albeit erroneously) toward those who perform social work services without a social work degree (LeCroy, Stinson, 2004). This only further complicates this issue. Even with licensing standards, the term «social worker» itself remains a point of contention. Only those who have fulfilled certain requirements may refer to themselves with the title of «social worker»; however, depending on in which state the person is licensed, these individuals can include a range of educational backgrounds, from bachelor's to master's to doctoral degrees in the field (Whitaker *et al.*, 2006).

Though all social workers within the Us share common core values and education standards, the qualifications for licensure still vary by

state (Whitaker *et al*., 2006). Most licensed social workers within the United States enter the workforce with a master of social work degree (Whitaker *et al*., 2006). However, because there is no nationwide licensing standard, some states even offer an additional licensed title for social workers with a bachelor's degree (Whitaker *et al*., 2006). Particularly with regard to policy changes in health care and subsequent changes in insurance billing, and also as other mental health disciplines grow to adopt a more person-in-environment perspective, it is becoming all the more crucial for social workers to distinguish themselves from other fields and assert social work in the United States as an important and needed profession (LeCroy, Stinson, 2004; Murdach, 2010; Whitaker *et al*., 2006).

Though the literature acknowledges social work values to be a distinguishing feature throughout all aspects of the profession (Haynes, 1999; Stewart, 2013), many sources struggle to identify a singular definition of what social work is (Whitaker *et al*., 2006). Part of this concern has been due to the overlap between other helping professions and the many different aspects of social work theory and practice (LeCroy, Stinson, 2004; Murdach, 2010; Whitaker *et al*., 2006). In response to this issue, some sources identify the value of social justice (Stewart, 2013) and support for human rights (Healy, 2008) as major defining characteristics of social work practice. While many sources urge the social work profession to align itself with one particular value, theory, or practice, others still point to the search for identity itself as a source of the confusion (LeCroy, Stinson, 2004; Wheeler , Gibbons, 1992).

Ironically, while the social work profession has set itself apart since its inception by employing a strength-based perspective, many still define the social work profession itself not by its diverse strengths, but by narrowly-focused attempts to define social work simply by values, practices, or theory. Historically, the social work field has struggled to legitimize itself by appealing to desirable traits of other professions rather than asserting its own multi-faceted strengths. These values were not formally articulated until well after the early years of the profession, largely due to the formation of larger organizing not having occurred until the middle of the 20th century (Haynes, 1999).

More succinctly, Barker identified clinical social work as, «the professional application of social work theory and methods to the diagno-

sis, treatment, and prevention of psychosocial dysfunction, disability, or impairment, including emotional, mental, and behavioral disorders» (Barker, 2003). Licensure may add to the difficulty that arises when trying to delineate the boundaries of the social work profession, as licensed social workers may work to receive their «clinical» licensed independent or clinical social worker license. However, not all licensed clinical social workers necessarily work in private practice or even with individuals and smaller groups doing «clinical» work.

5. Social work workforce

A national study performed by the Nasw demonstrates some important considerations of current workforce demographics in the social work field (Whitaker *et al*., 2006). According to the study, there are currently about 310,000 licensed social workers in Us, with a ratio of 101 social workers per 100,000 people across the Us (Whitaker *et al*., 2006). Social workers are also employed in a wide range of practice settings, from for-profit, to private nonprofit, to local government sectors (Whitaker *et al*., 2006). Within the for-profit sector, 57% of social workers are in private practice and 8% in for-profit hospital or medical centers (Whitaker *et al*., 2006). Within the private nonprofit sector, 19% of social workers are employed in hospitals and medical centers, 17% in social service agencies, and 17% are in behavioral health clinics (Whitaker *et al*., 2006). In local government, 22% of social workers are employed in social service agencies, and 32% are employed in schools (Whitaker *et al*., 2006).

Respondents to the Nasw survey overwhelmingly cited mental health as their specialization, accounting for approximately 37% of the workforce (Whitaker *et al*., 2006). The next largest specializations were health and child welfare/family, both at 13% each (Whitaker *et al*., 2006). Moreover, the smallest areas of practice with which social workers identified were occupational social work, homeless/displaced persons, criminal justice – each at 1% – and income assistance and community development, both at 0% (Whitaker *et al*., 2006). An overwhelming number of social workers – 96% – tend to spend the majority of their time providing direct services, and spend more than half their time on four tasks: indi-

vidual counseling (29%), psychotherapy (25%), case management (12%), and screening/assessment (10%) (Whitaker *et al.*, 2006). These figures may not be surprising, but their implications are significant: though the roots of social work practice were often more oriented toward macro- and meso-level practices, current workforce trends demonstrate that direct services and therapy provision represent the most common practice areas today (Whitaker *et al*., 2006). Consultation and administration are also among the most common services social workers provide, representing 73% and 69% of the workforce, respectively (Whitaker *et al*., 2006). Interestingly, only 9% of social workers spend time in research, highlighting a strong segment of need for Us social workers. Through social work research, the profession can develop better screening and assessment tools and interventions, evaluate the relative effectiveness of social work services, and demonstrate relative costs and benefits of social work services. Additional research could also help social workers better understand expected and unexpected impacts of policy on the clients they serve and also offer clinicians the opportunity to bill health care payers for evidence-based practices.

However, public opinion of what social workers do does not reflect these trends. A 2004 study by LeCroy and Stinson conducted a phone survey to identify public opinion of the social work profession and revealed several divergent themes. Though respondents appeared to have a strong general sense of what social workers do, identifying social workers as effective in the areas of child welfare and homelessness, they were also largely unaware of the vast range of possibilities of the field beyond direct social work practice, notably neglecting community organization and advocacy, as well as private practice and psychotherapy services (LeCroy, Stinson, 2004). Moreover, a majority of respondents recognized the value of social work as a needed profession, but placed that value behind the community need for nurses (LeCroy, Stinson, 2004). This study highlights several gaps between social work practice, public perception, and the individuals and communities they serve. Currently, the social work workforce in the United States is disproportionately female. Women comprise 81% of the social work workforce, whereas the overall Us population is 51% female (Whitaker *et al*., 2006). Licensed social workers also tend toward larger metropolitan areas of the country, as 84% of mental health social workers are located in metropolitan areas,

while 2% are located in rural areas (Whitaker *et al*., 2006). Despite the population density of major cities within the United States, this presents a huge area of need, as the overwhelming geographical majority of the United States is comprised of rural and suburban communities (Whitaker *et al*., 2006). This results in major gaps within rural areas, and prohibits needed access to services (Whitaker *et al*., 2006). Additionally, licensed social workers show less racial and ethnic diversity when compared to the Us population overall. An overwhelming majority of social workers identify as white and non-hispanic, and are also generally older overall than the Us. civilian labor force (Whitaker *et al*., 2006). Among the respondents surveyed, 41% reported that over half of their caseloads belong to non-white minority populations (Whitaker *et al*., 2006). At the very least, this demonstrates a need to cultivate stronger cultural competencies in social work education, but also suggests a need for greater diversity among social workers, not only as it relates to the overall Us population, but also as it pertains to the diverse communities which social workers serve (Whitaker *et al*., 2006).

6. Future practice for American social workers

From the end of the 20th century to today, social work in the United States has continued to uphold its tradition of responding to social, cultural, and political needs of its time. Not unlike a century ago, social work in the new millennium faces the needs of America's poor, while also addressing concerns for a new wave of immigrants, underserved populations in urban communities, and, particularly in light of America's recently passed Affordable care act, needs related to health care. However, these issues are compounded by an ever-growing community of older adults, as well as advances in technology, and a developing global and environmental consciousness.

The recent trend in social work toward evidence-based practice highlights the growing similarities between social work and other research-oriented helping professions, particularly psychology (Arnd-Caddigan, Pozzuto, 2009). Moreover, these similarities are not only due to changes within the social work field alone; rather, recent trends in psychology and other more medically-focused fields have also begun to

adopt the focus on the environment that has always been an integral and even defining feature of social work. As a result, the field of social work and other helping professions have begun to converge at some of the very points that once defined them as separate. These similarities, coupled with general public confusion on the role of social workers, underscore the need for social work to differentiate itself as a profession. Rather than consider these similarities a liability, social work must take ownership of the theory base it shares with other professions, while maintaining its own unique identity (LeCroy, Stinson, 2004; Wheeler , Gibbons, 1992).

Amidst the challenges facing social work over more than a century of change, social work has sustained the unique, multi-faceted role it has played in helping individuals, groups, and communities throughout its history. As America already enters its second century of social work practice, the profession must adapt to necessary changes while continuing to uphold its values and mission. With the changing nature of the structures that support intervention, transdisciplinary research and practice is needed in ways that it has never been before. In response to these changes, the Nasw recently identified several important issues facing social work in the United States, based on current concerns and future projections; these include: the replacement of retiring social workers, recruitment of new social workers, and retention of the current social work labor force (Whitaker *et al*., 2006). This is particularly relevant as workforce demands are projected to increase 25% per year (Whitaker *et al*., 2006).

However, these are only a handful of the critical needs facing the professional workforce in the United States. Major societal changes in the 21st century are going to have a dramatic impact that challenges accepted norms of social work ideologies and practices (Reisch, Jarman-Rohde, 2000). Environmental needs, such as climate change and man-made disasters, are also contributing to the scope of social work in new ways. Political, environmental, and global changes surrounding social work in the United States suggest many more areas of need for the profession, such as: meeting the needs of economic globalization, changing political climate, growing use of technology, demographic shifts and their impact, changing nature of social service agencies, and changes in American universities (Reisch, Jarman-Rohde, 2000).

These demographic changes are of particular interest for the United States, as many communities are projected to grow dramatically, such as veterans, older adults, and latino communities, while others remain underserved and in need of further recognition and assistance, such as the Lgbtqi and immigrant groups. Moreover, social and economic inequality in the United States has become higher than any other industrialized nation, demonstrating the need for social workers to address these issues as well as learn how to adapt to them using a global perspective (Office of economic cooperation and development, 1995, Reisch, Jarman-Rohde, 2000). Response to these issues require flexible, holistically-mindedthinkers who are trained to think critically, adapt readily, and are grounded in an ethical system that does not favor any one particular population.

With these new facets of justice in mind, social workers are also in a position to advocate for a return to preventive care rather than the prevailing reactive model, highlighting the great return on investment potential of social work services. Current trends within the field are also leaning toward interventions that are quick, cost-effective, and evidence-based, rather than comprehensive, long-term case management (Reisch, Jarman-Rohde, 2000). Though some recent changes within social policy, such as the Affordable care act, have bolstered this approach, it still remains contentious in the overall political climate within the United States. Particularly as medical care in the United States moves toward an electronic standard, American social workers will also need to acknowledge the benefits and detriments of technology as a means of record-keeping, as a care delivery system, its effects on clients, its impact on social work education (i.e. distance-learning), and its role amidst globalization (Reisch, Jarman-Rohde, 2000).

In addition to becoming more conscious of these responsibilities, American social workers are also becoming more cognizant of their role within a global context. Fortunately, the global agenda as determined by the International federation of social workers (Ifsw), International association of schools of social work (Iassw), and International council on social welfare (Icsw) echo many of the core values already present in American social work practice. This global agenda addresses four primary themes, described as: «Social and economic inequalities within countries and between regions, Dignity and worth

of the person, Environmental sustainability, and Importance of human relationships» (Ifsw, 2012). Though many of these concepts are central to social work practice in the United States, the growing need for a more global understanding reinforces the need for social workers to better identify their roles and clarify the major tenets of their practice.

As America embarks upon the 21st century, social work must continue to forge its identity as a profession, continuing its focus on the person-in-environment while responding to cultural, political, and ideological shifts facing populations in need. Moreover, as our world becomes increasingly more globalized and technologically advanced at a rapid rate of change, the social work field in the United States must make adjustments on a more fast-paced, larger scale than ever before. Historically, the United States maintains a proud tradition as a melting pot of diversity; as social workers look toward the future, the profession must work to reflect the growing diversity of the United States, adjusting to the varied needs of the individuals and communities it serves. Social work in the United States must continue to create a socially conscious, globally aware, and technologically and culturally competent workforce, bolstered by a strong professional identity, to carry the profession into the 21st century and beyond.

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