

**Final Legislative Mandate Report:
Identification of the Number of Persons Licensed as Social Workers Serving
Underserved Communities and Culturally and Ethnically Diverse Communities**

**For the
Minnesota Board of Social Work**

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CHAPTER I

STATEMENT OF PURPOSE & INTRODUCTION

Statement of Purpose

The purpose of this report is to address the Minnesota Legislative mandate to the Minnesota Board of Social Work (Board) which was requested at the end of the 2007 session. The Legislative mandate is as follows

“The Board of Social Work shall study and make recommendations to the legislature by December 15, 2008, on how to increase the numbers of licensed social workers serving underserved communities and culturally and ethnically diverse communities...” (Minnesota Statutes, 2007, Chapter 123, Sec.133 of 148E.290).

Introduction

Historical Overview of Social Work Practice and Licensure in Minnesota

Social work practice has been vital in Minnesota since the development of the Minneapolis Family and Children Services, Minneapolis Associated Charities, Juvenile Protective League, Children's Protective Society, and Family Welfare Association of 1876. Other important developments include the creation of Family Services of St. Paul of 1892, the development of Minnesota State Emergency Relief Administration in 1933, and the Minnesota State Board of Control in 1901-1933 which regulated the state hospitals. Social work practice within the state was primarily not regulated outside of institutional or organizational regulations (e.g., state or county Department of Human Services or National Association of Social Workers). In 1978 the Minnesota Coalition for Licensure of Social Workers (now the Minnesota Coalition of Licensed Social Workers) was established and in 1987 the Legislature created the first Minnesota social work regulatory board (Minnesota Board of Social Work, 2008).

In order to address the 2007 Legislative Mandate, which also included: “...to provide recommendations regarding the need to increase the numbers of licensed social workers serving underserved communities” (Minnesota Laws 2007 Chapter 123, Sec.133 of 148E.290), a brief history of social work licensure is presented. Social work licensure was enacted by the Minnesota Legislature in 1987 with an effective date of July 1, 1989. This law included a grandparenting period that extended from 1987 to 1989. Initially, 8,500 social work licenses were issued. The law that passed in 1987 had several exemptions that are no longer included in “the exemption status” of the initial law of 1987. These exemptions included school social workers (this was never intended to be an exemption but clarified explicitly in 1991) and nursing home and hospital social workers (exemption ended in 1995). The only exemptions that continue to exist include “social workers employed by city, county, and state agencies, federally recognized tribes, or by private nonprofit agencies whose primary service focus addresses ethnic minority

populations, and who are themselves members of ethnic minority populations within those agencies” (Minnesota Laws 2007 Chapter 123, Sec.133 of 148D).

In 1998 the Board increased supervision requirements from 50 hours to 75 hours. The Board conducted an operations evaluation in 1999; Special Committee on Board Operations Final Report was released in 2000. In 2003 the Minnesota Merit system agreed to accept Association of Social Work Board (ASWB) licensure exam scores as an alternative to requiring the Minnesota Merit System Employment Exam. For graduates of Council of Social Work Education accredited social work programs this meant a decrease in the number of exams for individuals who desired to work for the state or county. The recodification of 148B to 148D was initiated by the Board, passed in 2005 by the Minnesota Legislature and became effective as of 2006. The state developed the Office of Mental Health Practice (OMHP) for unlicensed practitioners and housed the OMHP with the Board. As a response from the State Legislature and the Minnesota Department of Human Services (DHS), the Board proposed new Clinical Standards which received state approval in 2007 along with the Provisional License and Temporary License changes.

Minnesota Statutes 2007 Chapter 148D.001-290 Statutory Duties of the Minnesota Board of Social Work

The Board is required by Minnesota state law to provide public protection through the regulation of social work practice. This regulation applies to all persons licensed as social workers. These licensees include:

Licensed Social Worker

Subd. 2. Licensed social worker. A licensed social worker may engage in social work practice except that a licensed social worker must not engage in clinical practice.

Licensed Graduate Social Worker

Subd. 3. Licensed graduate social worker. A licensed graduate social worker may engage in social work practice except that a licensed graduate social worker must not engage in clinical practice except under the supervision of a licensed independent clinical social worker or an alternate supervisor pursuant to section 148D.120.

Licensed Independent Social Worker

Subd. 4. Licensed independent social worker. A licensed independent social worker may engage in social work practice except that a licensed independent social worker must not engage in clinical practice except under the supervision of a licensed independent clinical social worker or an alternate supervisor pursuant to section 148D.120.

Licensed Independent Clinical Social Worker

Subd. 5. Licensed independent clinical social worker. A licensed independent clinical social worker may engage in social work practice, including clinical practice (Minnesota State Statutes, 148D.050 Licensing; Scope of Practice Subdivisions 2, 3, 4, & 5)

(Minnesota Statutes 2007 Chapter 123, Sec.48, 49, 50, 51 of 148D).

The primary mission of the Board, “to promote and protect the public health, safety, and welfare through licensure and regulation of persons who practice social work,” (Minnesota State Statute, 2007) is implemented through very specific functions of the Board. These functions include but are not limited to:

1. Establishing the qualifications and procedures for individuals to be licensed as social workers;
2. Establishing standards of practice for social workers;
3. Holding examinations or contracting with the Association of Social Work Boards or a similar examination body designated by the Board to hold examinations to assess applicants' qualifications;
4. Issuing licenses to qualified individuals pursuant to sections [148D.055](#) and [148D.060](#);
5. Taking disciplinary, adversarial, corrective, or other action pursuant to sections [148D.255](#) to [148D.270](#) when an individual violates the requirements of this chapter;
6. Assessing fees pursuant to sections [148D.175](#) and [148D.180](#); and
7. Educating social workers and the public on the requirements of the Board (§ 1).

Fields of Practice

To identify the social work underserved areas in Minnesota, the different fields of practice must be explained. Since the 1800s social workers have practiced in many fields at the micro (individuals and families), mezzo (groups and organizations), and macro (communities, state, national, and global) levels. Some of these fields are listed below. (Please note this list is not all inclusive.)

Family and Children's Services

- Family preservation
- Family counseling
- Foster care and adoption
- Day care
- Prevention of child abuse and neglect
- Prevention of domestic violence

Occupational Social Work

- Employee assistance programs
- Treatment for work-related stresses
- Job relocation programs
- Retirement planning

Mental Health

- Crisis management
- Psychotherapy
- Group therapy
- In-home services
- Community integration
- Day treatment

Gerontological Services

- In-home support
- Respite help for family caregivers
- Adult day care
- Long-term care
- Nursing home services
- Assisted living support

Housing

- Subsidized rents
- Homeless shelters
- Handicap accessibility programs

Health and Rehabilitation

- Hospital social work
- Public health work
- Maternal health work
- Vocational rehabilitation
- Hospice care
- Day treatment for drug and alcohol addiction

Information and Referral

- Provision of information on resources
- Publication of community directories
- First-call services
- Emergency relief

Juvenile and Adult Corrections

- Probation and parole services
- Police social work
- Work in detention facilities
- Work in training schools
- Prison work
- Deferment programs

School Social Work

- School adjustment counseling
- Educational testing
- Family counseling
- Behavior management
- Psychotherapy
- Crisis therapy

Community Development

- Social planning
- Community organization
- Neighborhood revitalization
- Organizational development, assessment and evaluation

Because of the variety of fields of practice, this report attempts to first identify the underserved areas of social work practice in regard to geographical location, and ethnicity.

Underserved Communities by Geography

An underserved area may be determined solely on geography and the number of people within the defined boundaries. This report uses the U.S. Census Bureau (2007) definitions to identify geographical boundaries.

Geographic Single County – a whole county. A social work underserved county means the whole county.

Geographic Region – portions of a county or portions of multiple counties as designated as a geographic area.

Geographical underserved areas are usually defined within the contexts of medical, financial, and residential services. The primary theme within the geographical definition relates to population density in comparison to professional availability, and/or household income. Often, the U.S. Department of Health and Human Services refers to the U.S. Census Bureau's definition of urban areas and urban communities.

“The U.S. Census Bureau (2007) classifies as "urban" all territory, population, and housing units located within an Urbanized Area (UA) or an Urban Cluster (UC). It delineates UA and UC boundaries to encompass densely settled territory, which consists of

- a. Core census block groups or blocks that have a population density of at least 1,000 people per square mile, and
- b. Surrounding census blocks that have an overall density of at least 500 people per square mile” (U.S. Census Bureau, 2007).

The U.S. Census Bureau (2007) defines “urbanized area as a densely settled area that has a census population of at least 50,000” (§ 1 section U).

The Bureau continues to define rural as all territory, population, and housing units located outside of urbanized areas and urban clusters. Because “urban” and “rural” are delineated independent of any geographic entity except census block, the rural classification may cut across all other geographic entities; for example, there is generally both urban and rural territory within both metropolitan and nonmetropolitan areas (§ 1 section R).

In Minnesota it is easier to identify urban areas or urban clusters. The urban areas or clusters include:

- Duluth-Superior, St. Louis County - The county includes rural areas.
- Fargo-Moorhead, Clay County – The county includes rural areas.
- East Grand Forks, Polk County - The county includes rural areas.
- Minneapolis-St. Paul – These counties are labeled urban areas/clusters as identified by the Census Bureau Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington and Wright.
- Rochester, Olmsted County – This county is identified as urban.
- St. Cloud, Benton, and Stearns Counties – These counties include rural areas.

The Minnesota Department of Demographics (2007) indicates that in 2000 there were 14 cities whose populations were 50,000 or greater. The state's population continues to grow and there were 20 cities that met this population criterion in 2006. Still, it is important to note that there are seven counties with populations over 100,000 and nine additional counties with populations over 50,000.

Table 1.1 defines the Twin Cities Metro area as defined by the U.S. Census Bureau (2007). Other definitions used by state agencies are in Appendix 1.

Table 1.1

**Definitions of Minnesota’s Metro Area
 Used by the U. S. Census Bureau**

Area Covered	Origin/Purpose
<p>Minneapolis-St. Paul-Bloomington, Minnesota-Wisconsin 13-county Metropolitan Statistical Area (MSA) Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, and Wright Counties in Minnesota and Pierce and St. Croix Counties in Wisconsin.</p> <p>2000 population 2,968,806 1990 population 2,538,834</p> <p>National comparison: This is the 13th in population size in 2000 among MSAs (boundaries based on 1990 census data). Using post-2000 boundary definitions our rank dropped to 16th because PMSAs (see below) were combined to redefine several MSAs in 2000.</p>	<p>The MSA boundary remained the same after the 2000 census, although a number of other areas changed, which changed our population rank.</p> <p>Metropolitan Statistical Areas (MSAs) are groupings of whole counties meeting various criteria related to population size of the central city(s), contiguity of development, density and commuting links. MSA’s have been defined after each census since 1950 by the Office of Management and Budget (OMB). These areas are intended for statistical analysis only, although they are widely used for various administrative purposes with financial ramifications.</p> <p>For statistical comparisons, the Metropolitan Council usually uses the combined CMSA/MSA list of metro areas (see CMSA definition below).</p> <ul style="list-style-type: none"> -Anoka, Dakota, Hennepin and Ramsey were designated as the first SMSA (Standard Metropolitan Statistical Area) in 1950. -Washington was added in 1958. -Carver, Chisago, Scott and Wright (Minnesota) and St. Croix County (Wisconsin) were added in 1973. -Isanti was added in 1983. -Sherburne (Minnesota) and Pierce (Wisconsin) were added in 1992. -Our MSA boundary remained the same after the 2000 census, although a number of other areas changed, which changed our population rank.

Underserved Ethnic Populations

The U.S. Department of Health and Human Services (2007) reported ethnic underserved areas are the “ratio of the number of persons in the population group to the number of primary care providers”, Part II Population Groups, 1A. Criteria, (a). The U.S. Department of Health and Human Services narrowed this definition in a few articles to include the number of professionals from minority groups who are providing medical services.

This report utilized the Minnesota Department of Demographic (2007) ethnic data and the number of licensed and non-licensed county social workers. Yet, this demographic data is aggregated at too high of a level for this study. Therefore, to obtain more specific ethnic information, the researcher has also used language data from the Minnesota Department of Education. This data captured the numerous languages spoken within each Minnesota school district. By using both data sets, a clearer picture of the social work ethnic underserved areas is presented.

Underserved Aged 65 and Older Individuals

The U.S. Department of Health and Human Services (2007) identified the aging population as underserved. The Minnesota aging population will more than double over the next few decades and it is expected that in 2030, 25% of the Minnesota population will be over age 65. This is in comparison to the aging population in 2000 which was 16% of the total state population (Minnesota Department of Health, 2003). Yet, according to NASW (2007), the number of social workers entering the profession whose field of practice is identified as the aging population is declining.

Underserved Low Income Households

Individual/household income is reported by the U.S. Department of Health and Human Services (2007). The definition of “Financially Underserved Areas” concentrates primarily on Section 8 Housing and employment. Using this limited definition, it must be noted that this criterion is prone to favor urban areas and urban communities over rural areas.

The U.S. Department of Health and Human Services (2007) stated that the Financially Underserved Areas include a percentage of the service area's population with incomes below the poverty level. This definition does not indicate the exact percentage of the civilian population that is below the poverty rate but rather provides the following:

“The number of Full Time Equivalent (FTE) primary care physicians would include only those serving the requested population group. The ratio of the FTE primary care physicians serving the population group per 1,000 persons in the group is used in

determining weighted value V4. The weighted value for poverty (V1) is to be based on the percent of population with incomes at or below 100% of the poverty level in the area of residence for the population group. If the total of weighted values V1 - V4 is 62.0 or less, the population group qualifies for designation as an IMU-based MUP” (U.S. Department of Health and Human Services, 2007).

The definition of poverty that is utilized by the U.S. Department of Health and Human Services (2007) is identified in Table 1.2.

2008 U.S. Department of Health and Human Services Poverty Guidelines

Table 1.2

Persons in Household	48 Contiguous States and D. C.	Alaska	Hawaii
1	\$10,400	\$13,000	\$11,960
2	14,000	17,500	16,100
3	17,600	22,000	20,240
4	21,200	26,500	24,380
5	24,800	31,000	28,520
6	28,400	35,500	32,660
7	32,000	40,000	36,800
8	35,600	44,500	40,940
For each additional person, add	3,600	4,500	4,140

(Federal Register, 2008)

Report Definitions of Underserved Communities

For the purpose of this report the following definitions are used to identify the areas that are underserved by the social workers who are licensed as a LSW, LGSW, LISW or LICSW.

Underserved Geographical Communities Served by Persons Licensed as Social Workers

Regions of the state that are not defined as urban areas or urban clusters in which the distribution of social work practitioners is disproportionate to the number of social workers, as outlined by the federal or state recommendations.

Underserved Ethnic Populations Served by Persons Licensed as Social Workers

Any area (region, county, city, or township) where the number of people that identify as a minority ethnic group is disproportionate to the number of social workers, as outlined by federal or state guidelines.

Underserved Aging Populations Served by Persons Licensed as Social Workers

Any area (region, county, city, or township) where the number of people that identify as over age 65 is disproportionate to the number of social workers, as outlined by federal or state guidelines.

Underserved Low Income Households Served by Persons Licensed as Social Workers

Any area (region, county, city, or township) where the number of people that are of low income is disproportionate to the number of social workers, as outlined by the federal or state recommendations.

Underserved Homeless Population Served by Persons Licensed as Social Workers

Any area (region, county, city or township) where the number of people who are identified as being homeless is disproportionate to the number of social workers, as outlined by the federal or state recommendations.

Baseline

Within the history of Minnesota social work practice, this type of research, which includes identifying the underserved areas of licensed social work practice, has never occurred. Therefore, the Board recognizes that this research is establishing an initial baseline of underserved populations, communities, or areas.

Geographic Information Systems

This report presents numerous graphics specifically utilizing Geographic Information Systems (GIS), figures, and analysis in order to fully answer the Legislative mandate.

“GIS is a system for capturing, storing, analyzing and managing data and associated attributes which are spatially referenced to the earth. In a more generic sense, GIS is a tool that allows users to create interactive queries (user created searches), analyze the spatial information, edit data, develop maps, and present the results of all these operations. Geographic information system technology can be used for scientific investigations, resource management, asset management...” (Association of American Geographers, 2007).

Estimated Number of BSW and MSW Graduates

In order to address the issue of social work underserved areas in Minnesota, it is important to aggregate the estimated number of social work graduates over the next five years in Minnesota. Table 1.3 provides the estimated number of BSWs and MSWs that will graduate from Minnesota programs in the next five years. The estimated number of graduates between 2008-2013 is 2,826 BSWs and 1,720 MSWs, for a total of 4,546 BSW and MSW graduates.

**Table 1.3
 Estimated Number Of Bachelors And Masters Graduates for 2008 - 2013**

Name of Minnesota Social Work Program	Estimated # of BSWs in next 5 years	Estimated # of MSWs in next 5 years	Total BSWs & MSWs in next 5 years
Augsburg College	75	200	275
Bemidji State University	125		125
Bethel University	100		100
College of St. Catherine/University of St. Thomas	300	500	800
College of St. Benedict/St. Johns University	55		55
College of St. Scholastica	125		125
Concordia College	106		106
Metropolitan State University	420		420
Minnesota State University, Mankato	300	160	460
Minnesota State University, Moorhead	285		285
St. Cloud State University	400	160	560
St. Olaf College	85		85
University of Minnesota, Twin Cities		500	500
University of Minnesota, Duluth		200	200
Southwest Minnesota State University	100		100
Winona State University	350		350
Total	2,826	1,720	4,546

(Social Work Program Directors, Personal Communication 2008).

Reasons for Licensure Discontinuance

Along with the number of social workers who graduate in Minnesota with a BSW or MSW, one must also consider the number of social workers who discontinue their licenses for a variety of reasons such as retirements, license expirations, and voluntary terminations. The Minnesota Board of Social Work (2007) reported that in the past 5 years there have been 2,208 social workers who have discontinued their licenses. One might believe that the simplest way to analyze this information is to subtract the number of graduates from the number of voluntary terminations, but this researcher would caution against this type of linear conclusion. Please see the Chapter Four Findings and Chapter Five Summary and Application of the Findings in the recommendation section of this report. See Table 1.4 for the detailed reasons for discontinuation.

Table 1.4
Reasons and Number of Social Workers Who Discontinued
Their Licenses from 2002-2006

	2002	2003	2004	2005	2006	Total
Emeritus Licenses	22	23	34	41	31	151
LSW	9	7	9	11	8	44
LGSW	2	0	0	2	1	5
LISW	3	8	6	6	3	26
LICSW	8	8	19	22	19	76
Expired Licenses	490	407	394	329	395	2015
LSW	305	262	263	227	261	1318
LGSW	55	49	39	36	44	223
LISW	56	34	22	24	32	168
LICSW	74	62	70	42	58	306
Voluntarily Terminated Licenses	34	31	36	20	21	142
LSW	17	17	23	11	11	79
LGSW	5	5	3	2	1	16
LISW	4	2	2	2	2	12
LICSW	8	7	8	5	7	35
Total Licenses Discontinued	546	461	464	390	447	2308
LSW	348	300	308	258	290	1504
LGSW	62	54	42	40	46	244
LISW	63	44	30	32	37	206
LICSW	90	77	97	69	84	417

The Board does not know the specific reasons for individuals voluntarily discontinuing their licenses. But, with the estimated number of graduates in the next 5 years being only 4,546, historical knowledge of 2,308 licensees discontinuing their licenses, and the overwhelming number of social and human services shortages throughout the state, it appears that the Minnesota CSWE accredited social work programs are not meeting the state's needs for social work graduates.

CHAPTER II
LITERATURE REVIEW

Literature Review

Geographically Underserved

The literature identifying geographically underserved areas is primarily focused on medical, mental health, financial, and/or housing services. The majority of the empirical data is directly linked to the ratio of physicians, nurses, dentists, and/or allied health practitioners (BSW or MSW not included) to the numeric population. Therefore, the geographically underserved definition is linked with the federally identified rural areas in Minnesota and the rest of the nation.

Yet, Medicare does identify the need for social workers to use alternative ways to meet the needs of people who live in federally identified rural areas. Medicare reaches out to people who live in geographically underserved areas of the United States by approving the reimbursement of telehealth services provided by clinical social workers. Effective October 2001, the Benefits Improvement Protection Act (BIPA) approved Medicare billing for telehealth services provided by clinical social workers through the amendment of Section 1834 and defined by Current Procedural Terminology (CPT) Codes 90804, 90806, and 90808. The services are provided in areas designated as Rural Health Professional Shortage Areas (HPSA) or in a county that is not included in a Metropolitan Statistical Area (Federal Register, 2001).

The shortcomings of mental health services for individuals who have experienced natural disasters was discussed by representatives from the National Association of Social Workers (NASW, 2007) with the U.S. Senate Committee on Health, Education, Labor and Pensions Hearing on Psychological Trauma. NASW's 2007 report entitled, *Assuring that Americans Received the Support They Need*, presented the facts that social workers provide 60% of mental health services nationally and 40% of all licensed mental health services by the American Red Cross. This report outlined the lack of disaster mental health services for Americans which are often provided by persons licensed as social workers.

The Elementary School Counseling Demonstration Act (2001) provided documentation of the federal government allocating funds to Minnesota. "Greater Minnesota received \$1,175,000 in 2000 and Minneapolis received \$376,128 in 2001 for the provision of mental health services primary to secondary school districts" (§ 17). These funds were partly utilized in Minnesota to include increasing the number of school social workers in the "no child left behind" program. On the national level the Government Relations & Political Action of the National Association of Social Workers (NASW, 2002) cited research that demonstrates the effectiveness of school social workers:

- 1) Increasing student achievement
- 2) Improving student classroom behavior
- 3) Recording more positive student attitudes towards school

- 4) Reducing the chances that students will commit violent acts, abuse alcohol, or engage in other risky behaviors (NASW, 2002).

The U.S. Department of Health and Human Services (2007) has set specific criteria for determining Health Professional Shortage. The geographical criteria include “1) the geographic area involved must be rational for the delivery of health services, 2) a specified population-to-practitioner ratio representing shortage must be exceeded within the area, and 3) resources in contiguous areas must be shown to be over utilized, excessively distant, or otherwise inaccessible. Even though the definition of health professional does not include social workers, the literature has clearly established the vital role of social workers within health and mental health services” (§ 24).

Ethnic Underserved

In the definition of “Ethnically Underserved” the literature frequently shows the empirical ratios between the number of physicians, nurses, dentists and allied health professionals and primary and secondary educators identified as minorities in relation to the number of minorities within a specific area or region. Literature also links the same professions as listed above (not identified as professionals who are in minority groups) that are providing services in areas identified as having a high percentage of diverse ethnicities. The literature empirically describes the “Ethnically Underserved” areas in relationship to child welfare and aging services. There appears to be little information regarding other social work fields of practice.

The U.S. Department of Health and Human Services (2007) also identifies “Ethnic Underserved Areas” stating “Barriers to access for the population group are primarily due to non-economic factors such as minority status, language differences, or cultural differences” (§ 6). Again, the U.S. Department of Health and Human Services (2007) does not recognize social workers as a part of the Health Profession Shortage but, a 2006 NASW study demonstrated that:

- More than half of health care social workers are employed in hospitals and 14% in health clinics and hospices.
- Health care social workers are most likely to practice in metropolitan areas (85%). Only 7% of health care social workers practice in micro-metropolitan areas with specific minority groups, 6% in small towns, and 2 % in rural areas.
- Social work in health care settings is a major practice area serving older adults. Health care social workers comprise more than one-third of all social workers.
- There are many different specialties in the health practice of social work, including oncology, hospital, nephrology, pain management, and hospice.
- Nearly 34 million people were admitted to hospitals in 2004.
- Social workers are an integral part of the multidisciplinary team, working closely with doctors, nurses, and other medical professionals.

- According to the Bureau of Labor Statistics, there were about 110,000 medical and public health social workers in 2004.
- Because hospitals are releasing patients earlier than in the past, social worker employment in home health care services is growing (NASW, 2007 ¶ 19).

Clark (NASW 2003) testified for the Human Resources Subcommittee of the U. S. Committee on Ways and Means Hearing on Bush Administration Foster Care Flexible Funding Proposal regarding the shortage of social workers in the field of child welfare. In Clark's testimony she reported shortages of social workers in "Ethnically Underserved Areas" for the youth who are in the foster care system. She indicated that the majority of child welfare workers were Caucasian, yet minority children are over-represented within the foster care placement system (Child Welfare League of America, 2001; Cicero-Reese, & Black, 1998; Harrison, 1995; Anderson, 1994; and Russell, 1987).

Aged 65 and Older Underserved

Clark's (NASW, 2007) testimony to the Special Committee on Aging U.S. Senate Hearing discusses the need to provide the "graying population" with adequate medical, mental health, and social services. Clark relates the shortages of social workers working with the aging population to "Medicare discriminations under Part B through the impositions of a 50% co-pay whereas all other services have a significantly lower co-pay of 20%. Example; the decision to reimburse clinical social workers directly for mental health services rendered to Part B beneficiaries in skilled nursing homes rests with the individual Medicare fiscal intermediaries. Some pay and others do not" (NASW, 2007 ¶ 14). Scharlach, Damron-Rodriguez, Robinson, and Feldman (2000) also report the extreme need for social workers who are committed to working with older adults and even greater need for social workers who will work with older adults who are minorities. Zlonik and Rosen (2001) found that "only about 16 percent of baccalaureate social workers and 4 percent of masters social workers work specifically with older adults" (Rosen & Zlonik, 2001).

Underserved Based on Household Income

For decades federally identified rural areas have been identified as having large gaps in social services for people with housing needs. Many federal programs have indicated social workers as key players in the provision of social services to the geographically underserved areas where people have housing needs. The list of programs include Health Resources and Services Administration (HRSA, 2003), the Ryan White Care Act (2001), The Department of Housing and Urban Development, Administers of Housing Opportunities for People Living With AIDS (2001), the McKinney-Vento Homelessness Assistance Grants Programs (2001), the Substance Abuse and Mental Health Services Administration (SAMHSA, 2001), Health Resources and Services Administration (2003), National Coalition for the Homeless (2001), the U.S. Department of Housing and Urban Development (2001, 2003), and the Urban Institute (2000).

The U.S. Department of Health and Human Services (2007) identifies economic barriers as a primary reason for Health Professional Shortages. The criteria for this identification includes; 1) lack of access for the low-income population, 2) lack of access for the Medicaid-eligible population, and 3) a minimum of 30 percent of the service area's population must be at or below 200 percent of poverty for consideration as a low-income Health Professional Shortage area.

Individuals living slightly above, below, or at poverty that do not have access to third party payment are less likely to seek non-emergent health/dental care (Levy & O'Connell, 2004). This distorted provision of medical care increases the complexities of diagnoses for people of poverty. According to Breakey et al. (1989), people who only access emergent medical/dental care on average have nine different diagnoses. The U.S. Census Bureau findings from the Current Population Survey (2006) show that about 9.2 percent of the population is below the federal poverty line. This is an increase from the 8 percent in 2003 and the 7.5 percent in 2002.

The Director of the Minnesota Children's Defense Fund (2005) stated that "the median household income has decreased approximately \$4,000 annually between 2000 and 2005." The reduction of Minnesota's median household income is a direct correlation to household income and the household member's access to resources such as child care, health care, transportation, clothing, and food. These are all basic needs that are increasing in costs.

The U.S. General Accounting Office (2007) reported, women of poverty are among the highest population of victims involved in domestic violence (55 to 65%). U.S. Department of Justice (2007) reports that health care costs for intimate partners of domestic violence are estimated to be 10 billion dollars, and this cost does not include mental health services for children who have witnessed domestic violence. The lack of social workers to provide preventive domestic violence services is correlated to the increase of costs of tertiary services for the victims and offenders.

The Children's Home Society & Family Services of Minnesota (2003) report supported the increased need for primary and secondary preventive interventions. This report includes

- More than 800 Minnesotans, or 16 of every 100,000 people, were treated in hospitals for injuries caused by an intimate partner in 2001.
- The most common reason for women to seek temporary shelter in Minnesota is to flee an abusive partner.
- In 2000, 30 percent of all women surveyed were homeless, at least in part, because of domestic abuse in the last 12 months.

- In 2003, at least 13 women and 10 children were murdered in Minnesota because of domestic violence; 22 children were left motherless because an intimate partner murdered their mother.
- In 2002, at least 16 women, 12 men and two children were murdered or committed suicide in the course of domestic violence in Minnesota
- In 2001, 33 women and 11 children were killed as a result of domestic violence.

Underserved Areas Based on Homelessness

According to the Wilder Research (2008), “9,000 individuals experience homelessness each night, about 7,000 are fortunate enough to receive shelter from a variety of homeless service providers across the state,” according to a number of quarterly shelter surveys conducted by the Department of Human Services over the past few years. Unfortunately, due to inadequate resources, sheltering programs turn away about 1,000 individuals each night. Worse yet, neither of these numbers include the hundreds of individuals who spend the night in a place not meant for human habitation, such as under a bridge or in a car” (¶4).

The social work profession has worked with people of poverty since the 19th century. Social worker’s involvement with people of poverty has and is currently utilizing many approaches to solving poverty and the issues related to it. “ Social workers' perspectives on both the person (those who are poor) and the environment (the circumstances that produce poverty) have engaged this profession's century-long efforts to mitigate the impact of poverty on people as well as to develop policies that either prevent poverty or ease poor people's rise to greater economic security” (NASW, 2007, ¶ 1).

Social Work Shortages in Mental Health

Social work shortages in mental health cut across all underserved areas and populations. Social workers have had a robust presence in the provision of mental health services since the 19th Century, and it has been demonstrated that social workers provide the majority of mental health services still today (SAMHSA, 2001). In 2001 President Bush created the New Freedom Commission. The Commission’s Report discusses the shortages of mental health providers (New Freedom Commission on Mental Health, 2003). This report specifically states that “people of color are underserved in the current system and face barriers to receiving appropriate mental health care” (¶ 7 Executive Summary) and improved access to mental health services is needed..

People with Cognitive Impairments Face Social Work Shortages

People with cognitive impairments are often among the economically poorest and most vulnerable populations. Yet, in the state of Minnesota the services are often compromised by extremely high caseload sizes as reported by the Minnesota Department of Human Services (Minnesota Department of Human Services, 2007).

There is a wide degree of variation in caseload size for cognitively impaired clients from county to county, with a range of 20 to 100 persons per worker. For amount of service provided, units billed annually per consumer range from 30 to 168. For persons with mental retardation and related conditions (MR/RC), Minnesota's average caseload size of 52.8 is higher than the national average of 40. Only eleven (generally smaller) counties are at or below the national average caseload size of 40.

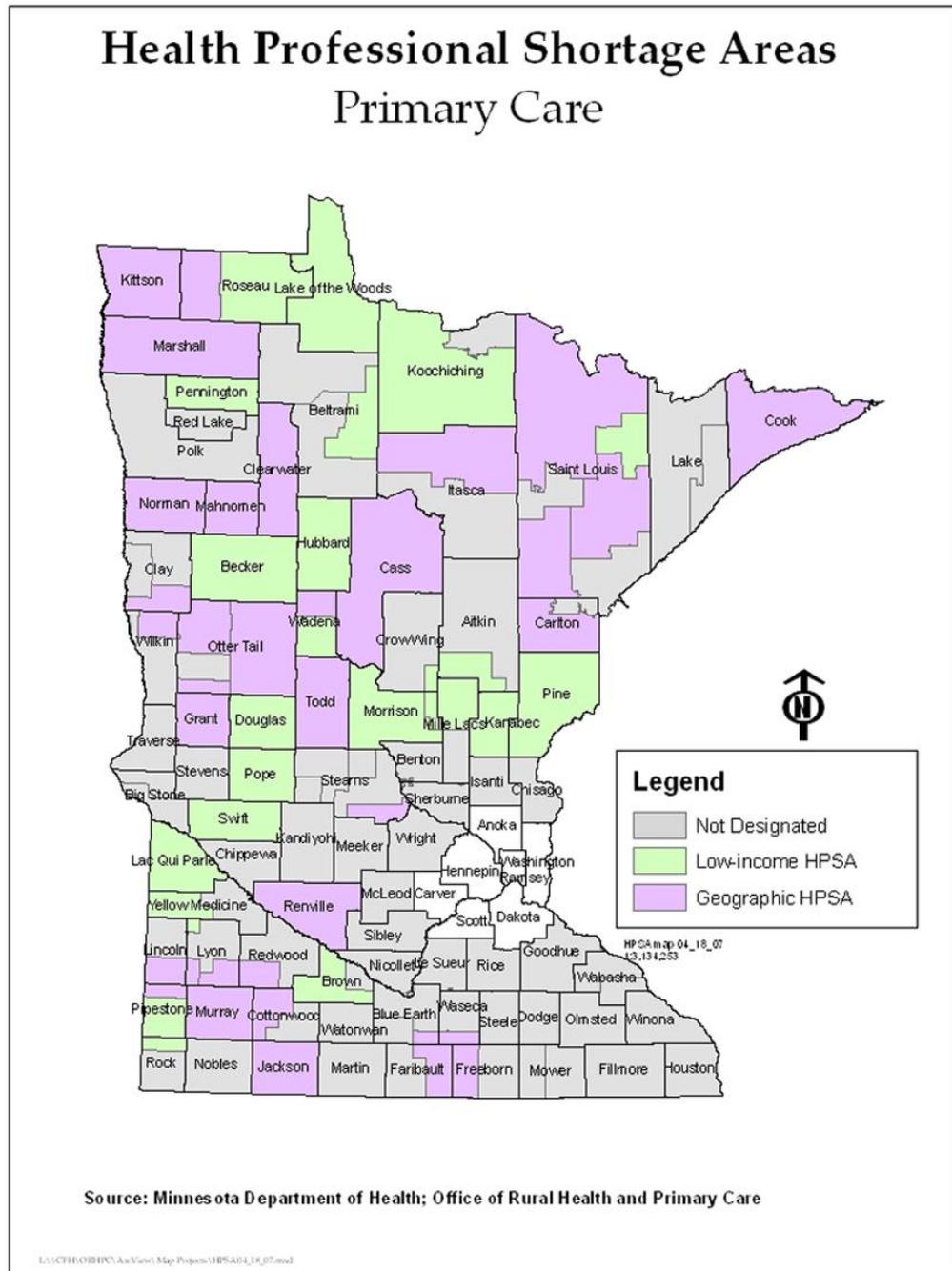
Many of Minnesota's larger counties have caseloads that are well above the nationwide norm. The relatively high caseloads that case managers are carrying explains why they spend a large proportion of their time dealing with crisis cases. In order for case managers to devote more time to individuals, their present caseloads need to be reduced. Standardizing caseload size assures that consumers have access to at least a baseline level of case management support county-to-county. A caseload standard can serve as a useful benchmark in addressing the adequacy of case management funding and the efficiency of case management delivery, and also serve as a basis for determining an appropriate payment rate per unit of service.

Minnesota's Health Professional Shortage Areas

Minnesota's Health Professional Shortage Areas and the Medically Underserved Areas (HPSA & MUA) are identified by the Minnesota Department of Health. According to the U.S. Department of Health and Human Services (2007) a health professional is a provider of primary medical, dental, or mental health care (§3). The counties described in Map 2.1 have been identified as low income geographic HPSA for primary health care.

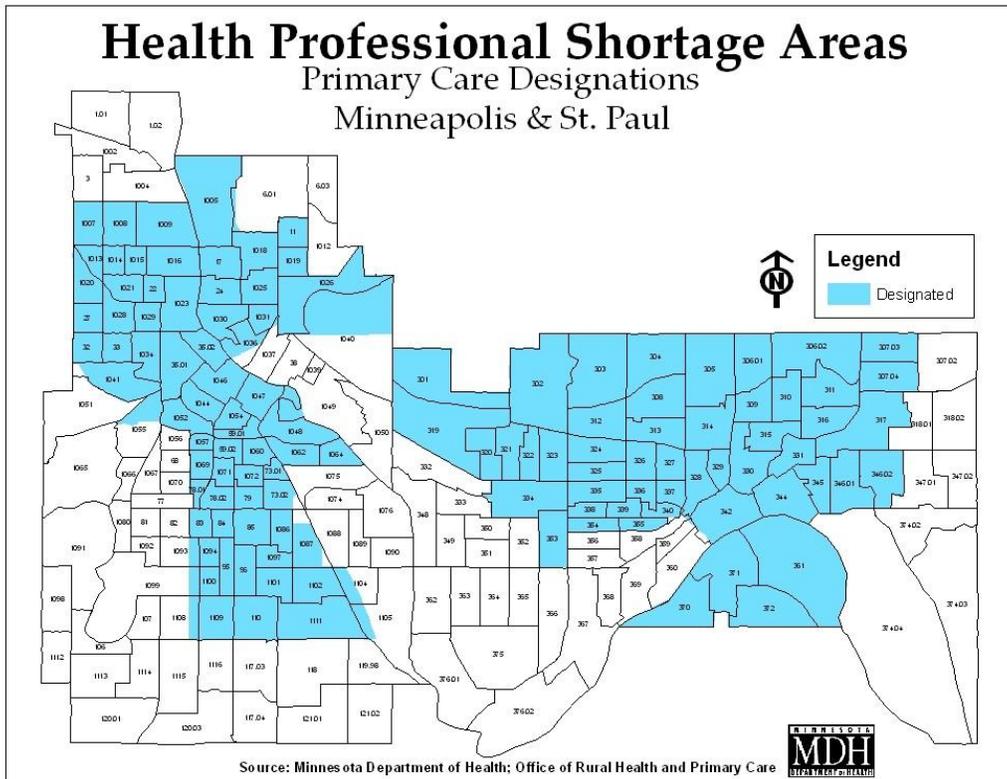
Map 2.1

U.S. Department of Health and Human Services Identified Health
Professional Shortage Areas in Minnesota by County, 2003



The Minneapolis and Saint Paul HPSA identified by the Minnesota Department of Health (2003) for primary care based on low-income HPSA and geographical HPSA is presented in Map 2.2 Health Professional Shortage Areas Minneapolis & St. Paul.

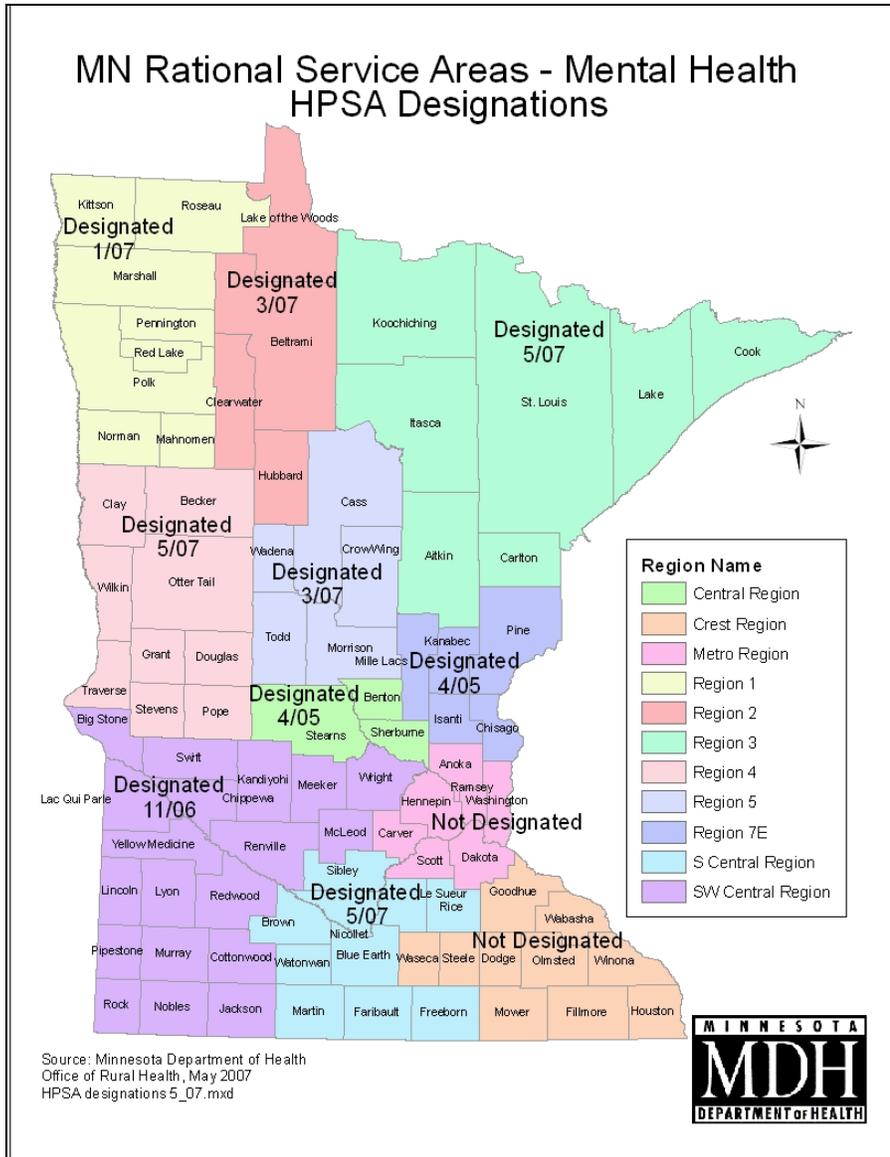
Map 2.2
U.S. Department of Health and Human Services Identified Health Professional Shortage Areas in St. Paul and Minneapolis, 2003



The Minnesota Department of Health (2003) also identifies the Mental Health HPSA and Medically Underserved Areas (MUA) based on geographical rural areas. These Minnesota counties may be seen on 2.3.

Map 2.3

U.S Department of Health and Human Services Identified Mental Health Shortage Areas in Greater and Rural Minnesota, 2003



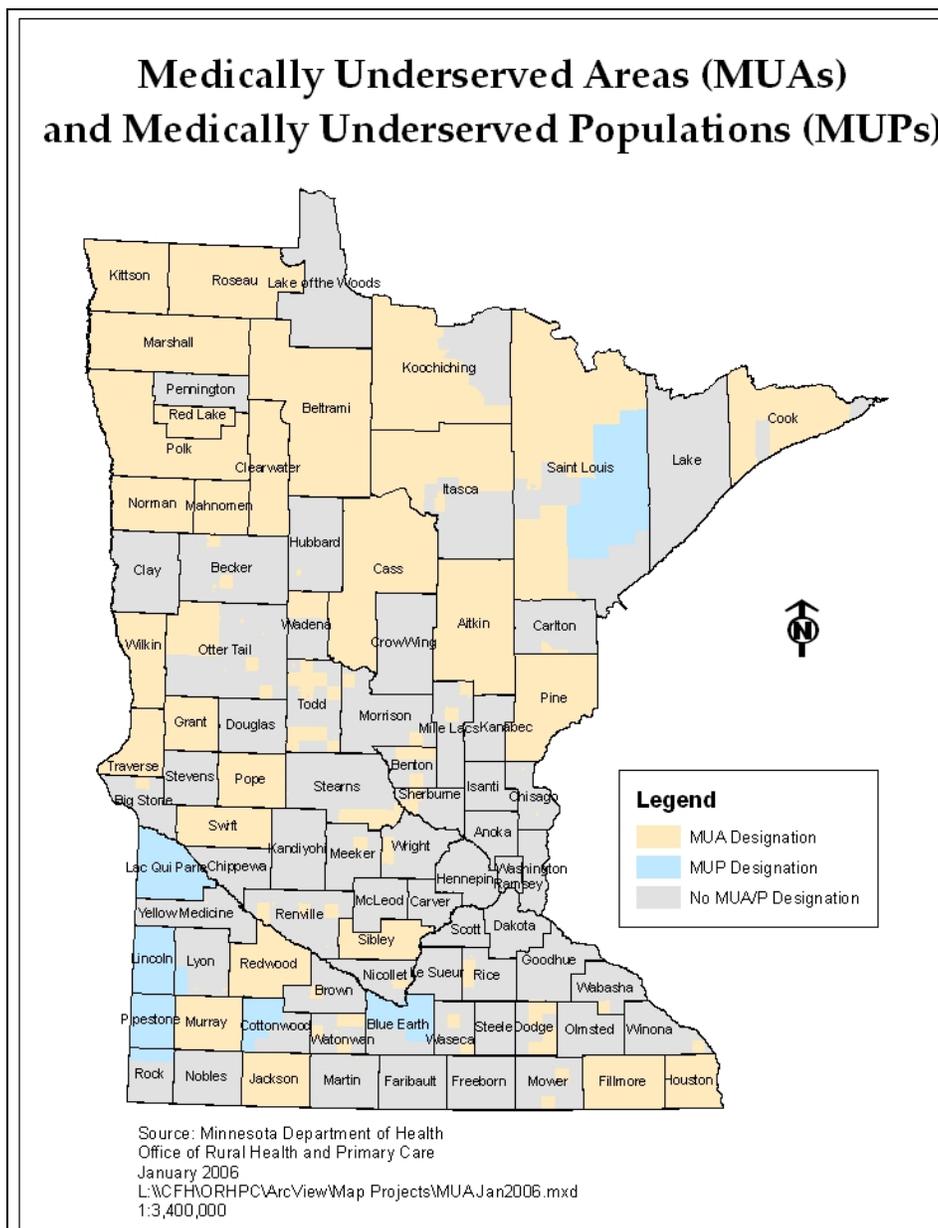
* It should be noted that currently the state has no mental health HPSA's in the Twin City metro/urban area (Minnesota Department of Health, 2003).

Medically Underserved Areas and Populations

To fully understand the state's health care delivery system, the Medically Underserved Areas (MUA) and the Medically Underserved Populations (MUP) within the state also require identification. The MUA and MUP rural counties are identified on Map 2.4.

Map 2.4

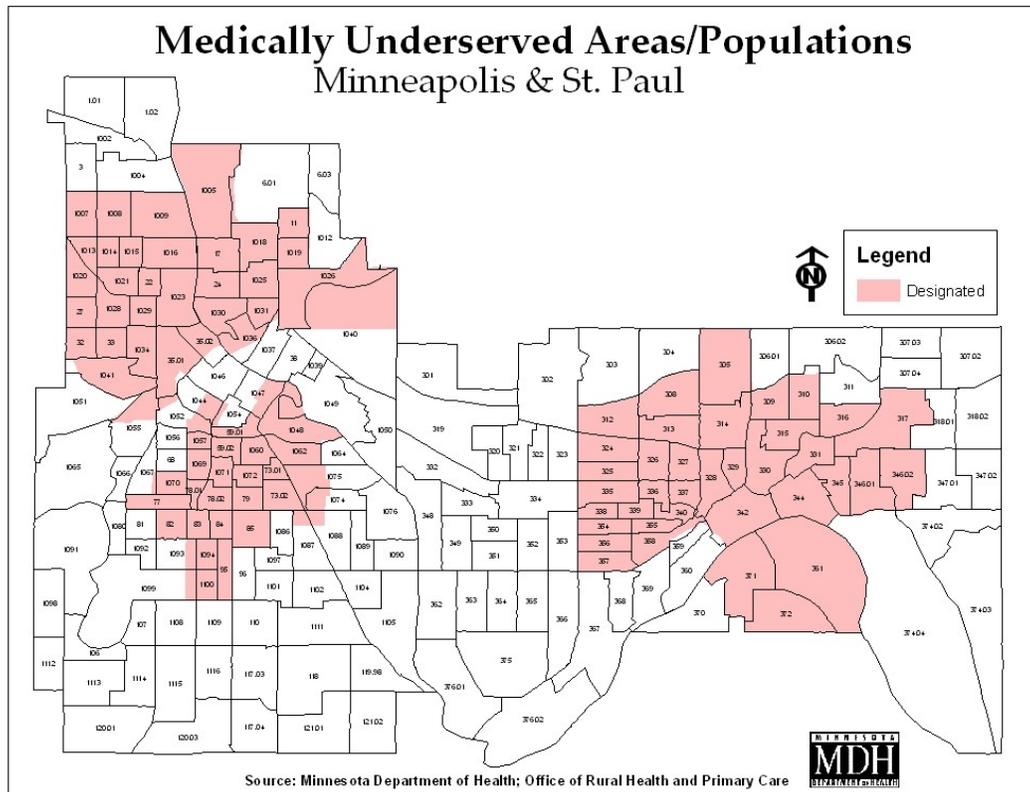
U.S. Department of Health and Human Services (2003) Identified Medically Underserved Areas and Underserved Populations in Greater and Rural Minnesota



The Minneapolis and Saint Paul MUA and MOP that are shown in Map 2.5 are located in areas of poverty or in areas of high concentrations of minority populations as defined by U.S. Health and Human Services (2007).

Map 2.5

U.S. Department of Health and Human Services Identified Medically Underserved Areas and Underserved Populations in Minneapolis and St. Paul, 2003



Minnesota Areas of Projected Growth

According to the Minnesota Department of Demographics (2007), the population in Minnesota, which was recorded by the U.S. Census Bureau in 2000 as 4,919,479 and is estimated in 2006 as 5,167,101, will increase 10% by 2015, and it will continue to grow to 6.4 million by 2035. These projections estimate that the Twin Cities suburbs (Scott, Dakota, Wright, and Sherburne) counties, Rochester and the St. Cloud Regions will have the most significant population growth. The Minnesota Department of Demographics also estimates that the North Central Region will decrease in population, while the 28 counties of the Western Region will also have a decrease in population.

North Central Region includes the following counties:

- Region 2 Beltrami, Clearwater, Hubbard, Lake of the Woods, and Mahnomen
- Region 3 Aitkin, Carlton, Cook, Itasca, Koochiching, and Lake
- Region 5 Cass, Crow Wing, Morrison, Todd, and Wadena

Western Region includes the following counties:

- Region 1 Kittson, Marshall, Norman, Pennington, Polk, Red Lake, and Roseau.
- Region 4 Becker, Clay, Douglas, Grant, Otter Tail, Pope, Stevens, Traverse, and Wilkins.
- Region 6W Big Stone, Chippewa, Lac qui Parle, Swift, and Yellow Medicine
- Region 8 Cottonwood, Jackson, Lincoln, Lyon, Murray, Nobles, Pipestone, Redwood, and Rock

The population increase to 6.4 million will represent a 24% increase in population. In summary, the metro areas will grow almost twice as fast and the non-metro areas.

Projected Need for Persons Licensed as Social Workers

The estimated growth in Minnesota will result in a need for additional persons licensed as social workers. According to Minnesota Careers (2007), the state is expected to need an increase in bachelor social workers as the population ages. Other fields of social work practice are already in crisis. These fields include “mental health, physically disabled, developmentally disabled families in crisis, chemical dependency, and community corrections specifically in rural areas” (p28).

NASW (2006) conducted a study “Assuring the Sufficiency of a Frontline Workforce: A National Study of Licensed Social Workers”. This study concluded that the number of social workers entering into the field of elderly services has decreased despite the extensive increase of the aging population. The study also shows an insufficient number of social workers in the field of families and children. These services include counseling, case management, information and referral services, and crisis interventions in diverse settings.

The study also addresses workload expansions. It reports the needs of social work in health care settings. Health care social workers are seeing an increase of caseloads with a “broad range of diagnoses” (NASW, 2007). Medical social workers are providing discharge services, case management, and psychotherapy. At the same time social and human service agencies are unable to provide adequate numbers of academically trained social workers based on client-worker ratios.

Cost of Social Work Education & Estimated Annual Salary for Minnesota Social Workers

In examining the underserved areas, one must also consider the annual salary of a county or state employed BSW/MSW, as well as the average salary of the non-profit agency employed BSW/MSW. Annual income and the cost of education must be considered as the Minnesota Board of Social Work provides recommendations “on how to increase the numbers of licensed social workers serving underserved communities and culturally and ethnically diverse communities” (Minnesota State Statute, 2008). The salaries in Table 2.1 represent the Minnesota Merit County System and Table 2.2 displays the Minnesota Non-Merit County Systems within the public and private sectors of social/human services. (Appendix 2 shows the complete Merit System Salary Distribution by County).

Table 2.1

**Minnesota Merit System and Non-Profit Agency
 Annual Social Work Salary Distribution for 2007**

Minnesota Merit and Non Profit Yearly Salaries, 2007	Minnesota Merit Social Worker (CPS) Salary	Minnesota Merit Social Worker (Master’s CPS) Salary	Minnesota Merit Social Worker (Masters, Not CPS) Salary
Minimum Yearly County Salary	\$35,524.29	\$38,959.00	\$37,406.00
Maximum Yearly County Salary	\$51,765.21	\$56,000.00	\$56,902.00
Average Yearly County Salary	\$43,644.75	\$47,480.00	\$47,154.00
Average Non Profit Yearly Salary	\$38,407.38	\$41,782.00	\$41,496.00
Average County and Non Profit Yearly Salary	\$41,026.07	\$44,631.73	\$44,325.00

Currently, there are 14 counties that do not utilize the Minnesota Merit System for hiring and the establishment of salary ranges. Table 2.2 illustrates the salary ranges of these counties and, by calculating the average 12 percent difference for the non-profit average yearly salary, one obtains a general picture of the salary ranges. Please see Appendix 3 for the complete Non-Merit System Salary Distribution by County tables.

**Minnesota Non Merit System Counties' Salary
 Distribution for 2007
 (BSW & MSW Salaries are Not Differentiated)**

Table 2.2

County	Minimum Yearly Salary	Maximum Yearly Salary	Average Non-Merit County Yearly Salary	Average Non-Profit Yearly Salary	Non Merit County and Non-Profit Average Salary
Anoka	\$41,881.00	\$70,691.00	\$56,286.00	\$49,532.00	\$52,909.00
Beltrami	Did not receive				
Blue Earth	\$39,707.00	\$53,192.00	\$46,449.50	\$40,875.56	\$43,662.53
Carver	\$39,541.00	\$68,530.00	\$54,035.50	\$47,551.24	\$50,793.37
Dakota	\$48,500.04	\$83,400.00	\$65,950.02	\$58,036.02	\$61,993.02
Hennepin	Did not receive				
Itasca	Did not Receive				
Olmsted	\$40,608.00	\$64,378.00	\$52,493.00	\$46,194.00	\$49,343.00
Ramsey	\$46,668.00	\$82,824.00	\$64,746.00	\$56,975.00	\$60,861.00
Scott	\$35,853.00	\$86,964.00	\$61,408.50	\$54,040.00	\$57,724.00
Sherburne	Did not Receive				
Stearns	Did not Receive				
Washington	\$39,603.00	\$68,882.00	\$54,241.00	\$47,733.00	\$50,987.00
Wright	Did not receive				

- The Minnesota Council of Non-Profits (2006) report that persons licensed as social workers who provide direct services to clients have a median salary that is about 12 percent less than the public or private-for-profit positions.
- The average BSW direct service provider's annual salary is between \$26,359 and \$27,653, according to the Minnesota Council of Non-Profits (2006).

- The Minnesota Council does not maintain records on Master’s level social workers providing clinical services, but the Council does have the salaries of directors. Often directors of non-profit organization will have a social work degree. The median salary range of directors is from \$42,000 to \$72,000. This range often depends upon funding, size of the organization, and physical location. Non-profit organizations in Greater and Rural Minnesota report directors’ annual salaries to be less than the metro or suburban areas (Minnesota Council of Non-Profits, 2006).

Table 2.3 and Table 2.4 are evidence of the average costs of a BSW and MSW degree from both private and public schools in the state (Anderson, 2006).

Table 2.3
Average Cost of BSW Degree in Minnesota Public and Private Schools, 2008

BSW Programs	Average Educational Cost
Nine Public Schools	\$36,000 for 16 Semesters*
Seven Private Schools	\$72,000 for 16 Semesters*

*Cost includes Tuition, Room and Board

Table 2.4
Average Cost of MSW Degree in Minnesota Public and Private Schools, 2008

MSW Programs	Average Educational Cost
Minnesota State Colleges and Universities St. Cloud State University & Minnesota State University, Mankato	\$18,947 for 4 Semesters*
Augsburg College	\$33,426 for 6 Trimesters
University of Minnesota, Duluth	\$21,480 for 4 Semesters*
University of St. Thomas	\$33,284 for 4 Semesters*
University of St. Catherine	\$33,120 for 4 Semesters*
University of Minnesota Twin Cities	\$24,776 for 4 Semesters*

*2007-08 fees include student fees
 Does not include Room and Board or Books

Cost of Living

In the analysis of social work salaries and the cost of education, one must also consider the cost of living differences within the state. It should also be recognized that within the state there are thirteen different economic regions. Table 2.5 displays these differences from a Basic Needs Budget point of view.

According to the Minnesota Department of Economics (2006), the Basic Needs Budgets are based on “no-frills standard of living. There’s no entertainment, no restaurant meals, no vacation, and nothing for emergencies. It assumes that insurance is covered by employers, retirement, or children’s education. The Basic Needs Standards clearly falls short of what’s usually called a middle-class standard of living” (p. 1). The Regions consist of the following Counties

- Metro Anoka, Carver, Dakota, Hennepin, Scott, and Washington
- Region 1 Kittson, Marshall, Norman, Pennington, Polk, Red Lake, and Roseau
- Region 2 Beltrami, Clearwater, Hubbard, Lake of the Woods, and Mahnommen
- Region 3 Aitkin, Carlton, Cook, Itasca, Koochiching, Lake, and St. Louis
- Region 4 Becker, Clay, Douglas, Grant, Otter Tail, Pope, Stevens, Traverse, and Wilkin
- Region 5 Cass, Crow Wing, Morrison, Todd, and Wadena
- Region 6E Kandiyohi, McLeod, Meeker and Renville
- Region 6W Big Stone, Chippewa, Lac qui Parle, Swift, and Yellow Medicine
- Region 7E Chisago, Isanti, Kanabec, Mille Lacs, and Pine
- Region 7W Benton, Sherburne, Stearns, and Wright
- Region 8 Cottonwood, Jackson, Lincoln, Lyon, Murray, Nobles, Pipestone, Redwood, and Rock
- Region 9 Blue Earth, Brown, Faribault, Le Sueur, Martin, Nicollet, Sibley, Waseca, and Watonwan
- Region 10 Dodge, Fillmore, Freeborn, Goodhue, Houston, Mower, Olmsted, Rice, Steele, Wabasha, and Winona

Table 2.5

Minnesota Economic Regions Annual Basic Needs Budget

	Size of Family	Size of Family	Size of Family	Size of Family	Size of Family
Region	1 Adult	1 Adult, 1 Child	2 Adults, 2 Children, 1 FT Worker	2 Adults, 1 Child, 2 FT Workers	2 Adults, 2 Children, 2 FT Workers
Metro	\$24,727	\$37,537	\$35,989	\$44,657	54,854
Region 1	\$20,240	\$26,235	\$24,478	\$35,283	\$40,541
Region 2	\$20,686	\$31,200	\$26,064	\$36,970	\$43,242
Region 3	\$20,414	\$29,441	\$24,666	\$36,510	\$42,475
Region 4	\$20,374	\$27,267	\$25,727	\$36,070	\$42,162
Region 5	\$21,814	\$30,478	\$26,919	\$39,123	\$44,775
Region 6E	\$21,873	\$30,368	\$28,341	\$38,842	\$45,529
Region 6W	\$19,315	\$24,331	\$22,610	\$33,957	\$38,841
Regions 7E	\$26,740	\$37,284	\$37,688	\$46,523	\$53,808
Region 7W	\$24,814	34,872\$	\$35,459	\$42,517	\$50,388
Regions 8	\$19,127	\$24,728	\$22,825	\$34,121	\$39,488
Region 9	\$20,561	\$27,878	\$25,682	\$36,410	\$42,929
Region 10	\$21,440	\$31,823,	\$28,432\$	\$39,070	\$45,988

The Minnesota Department of Economic Annual Basic Needs Budget (2007) projects the cost of living at the bare minimum. The budget does not take into account that the average cost of a house in Greater and Rural Minnesota is \$200,000 and \$226,000 in the Twin Cities and surrounding areas (Minnesota Department of Demographics, 2007). This budget allocates only between \$472 and \$777 per month for housing. Yet, as of December 2007, the average mortgage for a \$200,000 home is \$1,199 for a 30 year Fixed Rate of 6.24% (and rent averages \$800 per month).

Taking into account cost of living, the lowest annual county social work gross salary is \$35,472.17, and the highest is \$56,902.40 in Merit System counties. If one subtracts the average mortgage annual payment of \$14,388 from the lowest and highest social work salary, the remaining gross income is between \$21,084.17 and \$42,514.40. If the social worker is renting, the gross remaining income is between \$25,872, and \$47,302.40. This gross income minus housing costs does not include the cost of education.

As demonstrated above, the cost of a bachelor's degree at a public school is about \$36,000 dollars and the cost at a private school is about \$72,000. The lowest salary is typically for the social worker with a bachelor's degree. If one subtracts the cost of public education for a bachelor's degree which is about \$3,600 per year (standard educational loan is for 10 years), the gross salary is reduced to \$17,484.17. From this amount the cost

of taxes (local, state and federal), food, transportation, health care, insurance, and clothing will reduce the bachelor social worker's salary and put the person in the position of requiring a second job.

The upper limit of the salary range for the state Merit System of \$56,902.40 is usually for the social worker with a master's degree plus several years of experience. The cost of a master's degree ranges from \$18,947 (MNSCU) to \$33,120 (private school) for tuition only. If one subtracts ranges

- √ \$39,202 for a person who pays the average mortgage payment (in Greater and Rural Minnesota) and attended a private school;
- √ \$40,619.70 for a person who pays the average mortgage payment and attended a public school;
- √ \$43,990.40 for the person who rents and attended a private school;
- √ \$45,407.70 for a person who rents and attended a public school.

Again, this does not include the cost of taxes (local, state and federal), food, transportation, health care, insurance, and clothing. One must also take into account that the average age of a person who enters a masters of social work program is 33. Therefore, it is likely that the social worker with a master's degree and several years of employment also has dependents that rely on the income of the master's level social worker, which again leaves the social worker living within an unmanageable income level.

Federal, State or Organizational Recommendations for Client Social Work Ratios

Student to School Social Worker Ratio

According to the NASW (1992), the ratios for social worker to students depends upon the student population, the economic base of the school district, and other district wide characteristics. Based on information from the National Council of State Consultants for School Social Work Services, NASW has established guidelines for the student to social worker ratios. These guidelines are in Table 2.6. See Appendix 4 for the complete NASW Student to School Social Worker Ratio Recommendations. Table 2.6 is an abbreviated school social worker to student ratio description.

Table 2.6
NASW's Recommendations for Student to School Social Worker Ratios

School Social Worker/Student Population Ratio	School Population Served
1: 2,000	Total school population with no special concentration
1: 1,500	Total school population with poverty concentration
1: 800	Total school population with special education and poverty concentration
1: 500	Total school population with special education, poverty, and minority concentration
1: 350	Total school population with special education, poverty, and minority concentration; and federal impact issues
1: 50	Special education assignment only

American School Health Association recommendation for the number of school social workers per students is one social worker to 400 students. However, many school social workers are responsible for double or triple the number of students and serve not one, but multiple schools, which fragments services even more (NASW, 2001).

Child Safety and Welfare Clients to County Social Worker Ratios

Multiple studies have been conducted regarding the number of child protection workers per caseloads. Child Welfare League of America (2003) recommends these variations of caseload sizes need to be accounted for in computing the number of cases per social worker. For example:

- For investigative workers in child protective services, the recommended caseload is 12 active cases per month.
- This should not be construed to mean 12 active cases at any point in time, but 12 active cases in the workdays available during a designated 30-day period or month.
 - Moreover, if the worker is carrying forward cases from the previous month, the number of new cases should be reduced accordingly.
- In Ohio the Public Children Services Association of Ohio (1997) determined that within a normal 40 hours per week, the child protection worker is able to do about 11 investigations (Knox & Higgins, 2003).
- Yet, in 2002 the Allegheny County, Pennsylvania study reported that social workers could investigate 16 cases per month, but also added that the workers would not be utilizing “best practice skills” (Yamatani & Engel, 2002).
- Similarly, Portland State University and Washington State concluded that the caseload size for a social worker working with children in foster care should

be about 11 to 15 cases (Emlen, Lahti, Downs, McKay, & Downs, 1977; Katz, 1990).

The U.S. General Accounting Office (2003) report showed, "Some of the caseworkers we interviewed handle double the number of cases recommended by advocacy organizations and spend between 50 and 80% of their time completing paperwork, thereby limiting their time to assist children and families" (¶.7).

Ratio of Adult and Children Mental Health Clients to Social Worker

The U.S. Department of Health and Human Services (2007) provides the following guidelines for designating a geographic area as having a shortage of mental health professionals. These guidelines listed below only describe the practitioner to population:

- 1) A population-to-core-mental-health-professional ratio greater than or equal to 6,000:1.
- 2) The area has unusually high needs for mental health services, and has a population-to-core-mental-health-professional ratio greater than or equal to 4,500:1.
- 3) Mental health professionals in contiguous areas are over-utilized, excessively distant, or inaccessible to residents of the area under consideration.

Ratio of Adult Clients with Physical Disabilities and/or Cognitive Impairments to Social Worker

According to the Institution on Community Integration (2007), the state currently has little continuity in the caseload size from county to county for people with disabilities. The authors report that caseload sizes in the state range from 20 to 100 clients per worker. By calculating the units billed, the caseload sizes for the state increases from 30 to 168 clients per worker. This means the larger the caseload size, the poorer the quality of services. To continue, the authors add the average caseload size for people with mental retardation and related conditions is 52.8 clients per worker. Minnesota's caseload size for people with disabilities falls far behind the national level of 40 clients to 1 worker, which is the U.S. Health and Human Services (2007) recommended client to worker ratio. This report also supports the concept of establishing standardized caseload sizes to ensure client access to a "baseline level of case management services from county to county" (p. 6). This baseline would provide the opportunity to address the case management inadequacies and funding inefficiencies.

This 2007 report also provides a cost analysis to improve the client to worker ratio for people with disabilities. This cost analysis includes all four levels of waived services. The total state/federal Medicare dollars would be 16.2 million dollars or an increase of 8.2 million dollars in state monies (Institution on Community Integration, 2007, p. 6).

What are Waivered Services?

“In 1981 Congress passed a law which created the Title XIX Home and Community-Based Services Program. This act allows the federal government to waive, meaning to make an exception for, the traditional Medicaid requirements. It gives states the option of applying for a waiver to use Medicaid funds to provide home and community-based services as an alternative to institutional settings. Examples of institutional settings include hospitals, intermediate care facilities for persons with mental retardation or related conditions (ICF/MR), and nursing facilities. In 1984, Minnesota began its home and community-based services program for persons with mental retardation and related conditions, also referred to as the MR/RC Waiver.

The goal of the MR/RC waiver program is to provide necessary services and support that are meaningful to the person receiving the services, respectful of the person’s beliefs and customs, and cost-effective. Waivered services are different from institutional care services in that they are uniquely developed based on a person's needs, and are available or can be developed in the community. Waivered services help a person to become involved in the community where he or she lives and works and to develop skills to be as independent as possible” (The ARC of Minnesota, 2008 p. 32).

Ratios of People Aged 65 and Older to Social Workers

Establishing ratios for the aging population varies depending upon the social/human services provided. The literature does provide recommendations or mandates for some of the services provided by social workers, but many services are not covered under these recommendations or mandates. Services for the aging populations that have suggested ratios include vulnerable adult services, long-term care facilities, and hospice.

Minnesota State Statute, Chapter 80 (2007) mandates that long-term care facilities “must employ a qualified social worker or a social services designee. A nursing home with more than 120 beds must have at least one full-time qualified social worker position. The person or persons filling the qualified social worker position must be assigned full-time to the social services of the nursing home and must fill at least one full-time equivalent position of at least 35 hours per week” (§ 8).

The Institution on Community Integration (2007) Legislative report and Minnesota Department of Human Services (2007) report also suggests a 40 clients to 1 social worker ratio. This ratio would also bring the state in alignment with the national standards. Table 2.7 demonstrates the Minnesota proposed vulnerable adult to social worker ratio, the costs to meet the national standards, and the U.S. Health and Human Services (2007) recommendations without a state-buy-out of county share. Appendix 5 provides the Client to Social Worker Ratio and Cost for All Four Waivers Programs.

Minnesota Cost Analysis to Implement the U.S. Department of Health and Human Services Vulnerable Adult Social Work Ratio, 2007

Table 2.7

Funding Stream	2005 Case Management Cost Per Participant	Current Caseload	Benchmark Cost	Difference	Number of Individuals	Additional Amount Necessary to Implement 140 Caseload
VA/DD-TCM	\$1,848.00	48.2*	\$2228.00	\$380	4,863	\$1,847,940.00

* “This estimate is derived by dividing the MR/RC Waivers total expenditure per case manager (\$89,126) by the 2005 case management cost per participant” (Institution on Community Integration, 2007, p. 57). Note these estimates are solely based on the costs reported in the Continuing Care Matrix. They may be underestimates, especially with respect to county case management that falls outside of what is captured in the care matrix (p. 57).

Ratio of People in Poverty to Social Worker

The literature does not provide a recommendation for the number of people in poverty per social worker. Yet, it is clearly noted that many people of poverty are also suffering from mental health and/or chemical dependency issues. According to Paul Heyl, LSW, Minnesota Department of Human Services, Mental Health Division, the following are recommendations for people of poverty with mental disabilities and/or chemical dependency:

“In Minnesota the recommended case management caseload size is 30. For Assertive Community Treatment teams the caseload maximum is 1 to 10. In Minnesota Assertive Community Treatment teams in rural areas go as low as 1 to 7” (Heyl, 2008 personal communication).

Ratio of Juvenile and Adult Community Corrections Clients to Social Worker

The offender population is one of the fastest growing populations. According to the National Institute of Corrections (2007), the Minnesota prison population is estimated to increase 13 percent between 2006 and 2011. Yet, the projected overall population growth is only expected to grow 4.7 percent. Social workers have been working with adult and juvenile offenders since the late 1800’s.

The National Institute of Corrections (Institute) (2007) is prudent in their explanation of case ratios, because across the nation there are many different types of probation and

parole programs. The Institute also recognizes the individual needs of the offenders. The caseload ratios are based on specific and relevant criteria that sets appropriate levels of supervision and services. Table 2.8 demonstrates the recommended adult caseload ratios and Table 2.9 shows the juvenile caseload ratios.

Table 2.8

**National Institute of Corrections Recommendation for
Adult Probation Caseload Size**

Case Type	Cases to Staff Ratio
Intensive	20 : 1
Moderate to High Risk	50 : 1
Low Risk	200 : 1
Administrative	No Limit? 1,000:1 (No empirical data to support this ratio)

Table 2.9

**National Institute of Corrections Recommendation
for Juvenile Probation Caseload Size**

Case Type	Cases to Staff Ratio
Intensive	15 : 1
Moderate to High Risk	30 : 1
Low Risk	100 : 1
Administrative	No recommendation

Along with these recommendations the Institute (2007) also strongly acknowledges that in conjunction with the ratios, empirical program treatment must also be provided to prevent recidivism. Treatment begins with effective and accurate assessments at intake. The Institute recommends the importance of the assessor's use of reliable instruments to determine the level of risk along with professional clinical opinions.

CHAPTER III
METHODOLOGY

Methodology

Dr. Christine Black-Hughes currently serves on the Minnesota Board of Social Work's Advisory Committee representing the Minnesota Conference on Social Work Educators. Dr. Christine Black-Hughes volunteered to complete this task while on sabbatical.

An application for research approval was made to the Minnesota State University, Mankato Internal Review Board (IRB). Please see Appendixes 10, 11, and 12 for the IRB's Letter of Introduction, Application, and Approval.

The methodology used in this study was an analysis of archived records and data. The information gathered is the number of county social workers (licensed and non-licensed county workers); U.S. Census Bureau 2000 data, including population, ethnicity, household income and the aging population; Minnesota Demographics' data; and Minnesota Department of Education data, specifically languages spoken by district.

The analysis, summary, and conclusion are primarily based on public information from the Board's licensee data base (including work addresses of all licensees-LSWs, LGSWs, LISWs, and LICSWs); Merit System's employment data base; Non-Merit counties' employee data bases; and Minnesota Department of Human Service client data base. These data bases were then compared to the Minnesota State Demographic Center's population, racial, and income data bases and the Minnesota School Association language data base.

It should be noted that the Board's licensee data cut off date was August 29, 2007; Merit and Non-Merit System cut off date was August 18, 2007. The Minnesota State Demographic Center's population, racial and income data bases cut off date was indicated as 2000-2006, and the Minnesota School Association language data base cut off date was 2006. Also, as with many large data bases, there are gaps in information because there are 87 counties and 87 different ways of reporting the information. For example, some school districts report specific Native American Indian language that is spoken while others just report Native American Indian.

In regard to number of licensees, it was decided to use the social worker's employment address. Many licensed social workers are employed at more than one agency. Therefore, to reduce the possibility of counting one worker more than once, the first address was utilized. (Note: the Board currently does not distinguish between primary and secondary employment.)

Geographical Methodology

The analysis employed GIS by first identifying the number of licensees by county. This study established a baseline of practicing licensees in correspondence with specific

population groups or geographical areas in order to discover the locations of the social work underserved populations and geographical areas.

The numerous maps were developed to demonstrate and identify the social work underserved populations. Only the maps that illustrated the distribution of persons licensed as social workers were selected for this report. The Board has copies of 126 maps developed for this project.

Statistical Methodology

The geographical methodology involved analysis employing Geographic Information Systems (GIS) by first identifying the number of licensees by county. This study established a baseline of practicing licensees in correspondence with specific population groups or geographical areas in order to discover the locations of the social work underserved populations and geographical areas. Then a comparison was made of distribution of social workers to recommended caseload ratios.

The analysis was made with the Child Welfare League of America's (2003) recommendation of the number of child welfare workers (11 to 15 cases per worker) and the 2006 report of the number of child welfare cases per county. This comparison continued with the total number of students per school district to the number of social workers. The analysis examined the number of children who were also identified as requiring special education services.

The analysis used the recommended caseload level for people with disabilities at the caseload size of 40:1. The children's mental health caseload size of 25:1 was also used. Adult mental health services comparison employed the suggested ratio of 40:1.

In the identification of social work underserved areas for the aging population the ratio recommendation is 30 people aged 65 or older to 1 licensed social worker.

Projected geographical areas and populations that are underserved by licensed social workers and county social workers are also identified by utilizing the number of Minnesota residents with the percentage (from national statistics) of the population who have a mental illness, developmental disabilities, are aging, or homeless.

The Minnesota Department of Education's Staff Database (2007) provided a listing of school social workers by school district and the Department's student database provided the number of students per school district. By adding the number of school social workers per district and then dividing the number of students per district, one could examine the ratio of students per social worker. There are several different definitions of school districts and these two databases are maintained under different district definitions. Therefore, the researcher had to retrieve information about each of the districts in the two separate databases to insure an exact match.

CHAPTER IV
FINDINGS

Findings

Introduction

In this chapter of the legislative mandated report for the Minnesota Board of Social Work, the results are presented. As one reads the results, please note that the same licensees (LSW, LGSW, LISW, and LICSW) are used in the following ratios of clients to licensees:

- * 1000 residents to licensee
- * ethnic population groups to licensee
- * residents aged 65 and older to licensee
- * number of Minnesota residents in poverty to licensee

This limitation is because the Minnesota Board of Social Work and the Merit and Non-Merit systems do not maintain records of the number of licensed or county non-licensed workers within specific fields of practice. The exception to this limitation is the field of Child Safety and Welfare. Also, the Association of School Social Workers maintains the records of the number of workers in each school district. The Child Safety and Welfare and the School Social Work ratios specifically demonstrate the workers who are in those specific fields of practice.

Therefore, as one reads the findings, one should keep in mind that the overall ratios are not a true representation, but rather a very limited projection, to assist in identifying the licensee underserved areas.

Child Safety and Welfare Findings

According to Minnesota Department of Human Services (2007), there were approximately 8,499 children who were victims of neglect or abuse and 27,682 children were investigated for possible maltreatment in 2006. The total number of maltreatment reports was 18,843 in 2006. Given the recommended caseload size of 11 to 15 cases per worker statewide, the total number of social workers working in child welfare ranges from 466 (for a caseload size of 15) to 636 (for a caseload size of 11) workers. These child protection services serve the 87 counties and 11 American Indian Tribes (see Appendix 6 for the Map of the 87 counties and Appendix 7 for the Map of the American Indian Tribes.)

By totaling the number of reports by county 1) Traditional Investigations Alleged, 2) Traditional Investigations Determined, and 3) Family Assessments, for 2006 one can estimate the number of reports each county addressed from the initial intake, investigation, determination, and assessment. By dividing the number of full-time employees (FTEs) assigned to the counties' Child Welfare Units, the estimated number of cases per worker may be estimated (see Appendix 8) for the County List of Child

Welfare Caseload Sizes. Given the caseload recommendations for child welfare services, Table 4.1 provides a listing of counties that have caseloads that are larger than 30 cases per child welfare worker. One must consider that there are reporting issues including cases that are not officially closed due to delay in documentation, cases that are monitored on a biweekly or monthly basis, case aids are not included in the staffing ratio, possible duplicate reports, or other data collection problems that skew the findings.

**Minnesota Counties That Exceed the Child Welfare League Recommended
Caseload Size for 2006
The Recommended Caseload Size is 11-15 Clients to 1 Worker**

Table 4.1

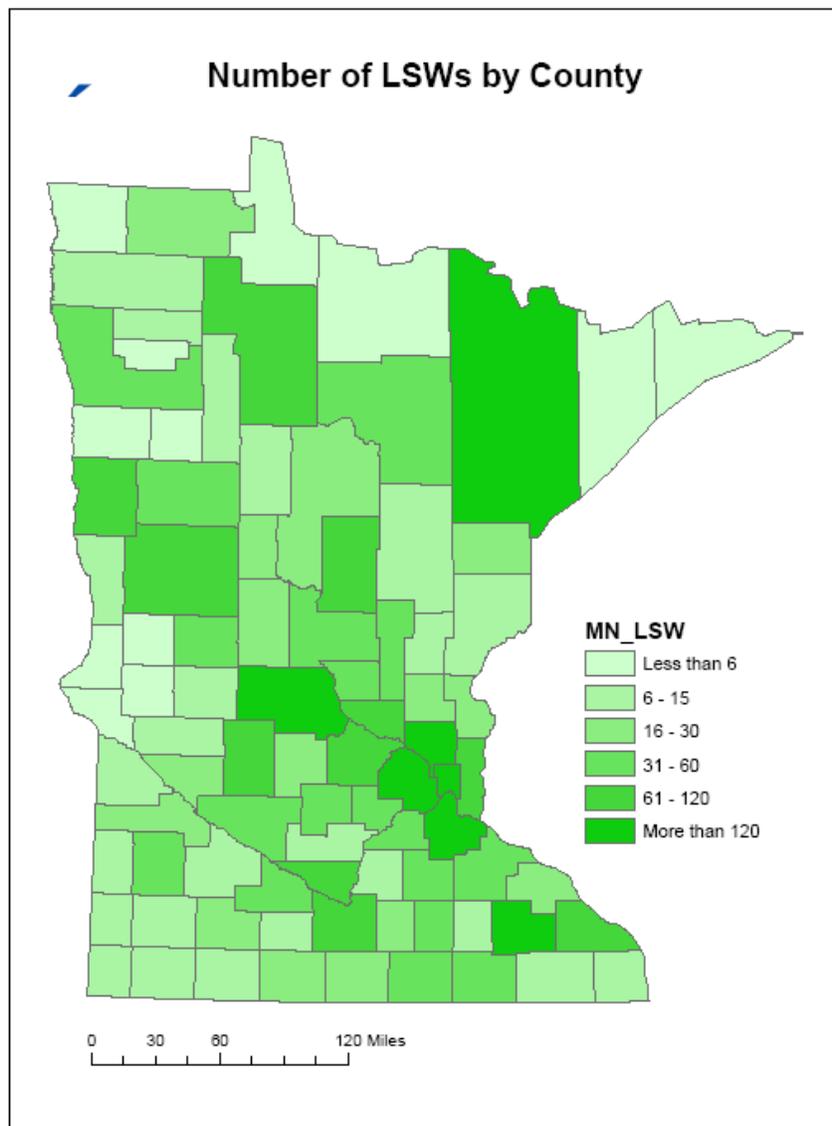
Name of County	Caseload Size per Worker
Becker	33.3
Cass	33.8
Chisago	46.2
Clearwater	65.7
Fillmore	31.3
Hubbard	50.5
Le Sueur	30.3
Otter Tail	30.8
Pipestone	50.0
Redwood	36.0
Scott	32.3
Swift	33.5
Winona	37.8
Faribault/Martin	31.5

Employment Locations of Social Work Licensees (LSW, LGSW, LISW and LICSW) and Non-licensed County Workers

The following geographical Maps 4.1, 4.2, and 4.3 display the employment locations of Licensed Social Workers (usually BSW level) throughout the state, metro counties, and St. Louis County.

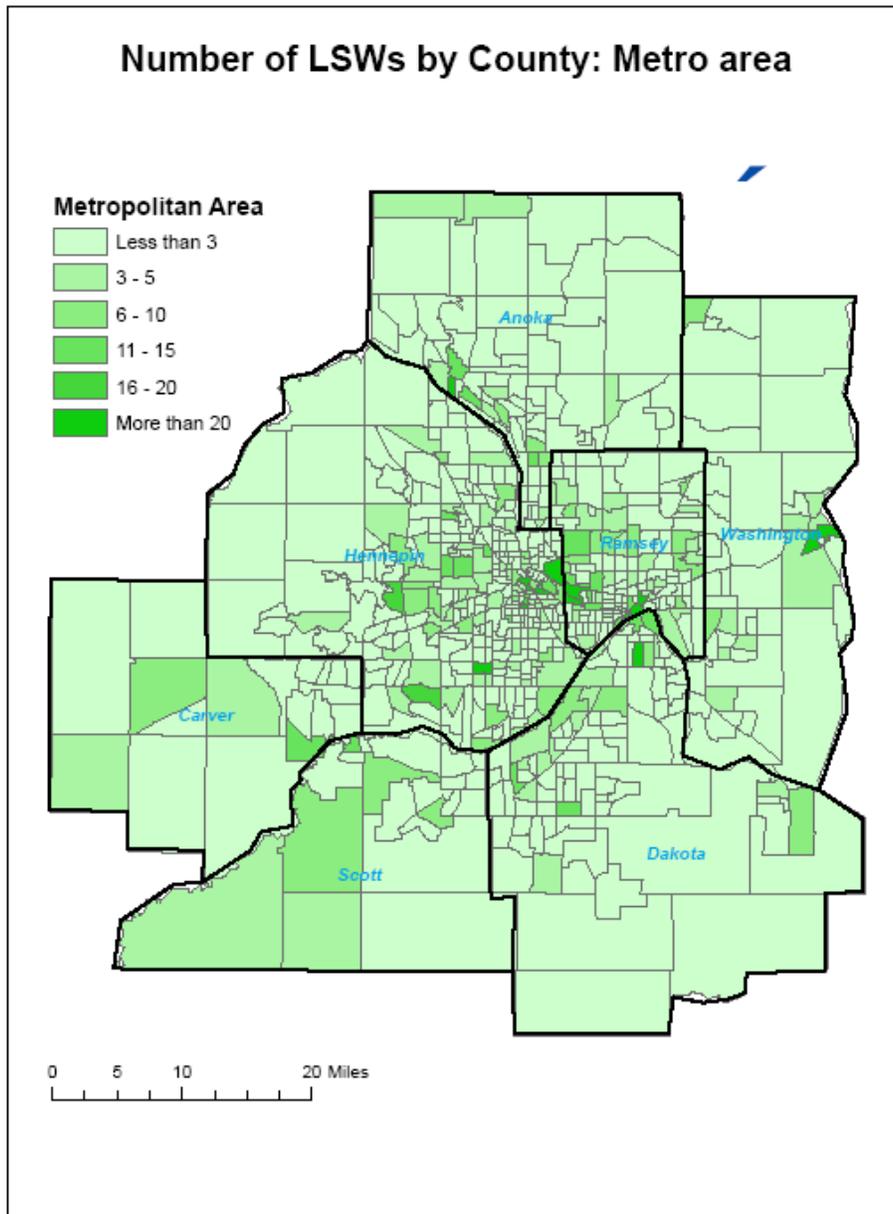
Map 4.1

Total Number of Licensed Social Workers (LSW) in Greater and Rural Minnesota



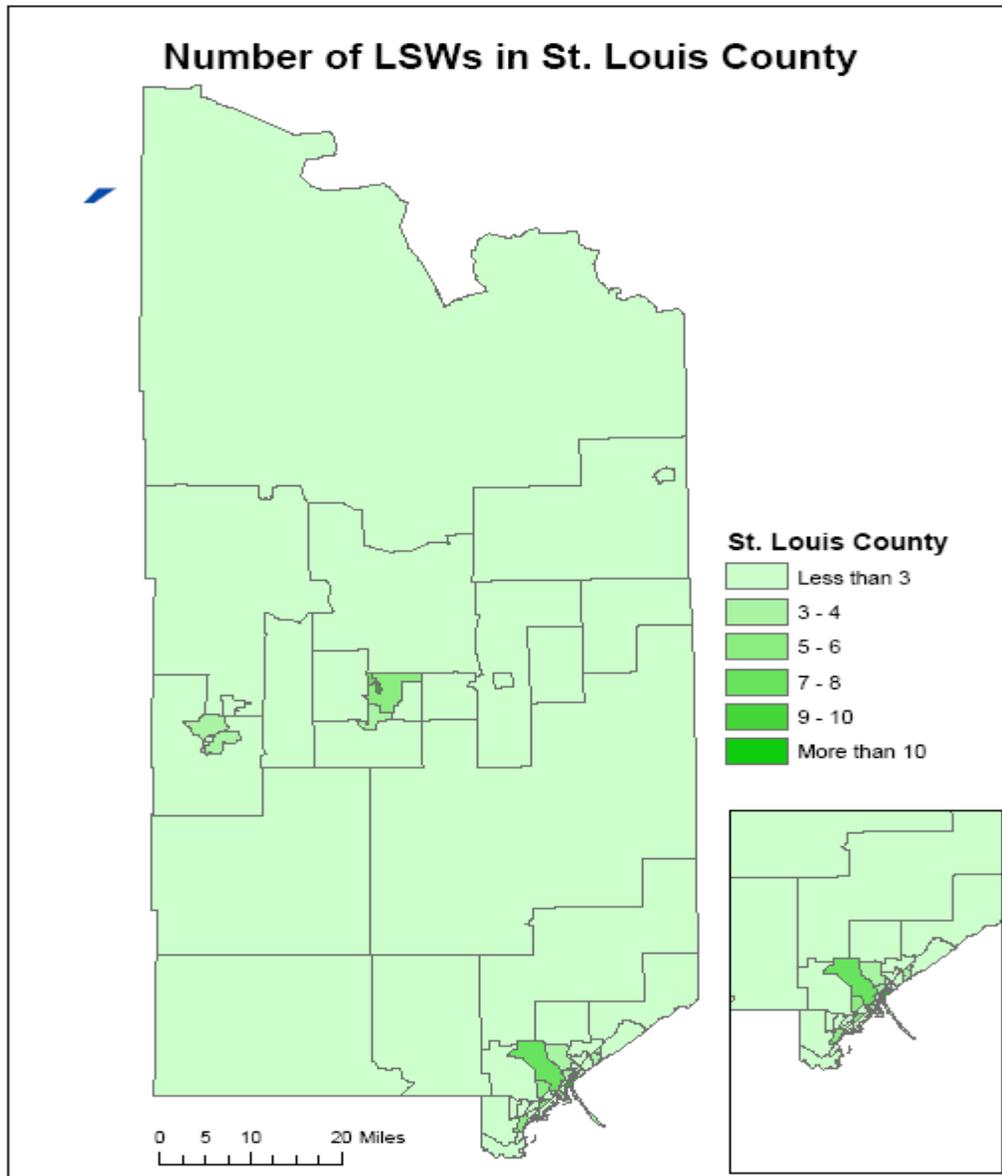
Map 4.2

Total Number of Licensed Social Workers (LSW) in the Metro Area



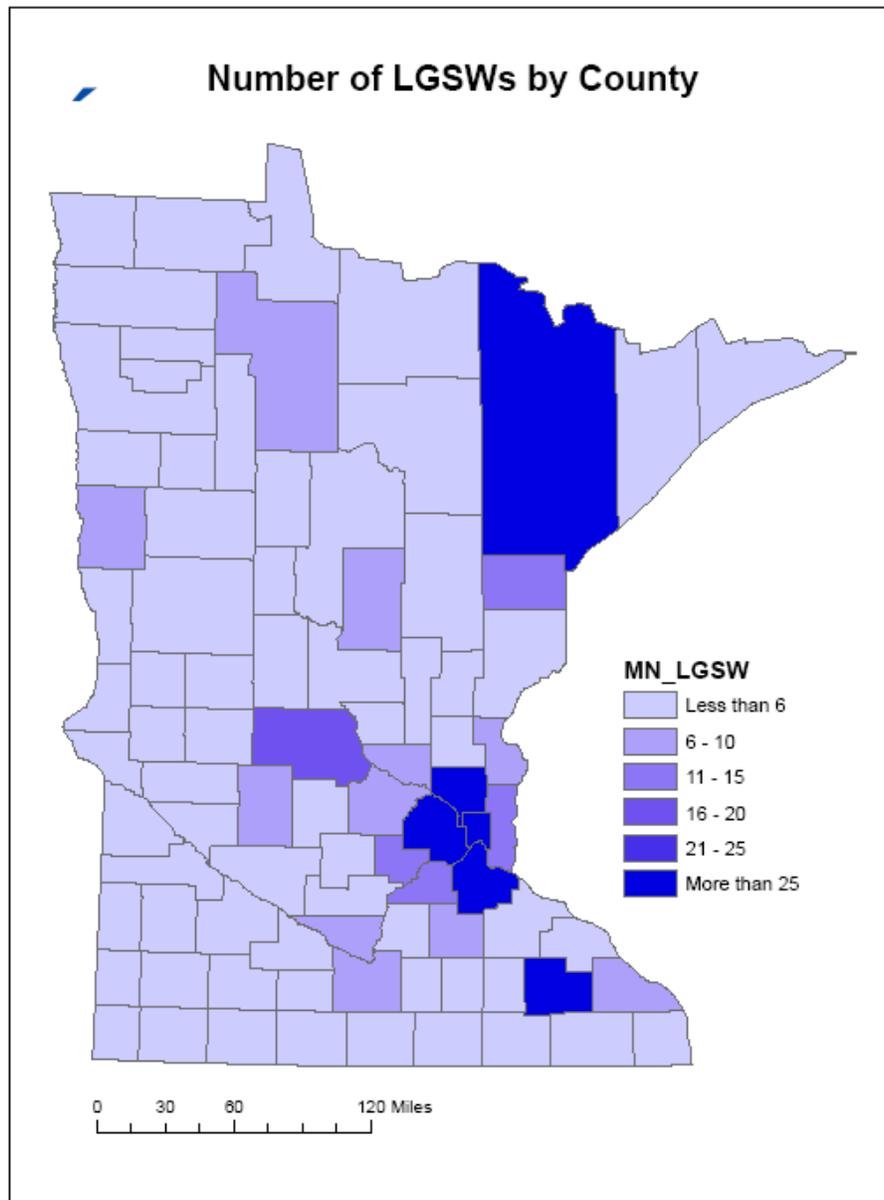
Map 4.3

**Total Numbers of Licensed Social Workers (LSW)
in Saint Louis County and Duluth**



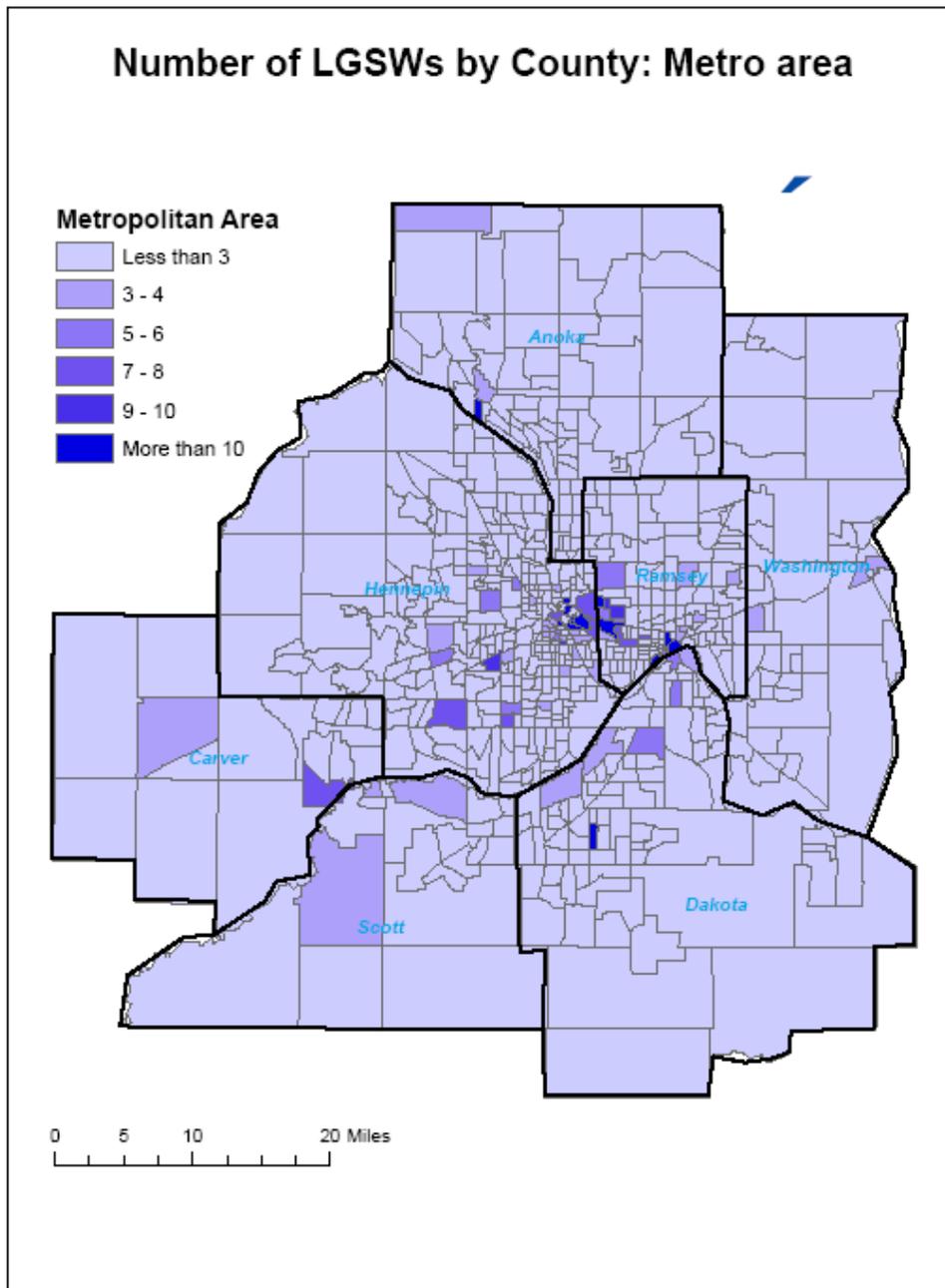
The following Maps 4.4, 4.5, and 4.6 explain the work locations of Licensed Graduate Social Workers in Greater and Rural Minnesota, Metro Counties, and St. Louis County.

Map 4.4
Total Number of Licensed Graduate Social Workers (LGSW) in Greater and Rural Minnesota



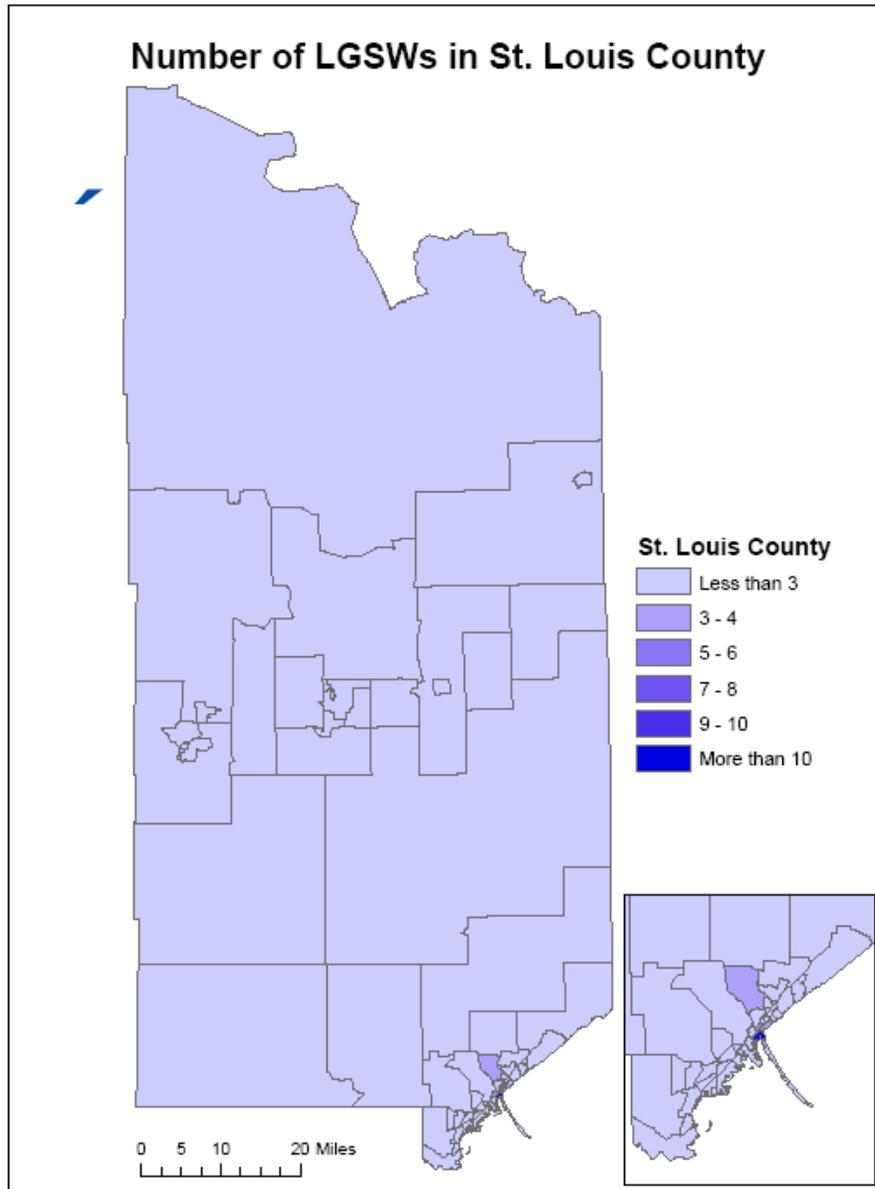
Map 4.5

**Total Number of Licensed Graduate Social Workers (LGSW)
in the Metro Area**



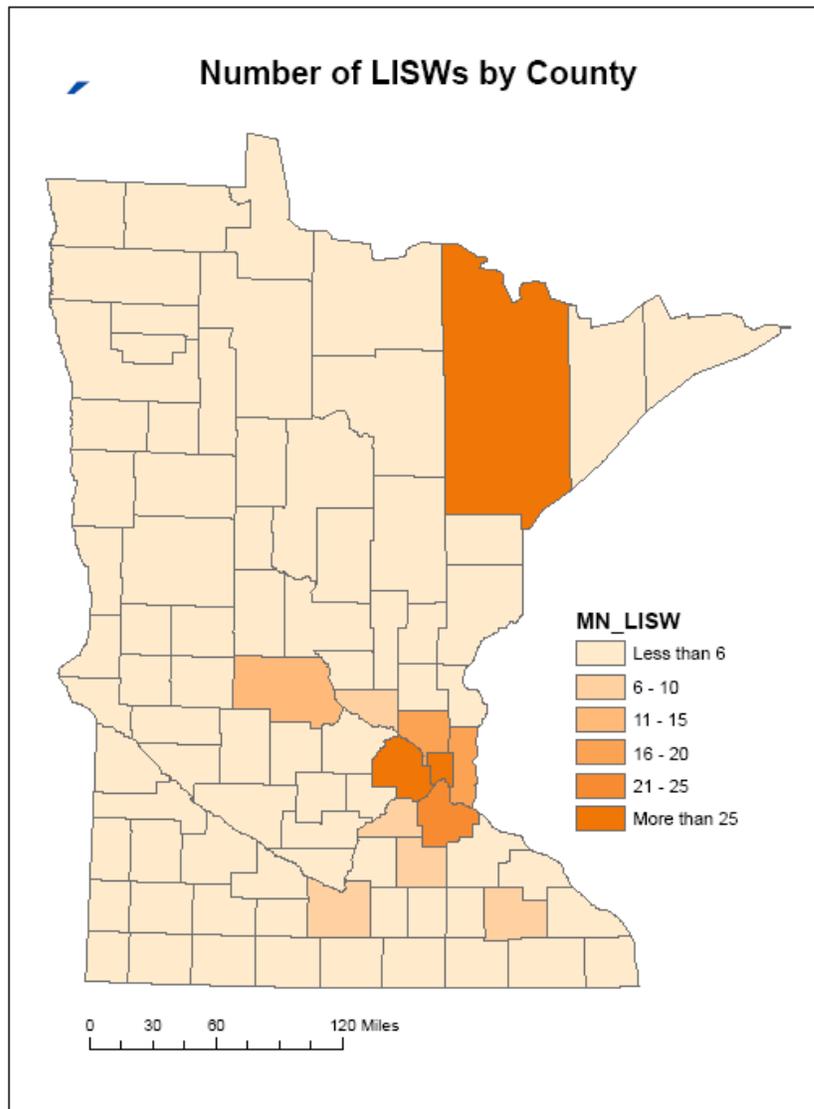
Map 4.6

**Total Number of Licensed Graduate Social Workers (LGSW)
in Saint Louis County and Duluth**

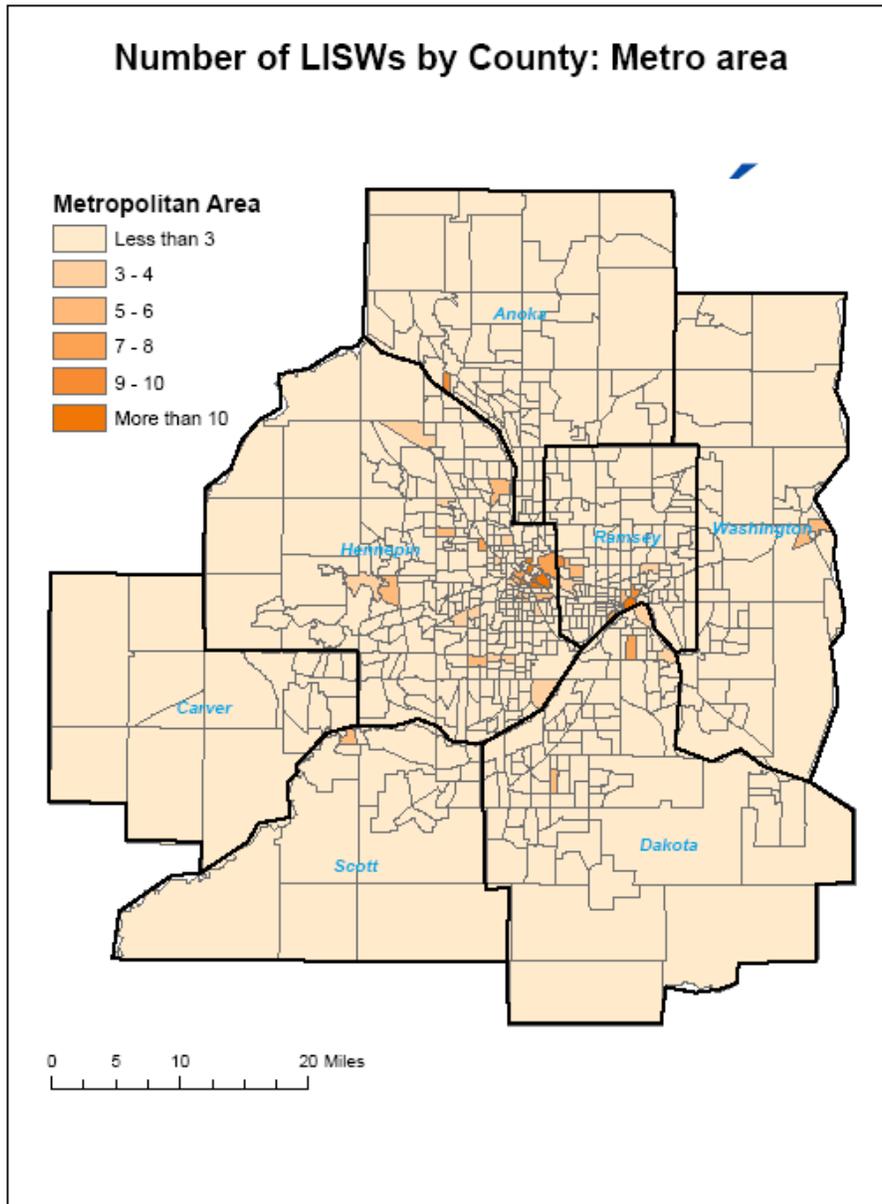


The following Maps 4.7, 4.8, and 4.9 demonstrate the employment locations of the Licensed Independent Social Workers in Greater and Rural Minnesota, Metro Counties, and St. Louis County.

Map 4.7
Total Number of Licensed Independent Social Workers (LISW) in Greater and Rural Minnesota

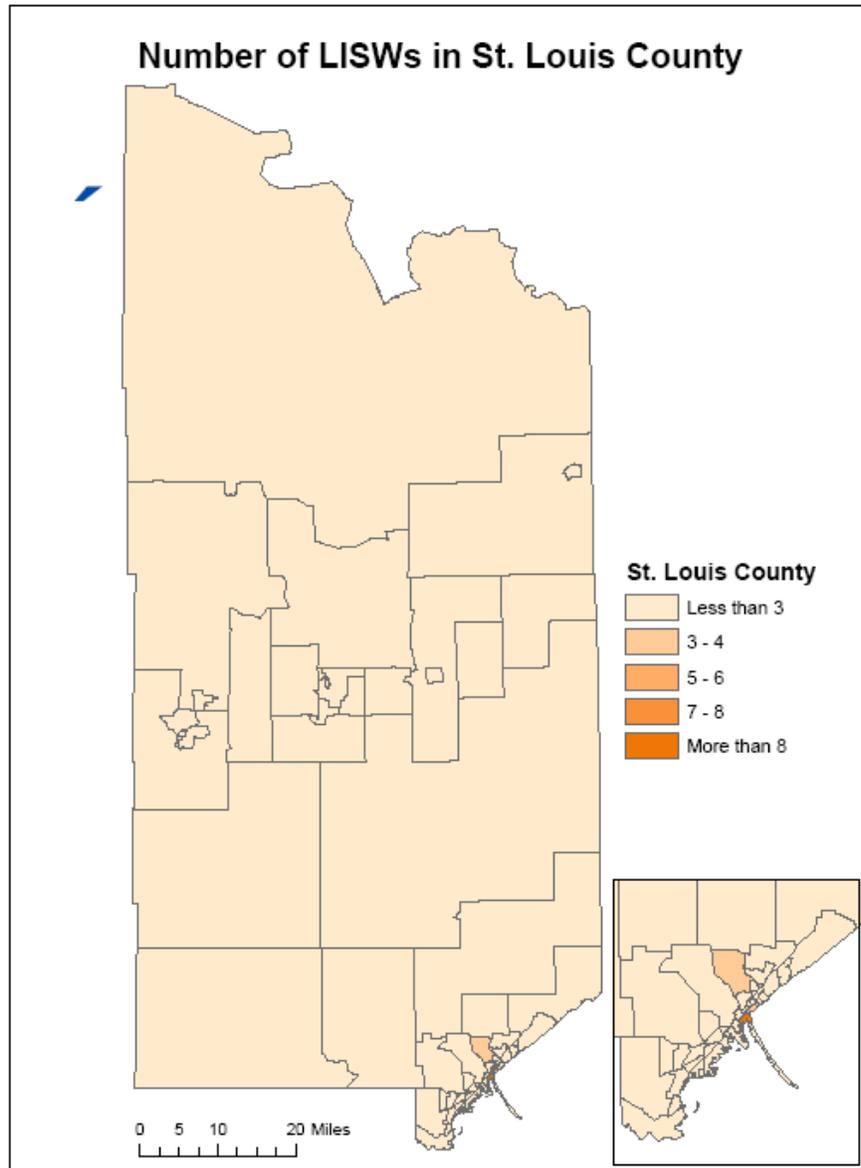


Map 4.8
Total Number of Licensed Independent Social Workers (LISW) in the Metro Area



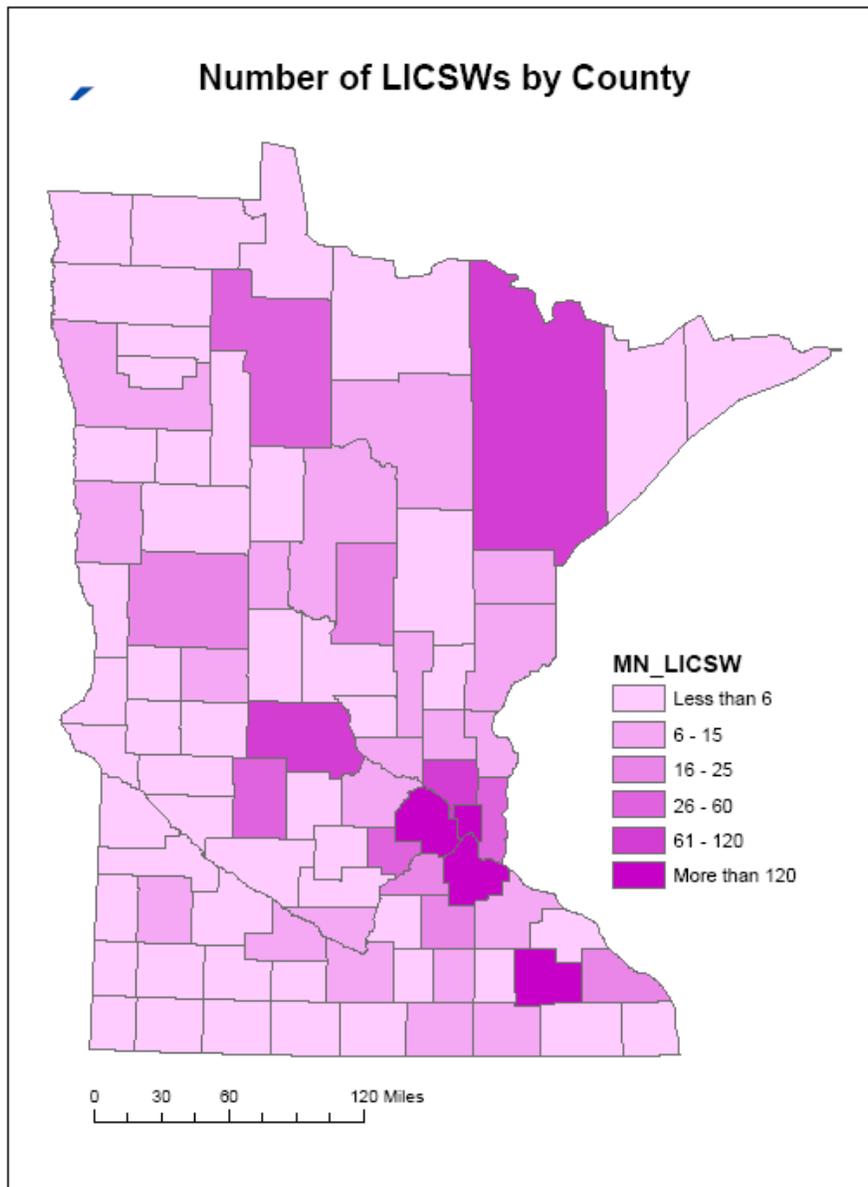
Map 4.9

**Total Number of Licensed Independent Social Workers (LISW)
in Saint Louis County and Duluth**

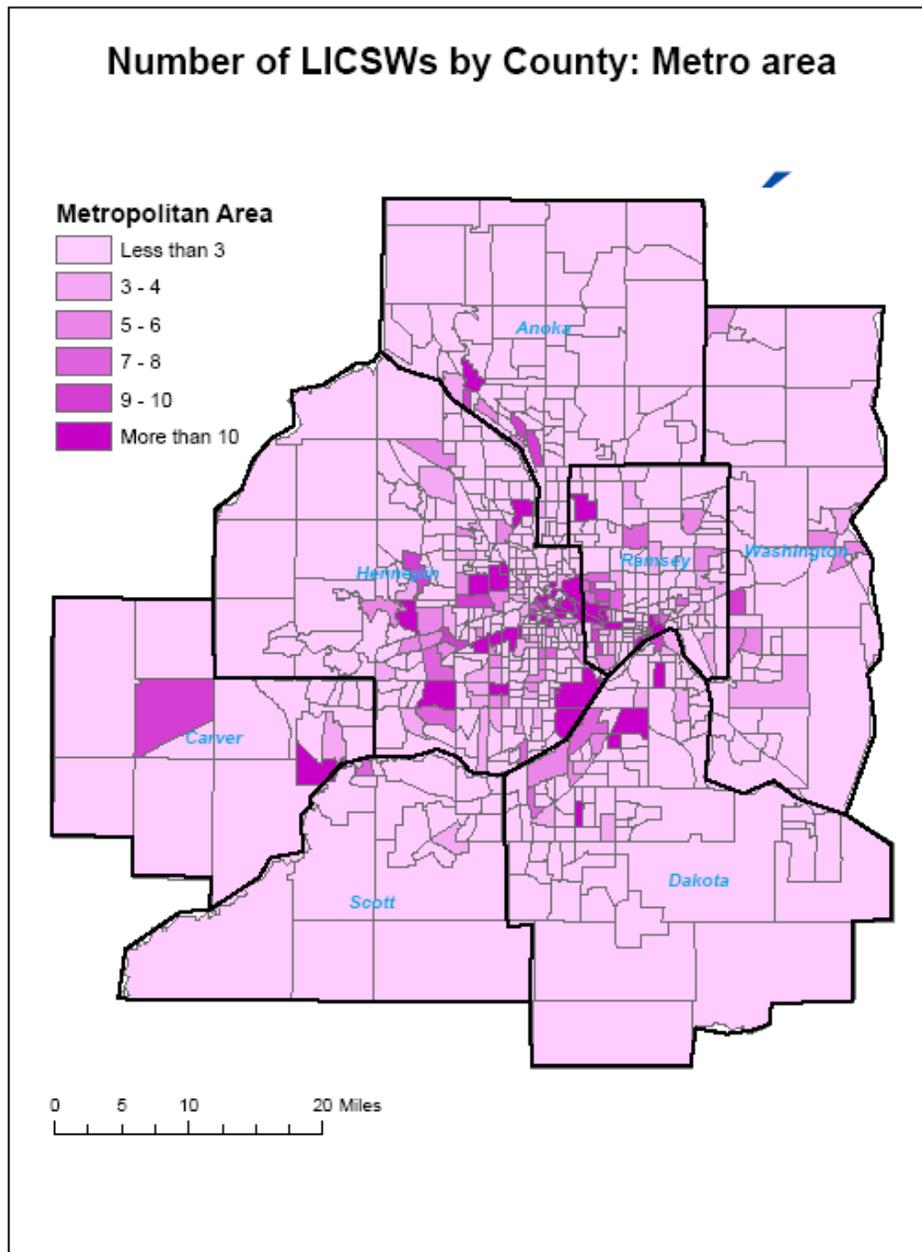


Maps 4.10, 4.11 and 4.12 illustrate the employment sites of the Licensed Independent Clinical Social Workers in Greater and Rural Minnesota, Metro Counties, St. Louis County, and Duluth.

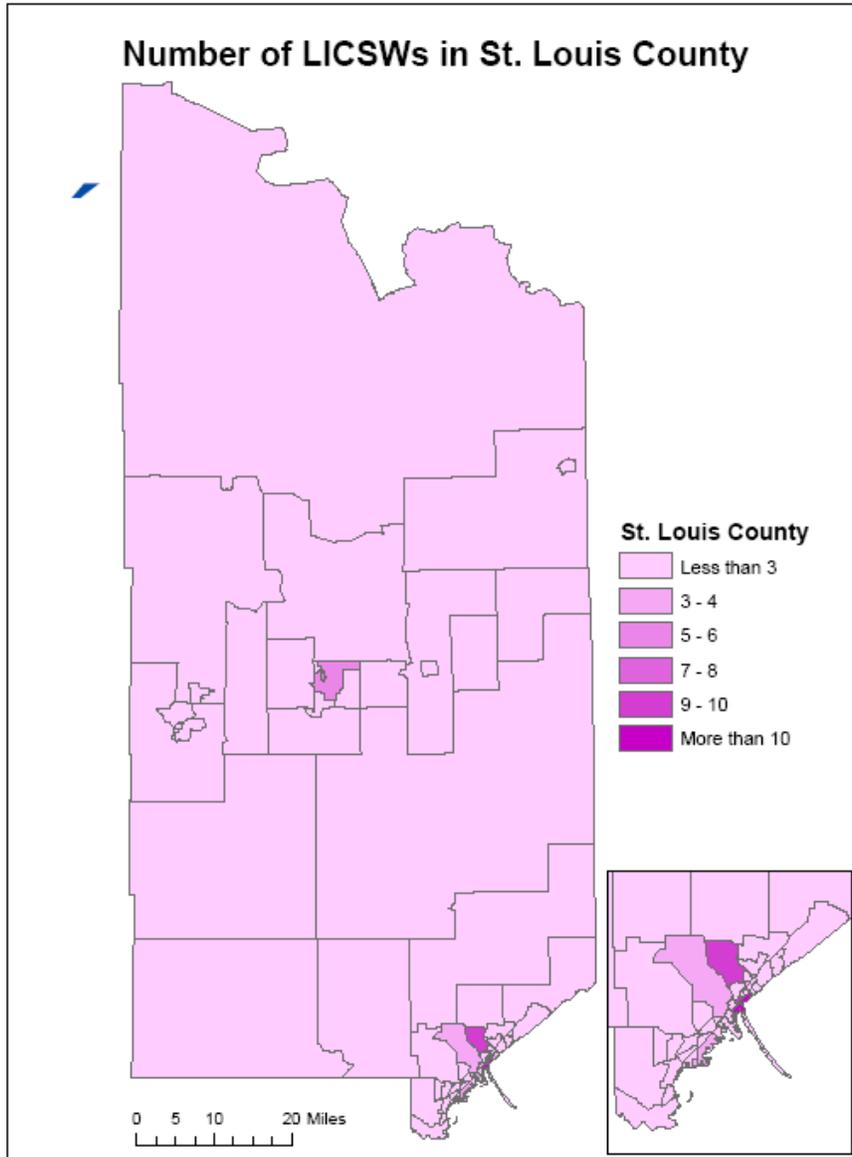
Map 4.10
Total Number of Licensed Independent Clinical Social Workers (LICSW)
in Greater and Rural Minnesota



Map 4.11
Total Number of Licensed Independent Clinical Social Workers (LICSW)
in the Metro Area



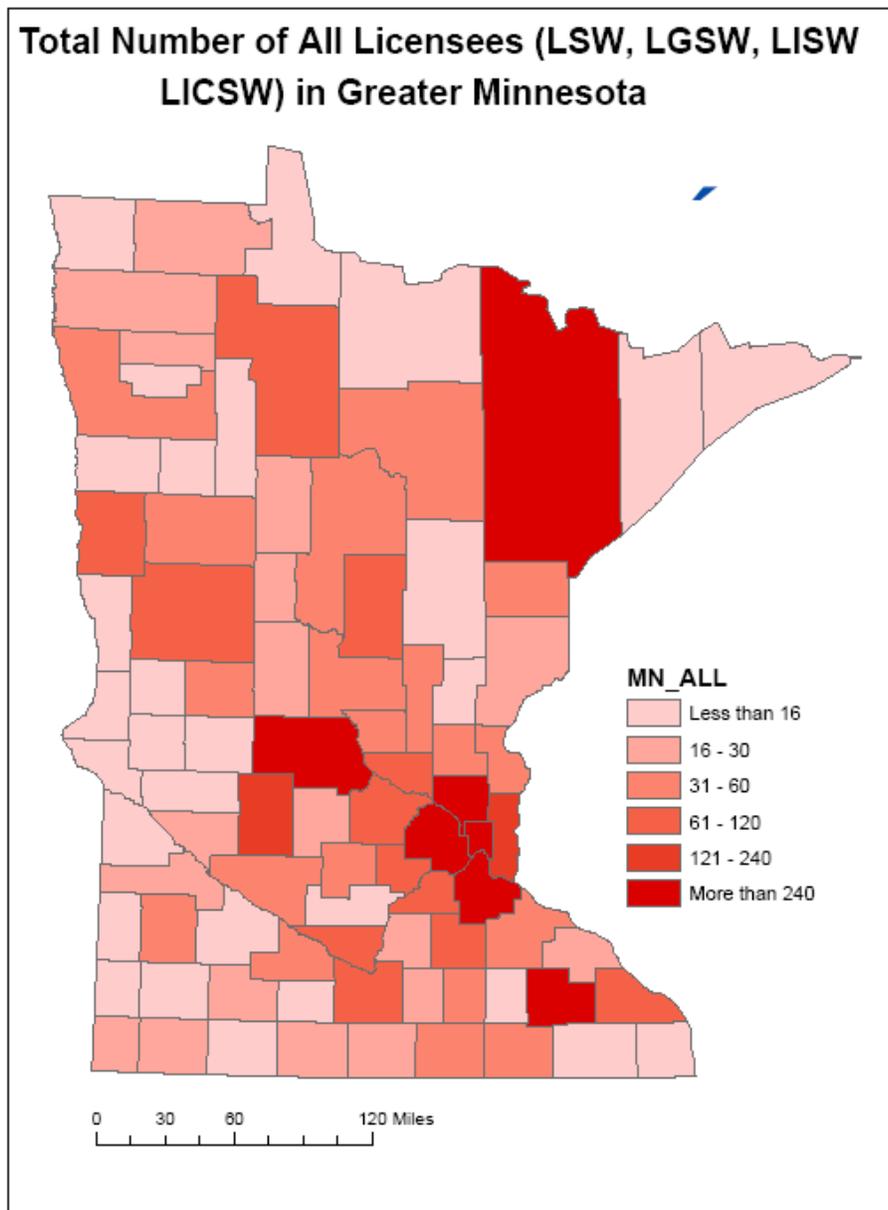
Map 4.12
Total Number of Licensed Independent Clinical Social Workers (LICSW)
in Saint Louis County and Duluth



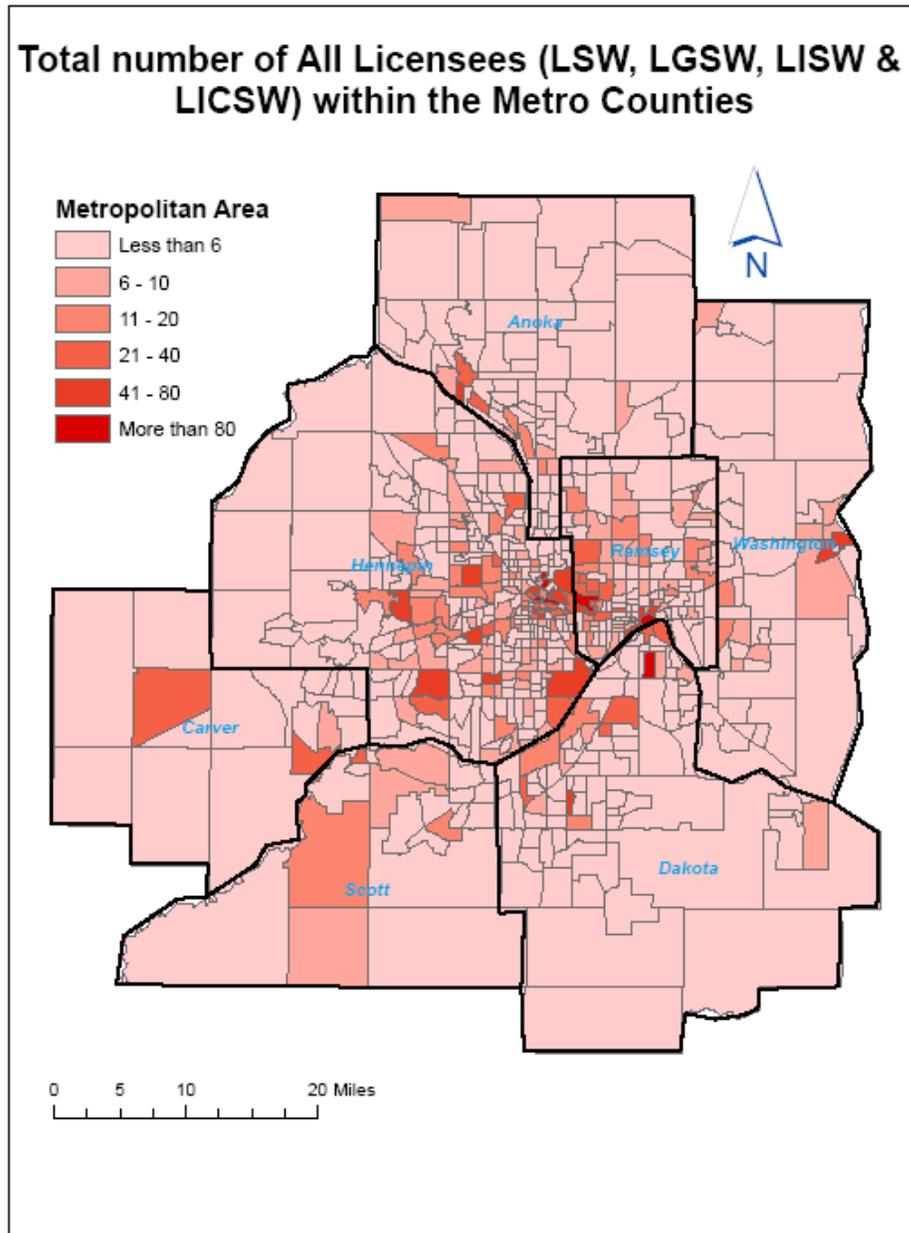
Maps 4.13, 4.14 and 4.15 indicate the number of social work licensees (LSW, LGSW, LISW, and LICSW).

Map 4.13

Total Number of All Licensees (LSW, LGSW, LISW, and LICSW) in Greater and Rural Minnesota

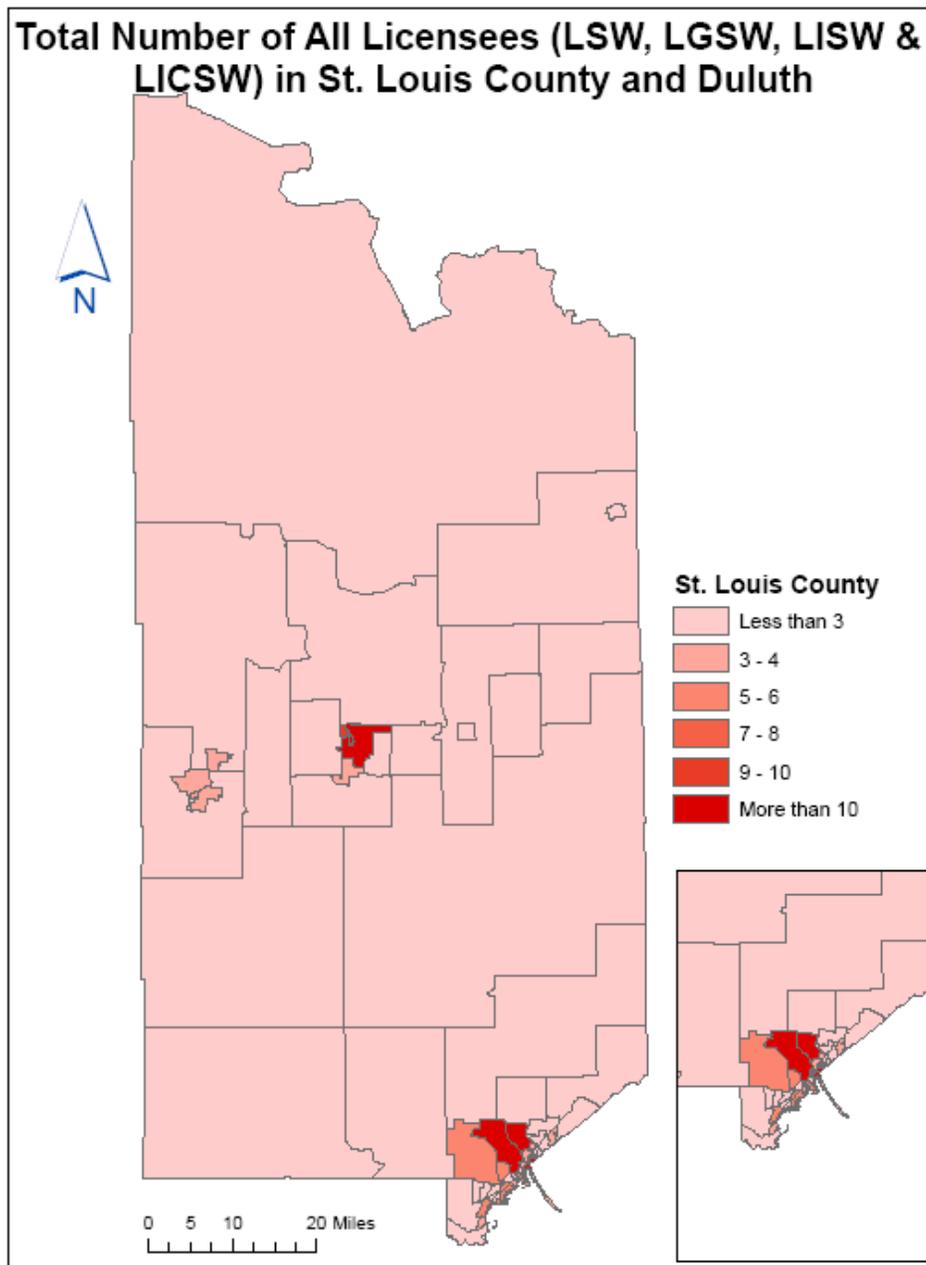


Map 4.14
Total Number of All Licensees (LSW, LGSW, LISW, and LICSW)
in the Metro area



Map 4.15

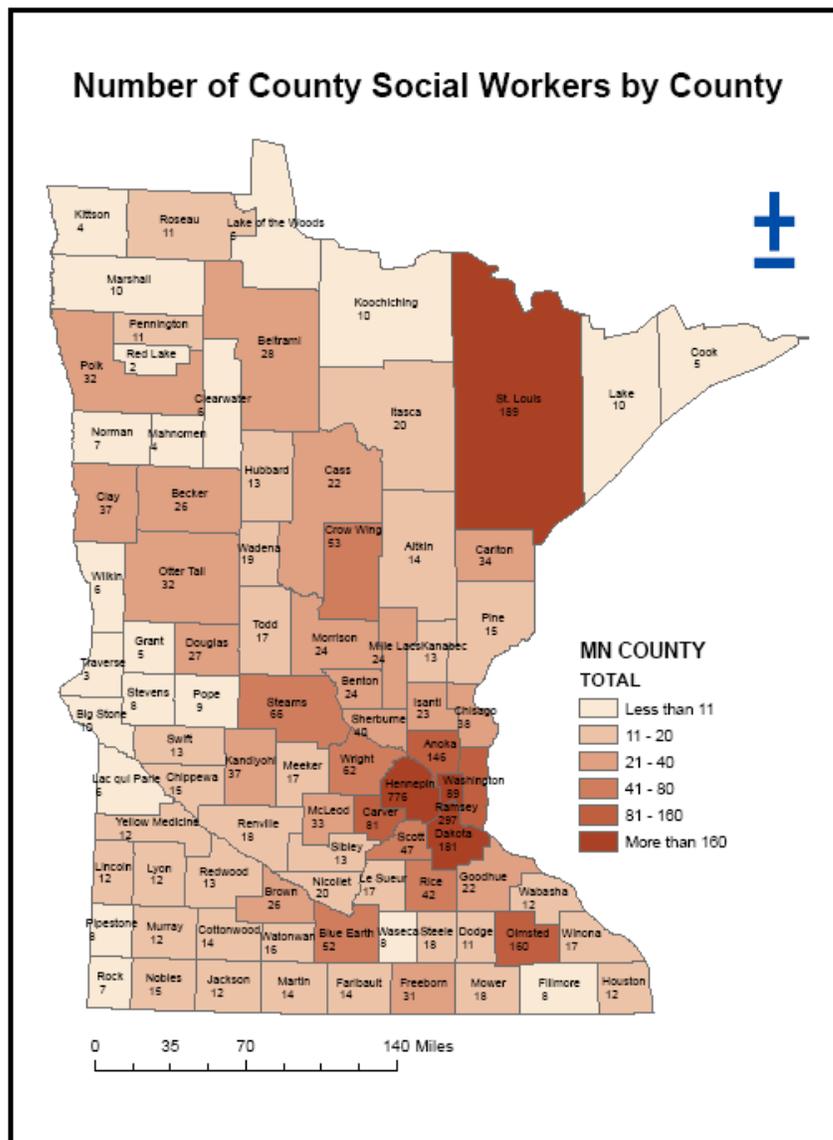
**Total Number of All Licensees (LSW, LGSW, LISW, and LICSW)
in Saint Louis County and Duluth**



Map 4.16 points out both the total number of non-licensed county workers and total county social workers who are licensed (LSW, LGSW, LISW, and LICSW).

Map 4.16

**Total Number of County Social Workers in Minnesota
 (Please note some of the county workers are licensed as social workers. All licensees are included, but the majority are non licensed workers.)**



County Populations and Licenses

The following Maps 4.17, 4.18, and 4.19 demonstrate the number of persons licensed as social workers (LSW, LGSW, LISW and LICSW) in comparison to county population.

Map 4.17
Total Number of Licenses (LSW, LGSW, LISW, and LICSW) and Population in Greater and Rural Minnesota

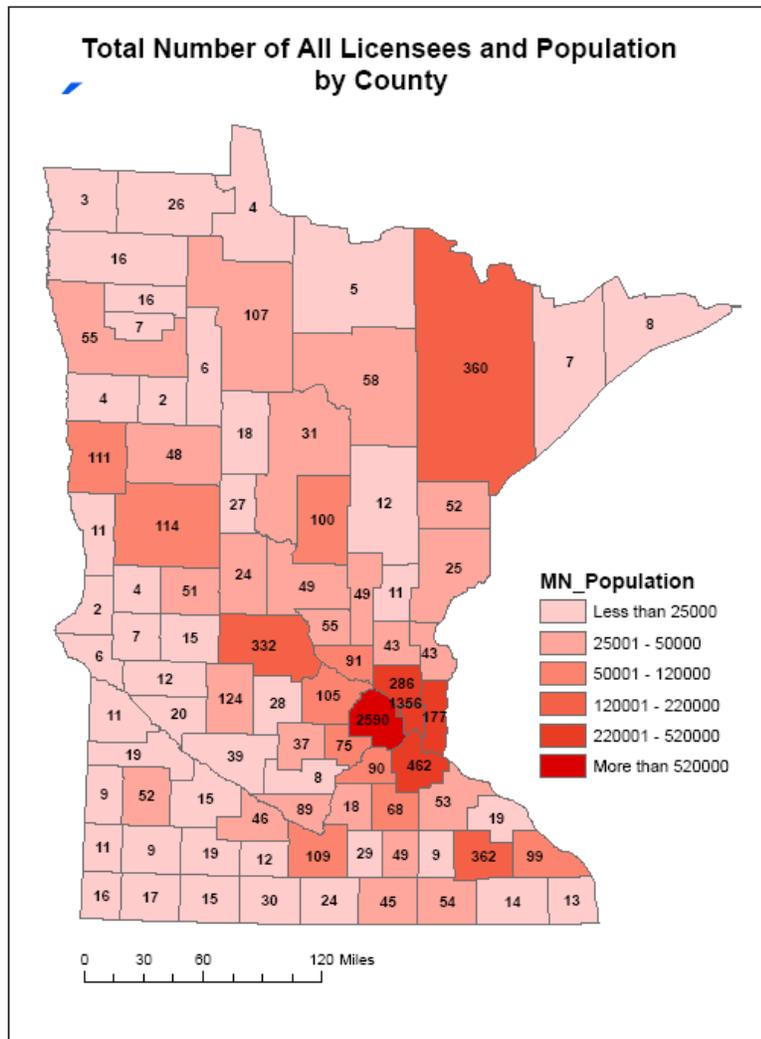


Table 4.2 lists the counties in which the number of persons licensed as social workers is greater than one licensee per 1,000 residents. By adding the number of non-licensed county workers to all licensees (LSW, LGSW, LISW, and LICSW), the number of counties with a greater ratio per 1000 residents decreases.

Table 4.3 lists the combination of non-licensed county workers (who may or may not have a degree in social work) with all licensees (LSW, LGSW, LISW, and LICSW) per 1,000 residents.

This ratio demonstrates that the U.S. Census Bureau (2000) identified 11 Metro Counties (excluding two Wisconsin counties) having only one licensee per 1,000 residents. In Greater and Rural Minnesota 61 counties are shown to have a ratio greater than 1 licensee to 1000 residents. There are 76 counties in Greater and Rural Minnesota, and the U.S. Department of Health and Human Services (2007) ratio of 1 medical professional to 1,000 residents was used.

Therefore, 80% of the counties in Greater and Rural Minnesota may be identified as underserved, and 72% of the 11 Minnesota Metro counties may also be identified as underserved.

List of the Counties That Have a Ratio Greater Than 1,000 County Residents to One Licensee (LSW, LGSW, LISW, and LICSW)

Table 4.2

1 Licensee & Non-licensed Social Worker/1000 County Residents		
Aitkin	Lac qui Parle	Rice
Anoka	Le Sueur	Rock
Benton	Lyon	Roseau
Big Stone	Mahnomen	Scott
Blue Earth	Martin	Sherburne
Brown	McLeod	Sibley
Carlton	Meeker	Stearns
Carver	Mille Lacs	Steele
Cass	Morrison	Stevens
Clearwater	Mower	Swift
Cook	Murray	Todd
Cottonwood	Nicollet	Traverse
Crow Wing	Nobles	Wabasha
Dakota	Norman	Wadena
Dodge	Otter Tail	Waseca
Douglas	Pennington	Washington
Faribault	Pine	Watonwan
Fillmore	Pipestone	Wilkin
Goodhue	Polk	Winona
Houston	Pope	Wright
Isanti	Red Lake	Yellow Medicine
Itasca	Redwood	
Kanabec	Renville	

Combining all licensees (LSW, LGSW, LISW, and LICSW) with the non-licensed county workers reduces the number of counties that have 1,000 residents to one social worker. Table 4.3 lists the counties with a ratio greater than one person licensed as a social worker or non-licensed county worker to 1,000 residents.

List of the Counties That Have a Ratio Greater Than 1,000 Residents To One Person Licensed as a Social Worker or Non-Licensed County Worker

Table 4.3

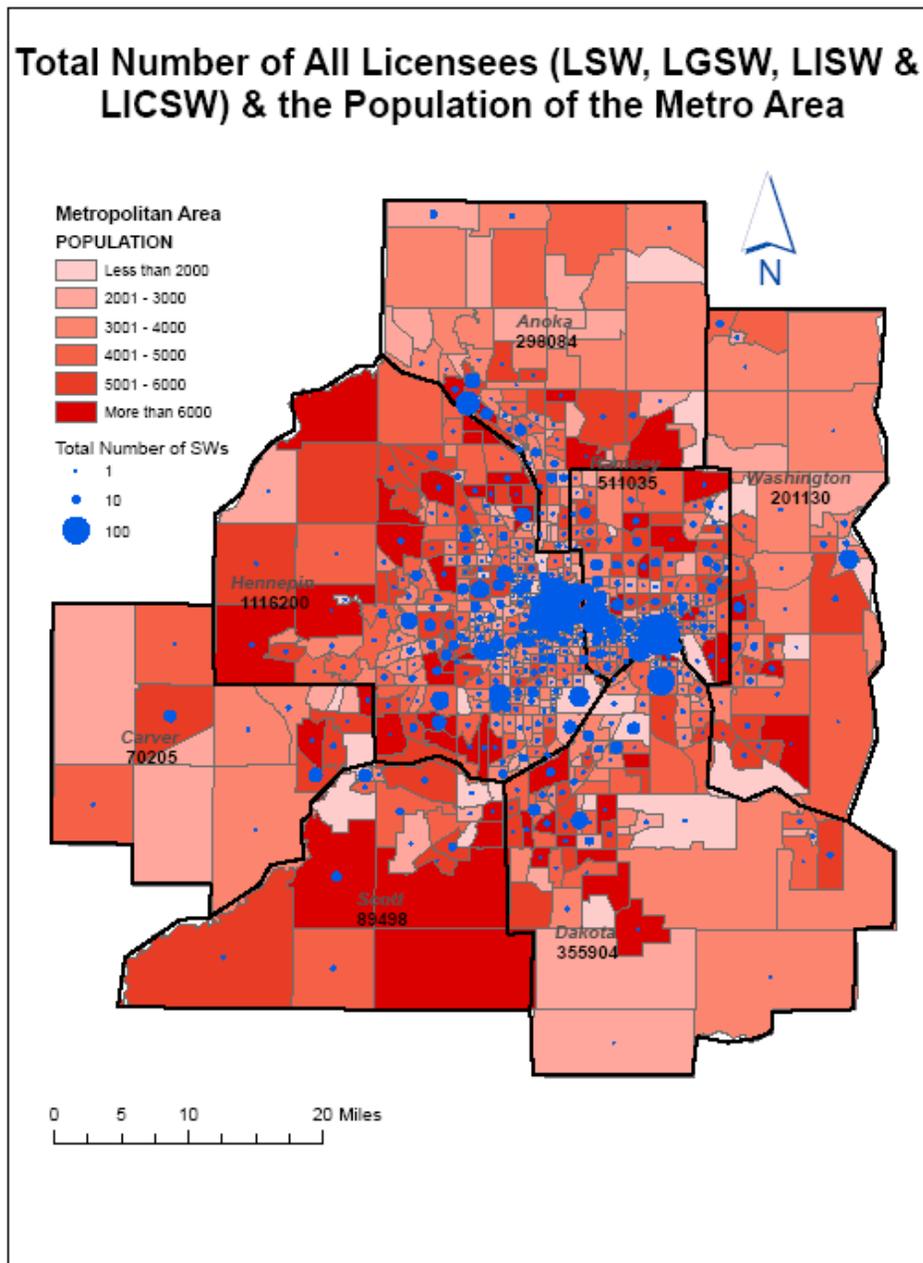
1 Licensed & Non-Licensed Worker/1000 County Residents		
Atkins	Kittson	Redwood
Anoka	Lac Qui Parle	Sibley
Clearwater	Le Sueur	Stevens
Dakota	Mahnomen	Traverse
Dodge	Murray	Washington
Fillmore	Nobles	Wabasha
Houston	Norman	
Kanabec	Pine	

The list above indicates that only two counties, Dakota and Washington, are within the Metro area. The remaining 19 counties are in Greater and Rural Minnesota. These counties may also be identified as social work underserved.

Map 4.18 illustrates that within the immediate Metro area (11 Metro counties) there are 3,428 licensees (LSW, LGSW, LISW, and LICSW) and the Metro counties' population is 2,861,430. These counties make up 58% of the state's total population and 62% of the total number of persons licensed as social workers.

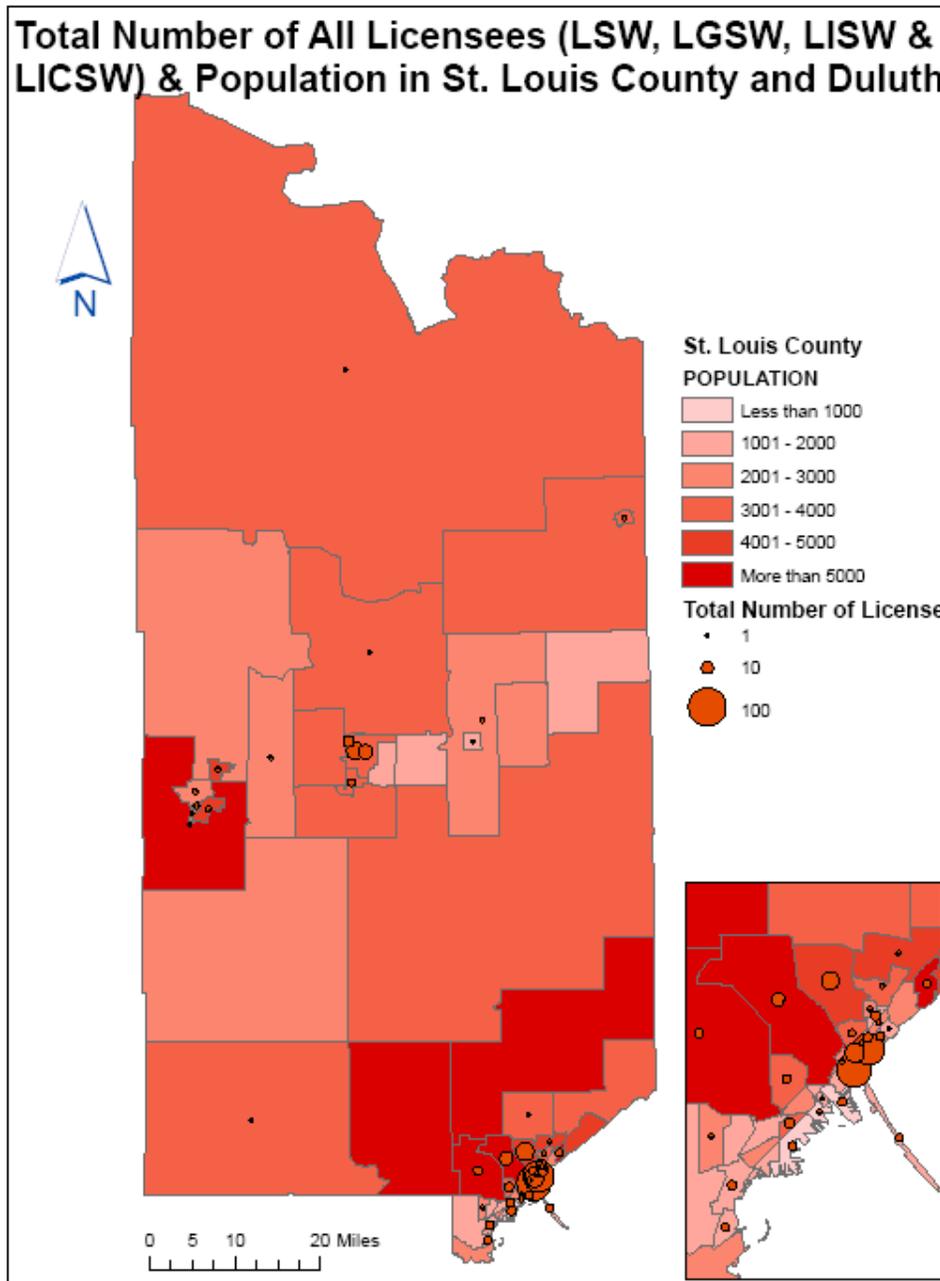
Map 4.18

**Total Number of All Licensees (LSW, LGSW, LISW, and LICSW)
and Population of the Metro Area**



Map 4.19

**Total Number of All Licensees (LSW, LGSW, LISW and LICSW)
and Population in Saint Louis County and Duluth**



Ethnic Population Findings

The sum of all licensees (LSW, LGSW, LISW and LICSW) whose employment addresses are in Minnesota equals 10,436. The total number of licensees, self-identified as minority ethnic groups, is 487.

Comparing the number of licensees who identify themselves from a minority ethnic group with the percentages of minority populations within the state, it is easily observed that this is an underserved area of great concern. The percentages in Table 4.4 demonstrate the need to recruit minority populations into the social work profession as licensees

Percentage of Ethnic Minorities in the State of Minnesota and the Percentage of All Licensees Who Self-Identified Membership of an Ethnic Minority Group

Table 4.4

Ethnicity	Sum of all licensees (LSW, LGSW, LISW, and LICSW)	Percentage of population by ethnic group within the state (2000 Census)
African American	207 (1.98%)	3.0%
Asian/Pacific Islander	116 (1.11%)	2.4%
Caucasian	8,966 (85.91%)	88.4%
Hispanic	79 (0.75%)	3.0%
Multiracial	15 (0.14%)	1.1%
Native American - Alaskan Native	70 (0.67%)	0.9%
Other Ethnicities	Not reported	1.1%

Specific licensees and ethnic identification are as follows:

- o LSWs total 5,108 in the state
 - 54 (1.1%) identified themselves as African American
 - 46 (0.9%) as Asian/Pacific Islanders
 - 4,524 (88.6%) as Caucasian
 - 22 (0.4%) as Hispanic
 - 6 (0.1%) as Multiracial
 - 32 (0.6%) as Native American/Alaskan Native
 - 424 (8.3%) did not report their ethnicity
- The total LSWs identified as minority ethnic group is 160 (3.1%).

- LGSWs total 1,161 in the state
 - 58 (5%) as African American
 - 30 (2%) as Asian/Pacific Islanders
 - 917 (79%) as Caucasian
 - 23 (2.0%) as Hispanic
 - 3 (0.3%) as Multiracial
 - 18 (1.6%) as Native American/Alaskan Native
 - 112 (9.6%) did not report their ethnicity

The total LGSWs identified as minority ethnic group is 244 (21%).

- LISWs total 732 in the state
 - 34 (4.6%) as African American
 - 5 (0.7%) Asian/Pacific Islanders
 - 594 (81.1%) Caucasian
 - 4 (0.5%) Hispanics
 - 0 (0%) as Multiracial
 - 5 (0.7%) Native American/Alaskan Native
 - 90 (12.3%) did not report their ethnicity

The total LISWs identified as minority ethnic group is 48 (6.6%).

- LICSWs total 3,435 in the state
 - 61 (1.8%) as African American
 - 35 (1.0%) as Asian/Pacific Islanders
 - 2,931 as (85.3%) Caucasian
 - 30 (.9%) as Hispanic
 - 6 (0.2%) as Multiracial
 - 15 (0.4%) Native American Indians/Alaskan Native
 - 357 (10.4%) did not report their ethnicity

The total LICSWs identified as minority ethnic group is 147 (4.3%).

The county location of persons licensed as social workers is vital to identifying the areas of greatest shortages of minority licensees providing services to minority populations. In conclusion, another underserved area is the availability of minority licensees to serve people from minority ethnic groups.

Table 4.5 demonstrates the county distribution of LSWs who are a part of a minority ethnicity group. Please note that 4,305 are Caucasian and 410 LSWs did not identify their ethnicity.

Table 4.5
County Distribution of Licensed Social Workers (LSW) By Ethnicity

County	African American	Asian Pacific Islanders	Hispanic	Multiracial	Native American/ Alaskan Native
Anoka*	2				
Becker					4
Beltrami				1	1
Benton					1
Big Stone					1
Blue Earth	1				
Carlton					2
Carver*		2			
Cass					1
Chisago					2
Clay			1		
Crow Wing					1
Dakota*	12	23	7	2	4
Hennepin*	31	12	10	2	1
Isanti					1
Kittson		1			
Mille Lacs					1
Morrison					2
Olmsted	3	2	1		
Otter Tail		3			2
Polk			1		
Ramsey*	1	1	1		
Red Lake					3
Saint Louis	1	1			1
Scott*					1
Sherburne*	1				
Stearns	1	1			1
Wadena					1
Winona			1	1	
Wright*	1				
Yellow Medicine					1
Total	54	46	22	6	32

From Table 4.5 one can not make definitive conclusions due to the large number of LSWs (424) who did not report their ethnicity. However, out of 160 LSWs who identify themselves as members of minority populations within the state, 120 of these LSWs work in the Metro area and 40 minority LSWs work in Greater and Rural Minnesota..

Table 4.6 shows the dispersal of LGSWs who have identified themselves as members of a minority ethnic group. Please note that 917 are Caucasian, and 112 did not identify their ethnicity.

Table 4.6
County Distribution of Licensed Graduate Social Workers by Ethnicity (LGSW)

County	African American	Asian/Pacific Islander	Hispanic	Multi-Racial	Native American/Alaskan Native
Carlton			1		1
Carver*	2				
Cass					
Chisago		1			
Clay					1
Dakota*	21	19	8	1	6
Goodhue	2				
Hennepin*	29	5	11	2	6
Mille Lacs					2
Olmstead		1			
Pine	2				
Ramsey*	2	2	1		
Red Lake					2
Sherburne*		1			
Stearns			1		
Waseca					
Washington		1			
Wright*			1		
Total	58	30	23	3	18

Table 4.6 does not provide a conclusion regarding the distribution of LGSWs who identify themselves as belonging to a minority ethnic group because of the large number of unidentified (112) LGSWs. Yet, one can see that 119 of the LGSWs work in the Metro area and 13 work in Greater and Rural Minnesota.

Table 4.7 demonstrates the county distribution of LISWs who identified themselves as part of a minority ethnic group. Please note that 594 self-identified Caucasian, and 90 LISWs did not identify their ethnicity.

Table 4.7

**County Distribution of
 Licensed Independent Social Workers (LISW) by Ethnicity**

County	African American	Asian/ Pacific Islander	Hispanic	Multi- Racial	Native American/ Alaskan Native
Anoka*	1				
Carlton					1
Dakota*	6		1		
Hennepin*	24	3	2		3
Ramsey*	1		1		
Saint Louis					1
Stearns	1	2			
Washington*	1				
Total	34	5	4	0	5

Table 4.7 does not provide a conclusion regarding the distribution of LISWs who identify themselves as belonging to a minority ethnic group because of the large number of unidentified (90). Yet, one can see that of the LISWs who identify themselves as belonging to a minority population, 43 of the LISWs work in the Metro area, and 5 work in Greater and Rural Minnesota.

Table 4.8 provides a breakdown of the Licensed Independent Clinical Social Workers who identify themselves as a member of a minority ethnic group by county.

Table 4.8
County Distribution of Licensed Independent Clinical Social Workers (LICSW) by Ethnicity

County	African American	Asian/Pacific Islander	Hispanic	Multi-Racial	Native American/Alaskan Native
Anoka*		2	1		1
Blue Earth		1			
Carlton					1
Cottonwood	1				
Cass					2
Crow Wing				1	1
Dakota*	15	15	14	2	3
Hennepin*	42	12	12		1
Itasca					1
Lyon	1				
Mahnomen					1
Olmstead	2	2	2	1	
Pipestone		1			
Ramsey*			1	1	
Saint Louis		1			3
Steele				1	
Washington*		1			1
Total	61	35	29	6	14

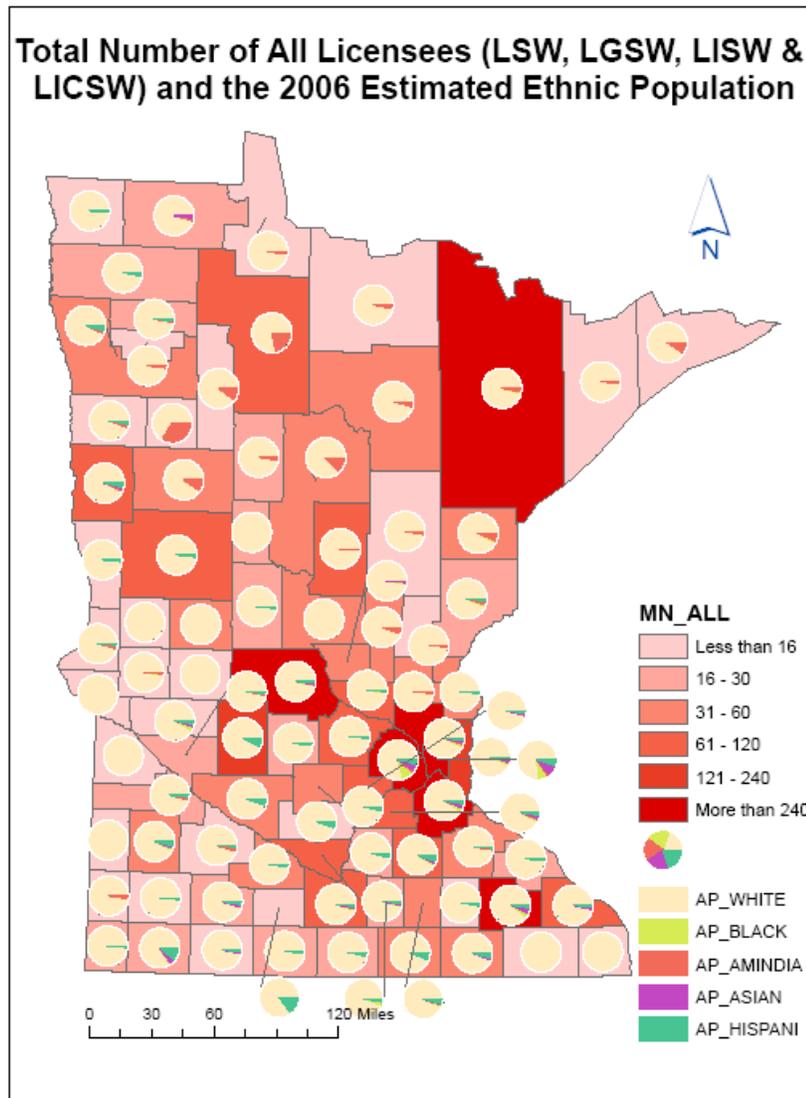
Out of the total 3,435 LICSWs, the number of self-identified Caucasians is 2,931, and 357 selected not to report their racial identity. In Table 4.8 the largest number, 124 of LICSWs who identify as having membership in a minority ethnic group, are employed primarily in the Metro area. The remaining 23 self-identified minority ethnic group LICSWs work in Greater and Rural Minnesota

The committee must caution that a statistical conclusion is not possible regarding the specific employment location of all licensees, because the identification of one's ethnicity is optional. Yet, this information clearly demonstrates that there is a need to increase the number of licensees who are racially diverse

Maps 4.20 4.21 and 4.22 demonstrate the total number of persons licensed as social workers in comparison to the 2006 estimated ethnic population by county.

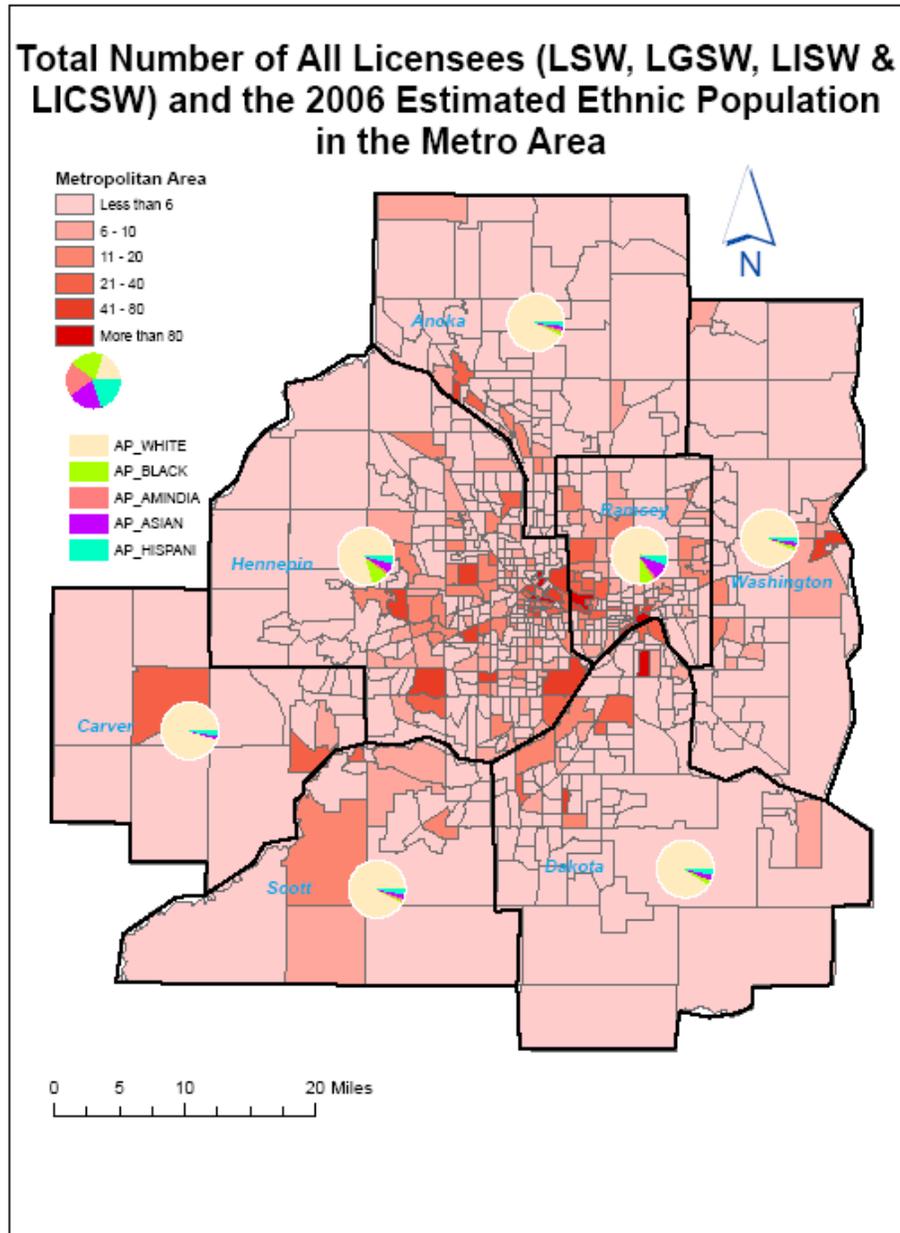
Total Number of All Licensees (LSW, LGSW, LISW, and LICSW) and the 2006 Estimated Ethnic Population

Map 4.20



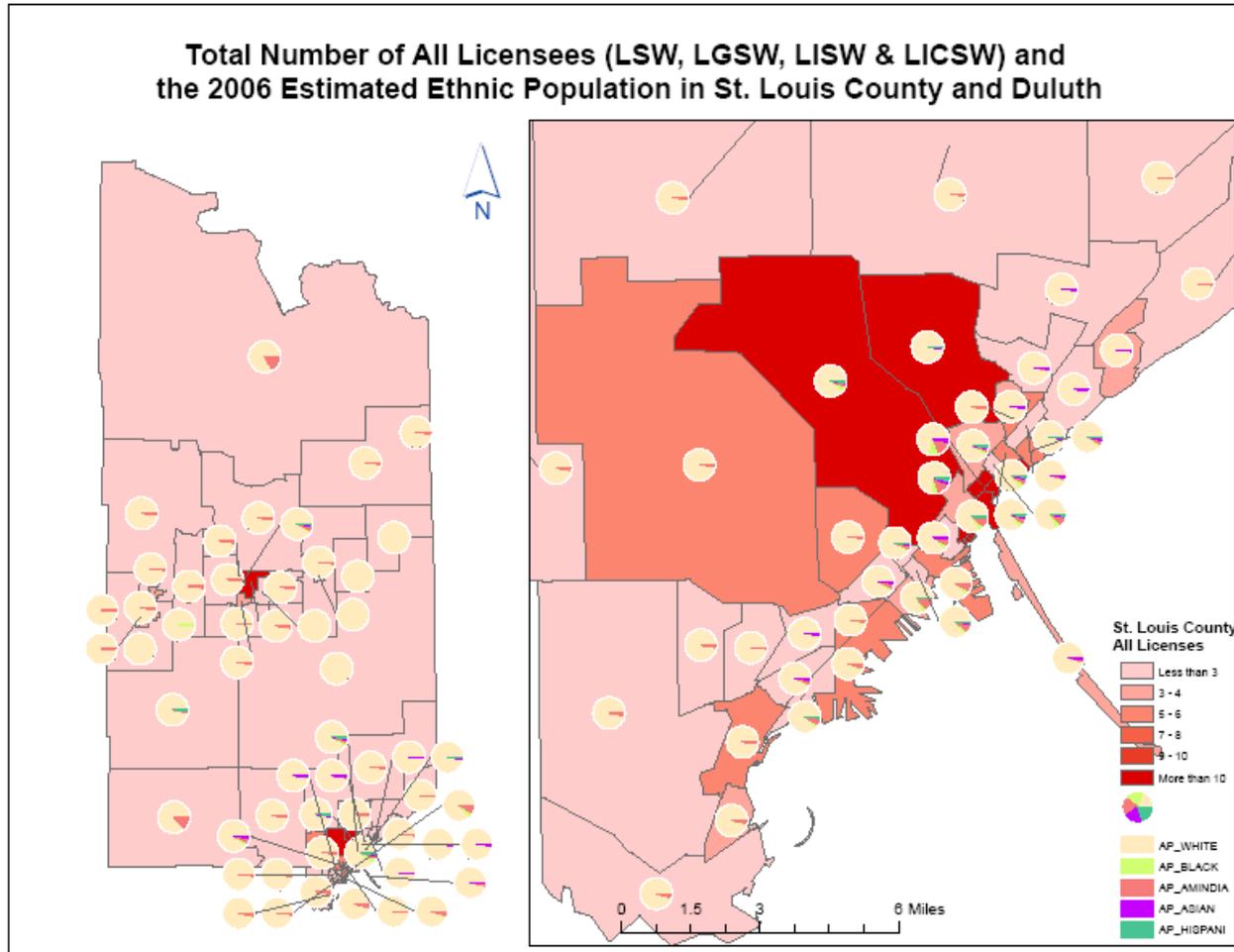
Total Number of All Licensees (LSW, LGSW, LISW, and LICSW) and the 2006 Estimated Ethnic Population in the Metro Area

Map 4.21



Map 4.22

Total Number of All Licensees (LSW, LGSW, LISW, and LICSW) and the 2006 Estimated Ethnic Population in Saint Louis County and Duluth



Explicit Breakdown of Ethnic Population in Minnesota

The U.S. Census Bureau and the Minnesota Department of Demographics collect ethnic data utilizing limited categories such as African American, Asian/Pacific Islander, Hispanic, Multi-Racial, and Native American/Alaskan. These are considered limited because it blends many ethnic groups together and does not identify specific populations. By examining the Minnesota Department of Education's (2007) Language Data Base it is possible to see the break down of different ethnicities by language. This method is also limited because it does not identify different ethnic groups that speak the same language. Yet, this method does provide the reader with a clearer identification of different ethnic groups that reside in Minnesota.

The Minnesota Board of Social Work also does not collect an explicit break down of the ethnicity of licensees. Therefore, a complete analysis of the number of licensees who self identify their ethnicity in comparison to the students' recognized first language is impossible. This language break down is vital to the acknowledgement of the need for additional licensees from minority ethnic groups, who are bilingual, or competent in specific cultures.

Table 4.9 illustrates the different first languages spoken within the Minnesota school districts. Table 4.9 only portrays languages in which more than 100 students report as their first language. Only through the understanding and recognition of the changes in Minnesota's residents will social and human services be able to address the needs of the state's citizens.

Table 4.9

**First Languages Spoken in Minnesota's Schools
 by More Than 100 Students
 Minnesota Department of Education's Language Database**

First Language Spoken	Number of Students Identified in Minnesota	First Language Spoken	Number of Students Identified in Minnesota
Adangme	121	Laotian	2,023
Afrikaans	525	Not Specified	962
Arabic	1,220	Oromo	785
Burmese	259	Persian	189
Cambodian	1,620	Polish	111
Cebuano	453	Portuguese	139
Chinese	1,753	Romanian	145
Chippewa	195	Russian	2,534
Cutchi	872	Serbo-Croatian	640
English	737,371	Sign Language	389
English-CR	1,193	Somali	9,583
French	487	Spanish	32,239
German	485	Swahili	422
Hebrew	731	Thai	144
Hmong	22,624	Tibetan	149
Igbo	140	Tigrinya	211
Icelandic	219	Ukrainian	304
Korean	591	Vietnamese	3,215
Krio	518	Yoruba	257
Kurdish	172		

By looking at the different languages spoken as Minnesota's first language, it is easy to recognize that the current ethnic data collection methods do not provide a clear representation of the multiple ethnic populations within the state.

Persons Aged 65 and Older Population Findings

One must consider the aging population in analyzing specific populations as licensees' underserved areas. Maps 4.23, 4.24 and 4.25 display the total number of licensees (LSW, LGSW, LISW, and LICSW) and the 2006 Estimated Number of People Aged 65 or Older within the state.

As noted in the literature review, there currently is limited information of aging population ratios to licensees, recommendations, or mandates other than the number of long-term care facility residents per licensee. Yet, the Minnesota Department of Human Services recommends a caseload size of 30 people with cognitive impairments to one practitioner. One might consider using this ratio for people aged 65 or older, with chronic illness or cognitive impairments, who may require similar services. It is also impossible to estimate the percentage or number of people aged 65 and older who may be in need of social services. Yet, the literature review demonstrates that as the population ages, additional social services will be required.

The total number of Minnesota county residents aged 65 and over per total licensee (LSW, LGSW, LISW and LICSW) reveals that 53 of the 87 counties in the state have more than 100 residents per one licensee. All 53 counties are in Greater and Rural Minnesota. There are only five counties that have a ratio greater than 300 residents, aged 65 and older, to one licensee. Table 4.10 provides a list of the counties with greater than 100 residents per licensee.

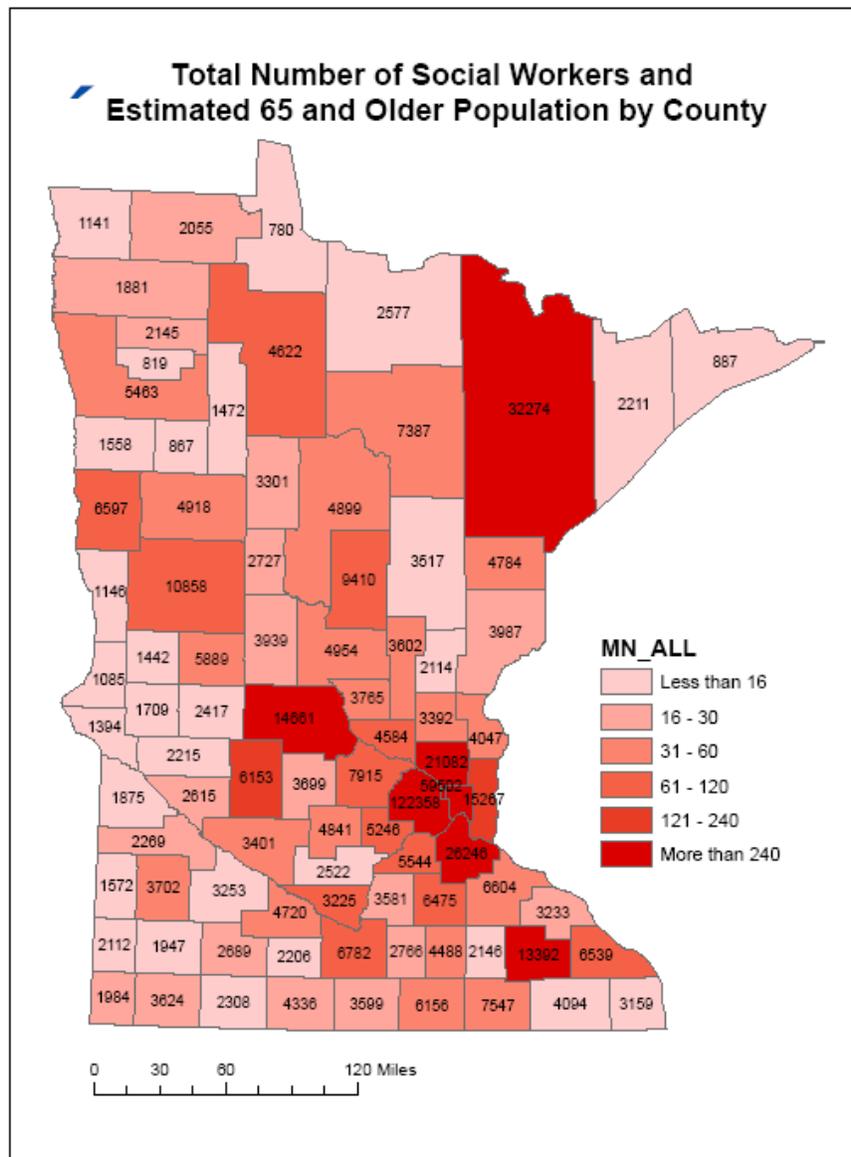
The literature reveals that the 65 and older social work field of practice is often recognized as having low numbers of practicing social workers (John A. Hartford Foundation, 2007). The issue of persons licensed as social workers practicing with the 65 and older population is on the brink of an extreme crisis in the state of Minnesota. The licensees included in this ratio also work with children, adolescents, young adults, middle aged adults, as well as the aging population.

Table 4.10
List of Counties That Have a Ratio of People Aged 65 and Older
Greater Than 100 to 1 Total Licensee
(LSW, LGSW, LISW and LICSW)

County	# of Residents per Licensee	County	# of Residents per Licensee
Benton	102	Swift	148
Brown	105	Pope	151
Douglas	107	Wabasha	154
Goodhue	108	Lac qui Parle	156
Marshall	111	Watonwan	158
Cook	111	Norman	173
Cottonwood	112	Hubbard	174
Yellow Medicine	113	Lincoln	175
Freeborn	114	Pipestone	176
Mower	114	Redwood	181
Faribault	116	Lake of the Woods	195
Red Lake	117	Big Stone	199
Rock	124	Sibley	210
Chippewa	125	Clearwater	210
Pine	125	Stevens	214
Cass	126	Dodge	215
Pennington	126	Murray	216
Todd	127	Nobles	227
McLeod	127	Fillmore	227
Martin	128	Houston	243
Meeker	128	Aitkin	271
Le Sueur	128	Mahnomen	289
Jackson	128	Lake	316
Itasca	130	Grant	361
Renville	131	Kittson	380
Kanabec	132	Koochiching	430
		Traverse	543

Map 4.23

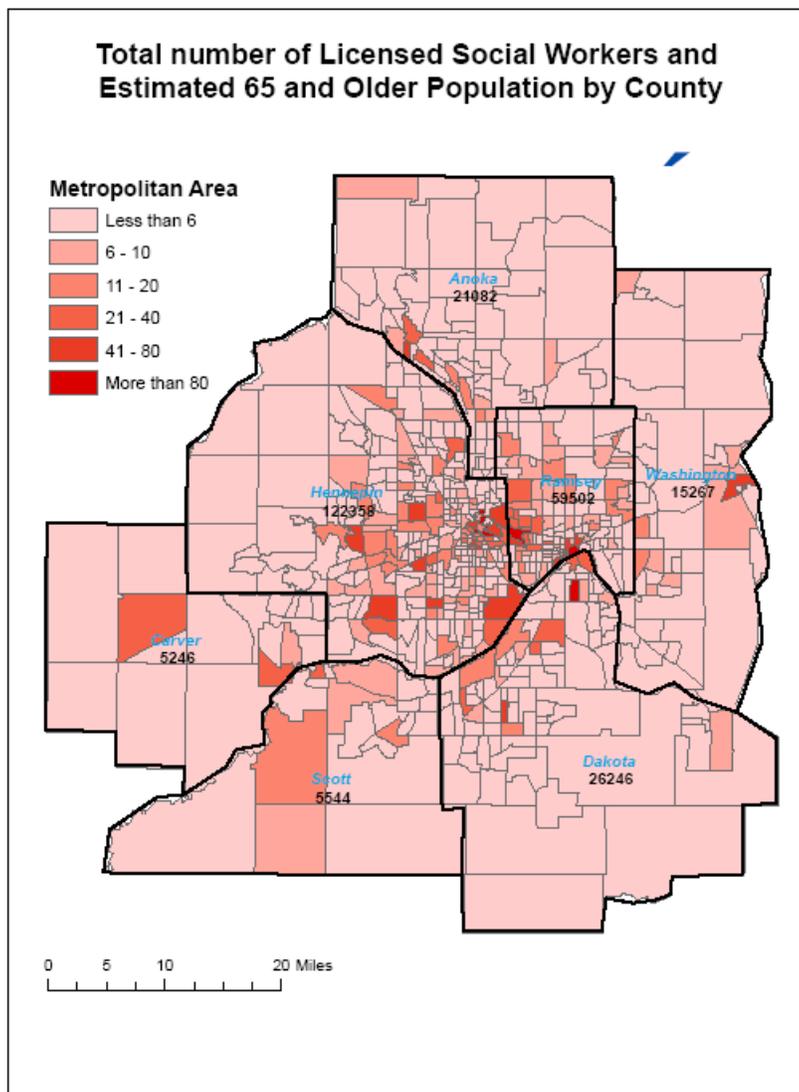
**Total Number of All Licensees (LSW, LGSW, LISW, and LICSW) and
 The 2006 Estimated Number of People 65 or Older**



Map 4.24 illustrates the sections of the Metro area and the aging population even though the Metro counties are not represented in the 100 residents 65 and older per one licensee. Map 4.24 uses the same licensees that may work with other fields of practice. With this knowledge it is clear the aging population is currently, or will soon be, in a state of social service crisis.

Map 4.24

Total Number of All Licensees (LSW, LGSW, LISW, and LICSW) and the 2006 Estimated Number of People 65 or Older in the Metro Area



School Social Work Findings

Discovering the ratio between the number of students (K-12 Grades) and persons licensed as school social workers was difficult. Yet, there are findings to report. The school district data examined 505 school districts in Minnesota. Of this total, 259 districts report having no persons licensed as social workers within the districts (51.28% of the districts). According to the Minnesota Department of Education (2007), there were a total of 828,241 students registered in the 505 school districts in 2007, and of this total 154,676 students do not have access to a licensed school social worker (18.67% of the total number of registered students). As one can observe in Appendix 9, the majority of schools without licensed school social workers are private or charter schools. This finding accounts for 18.67 percent of the total students and 51.28 percent of the total districts.

The eleven Metro Counties (Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, and Wright) comprise 60.49% (500,969 actual numbers) of registered students in 2007 (Minnesota Department of Education, 2007). Yet, the Metro Counties' licensed school social workers equal 66.86% (676 actual numbers) of the total 1,011 licensed school social workers.

The U.S. Department of Education (2007) has adopted the National Association of Social Workers (NASW) recommendation of a 500 students to one licensee ratio to work solely with the general student population. This recommendation does not include any of the special populations. The result is the licensed school social worker only provides the following services (within this rank order) with a concentration on students from the general population and poverty.

1. Crisis intervention
2. Social developmental assessment
3. Teacher consultation
4. Outside agency referral
5. Educational system assessment and program development
6. Home-school-community liaison
7. Staff in-service training
8. School social work program planning and evaluation
9. Large group intervention
10. Ongoing intervention

Within Minnesota there are 125 school districts with greater than 600 students to one licensed school social worker. (Minnesota mandates that all school social workers hold a valid and current social work license). Greater and Rural Minnesota school districts make up 66.4%, (83 total schools) with a ratio greater than 600 students to one licensed school social worker. While the eleven Metro county school districts total 33.6%, 42 Metro districts have a similar ratio. The Mankato School District 77 has the poorest ratio of

6,984 students to one licensed social worker. See Appendix 9 for the List of School Districts With and Without Licensed Social Workers and Student to Social Worker Ratios.

The Minnesota School Social Workers Association (MSSWA) is in agreement with the basic findings regarding shortages, however, is opposed to the use of ratios in determining hiring or assignment of licensed school social workers. The Student Support Services Task Force recommended to the Minnesota Department of Education that 1) workload, not ratios, should determine hiring (Communication from MSSWA, 2008), and 2) these high ratios do not allow for best practices services for students.

Homelessness Findings

In Minnesota the total number of people who are homeless, and between the ages of 18 and 80 years of age or older, is 4,781 (Wilder Research, 2007). As noted before, the specific number of licensees that work with the homeless populations is not maintained in statewide records. Therefore, to project the number of social workers engaged in practice with this population is not possible and would utilize the same licensees as in the other ratios explored earlier in this report.

Yet, one is able to understand the limited access this population has to licensees upon review of the number of people in shelters. Wilder Research (2007) reported that 266 women who are battered utilize battered women's shelters; 1,487 people use emergency shelters; 1,880 people use transition shelters; and 571 people are unsheltered. The majority of Minnesota residents who are homeless are also in need of services from persons licensed as social workers. The concern for the limited number of licensees available becomes even greater, when one considers the concern of children who are homeless. A total of 2,862 Minnesota children were homeless in October, 2003 (Wilder Research 2004 & 2007). The following are some of the characteristics that describe the Minnesota children who were homeless in 2003 and 2006.

2003	2006
▪ 4% under the age of 5	49%
▪ 38% between ages 6 and 12	35%
▪ 18% between ages 13 and 17	16%
▪ 82% have female caretakers	75%
▪ 69% of homeless women have children under 18	69%
▪ 53% of homeless women have at least one child with them	55%
▪ 36% of homeless men have children under 18	35%
▪ 6% of men have at least one child with them	

The Minnesota Department of Human Services (2007) reports people who are homeless often have the greatest needs and receive the fewest services. Minnesota DHS also recommends that the caseload size for this population should be 30 adult clients to one social worker, and if a family with children is homeless, the caseload size is recommended to be 15 families to 1 social worker. If the public and private agencies addressed the homelessness problem in the state, there would be 160 licensees working with this population. Given the shortages of licensees in the other fields of practice, it is believed that the state does not have 160 persons licensed as social workers practicing with this population. Providing quality services for the homeless population is a challenge.

People in Poverty Findings

The median household income in 2005 was \$45,000 and the average household size was 2.52 people in 2000 (Minnesota Department of Demographics, 2007). The U.S. Census Bureau uses the poverty thresholds to define the size of the family and the household income to define poverty. Table 1.2 clearly demonstrates that the U.S. poverty thresholds are out of date because a family of three can not realistically manage on \$17,600 per year without also having to deal with continuous financial, social, educational, and physical crises. The Minnesota Department of Demographics does not maintain the number of people in poverty by county, but the 2000 U.S. Census Bureau state data shows that there are 168,089 males and 212,387 females for a total of 380,476 people living below the poverty level in 2000.

It is impossible to establish a clear ratio between the number of people who are homeless and licensed social workers, but the Minnesota Department of Human Services recommends that the ratio should be 30 people who are of low income to 1 social worker. It is presumed that there are not 12,684 social workers in the state working with people of poverty.

CHAPTER IV

SUMMARY AND APPLICATION OF THE FINDINGS

Summary and Applications of the Findings

This report illustrates the critical need to increase the availability of licensed social workers at all categories of licensure. Professionally trained social workers are essential in providing competent, culturally appropriate services to vulnerable populations throughout Minnesota.

This report provides the ratios of the number of persons licensed as social workers in several fields of social work practice to number of clients. The report indicates there are many more residents in the state who are in need of services provided by persons licensed as social workers than available.

Due to the fact that the Board of Social Work, Minnesota Department of Human Services, and other agencies do not include the field of practice in data collection (except for Child Safety and Permanency Workers and School Social Workers), the underserved identified counties are not proven by a sound statistical level of significance. Therefore, the identification is through the discovery of recommended federal, state, or organizational client to social worker ratios in comparison to the actual number of Minnesota residents or specific population groups to the number of licensees. The presentation of this baseline data reveals shortages in several different geographical locations, or within services to specific populations that range from a state of crisis to a crisis within the delivery of services by licensed social workers to Minnesota's most vulnerable populations. The areas of shortages are identified in "Application of Findings" with recommendations for corrective action. In Chapter 4, Findings, the areas identified as underserved social and human service areas served by persons licensed as social workers include

- * Ethnic Populations Findings
 - o Explicit Breakdown of Ethnic Populations in Minnesota
- * Child Safety and Welfare Findings
- * Employment Locations of Social Work Licensees and Non-Licensed County Workers
- * County Populations and Licensees
- * Persons 65 or Older Population Findings
- * School Social Work Findings
- * Homelessness Findings
- * People of Poverty Findings

This chapter also provides a summary and recommendations regarding factors that may contribute to the issue of licensee shortages within the state. A few of these factors are listed below:

- * Shortage of Graduates
 - o Cost of Education in Comparison to Annual Salary Findings
- * Estimated Population Growth and Availability of Licensees

In the review of this report the reader must also take into account that each ratio presented is utilizing the same licensees (LSW, LGSW, LISW, and LICSW) except in the fields of Child Safety and Permanency and School Social Workers. The Minnesota Board of Social Work does not collect the information specific to the fields of practice for the licensees, nor does the Minnesota Merit System, or the 14 Non-Merit Counties. Therefore, the ratios in Chapter 4 Findings are much more disproportionate, because the licensees and the non-licensed county workers work in a variety of practice settings. With the above major limitation of this study noted, the application of these findings is discussed below.

Ethnicity and Licensee Shortage

The shortage of licensees from minority ethnic populations is an issue which requires attention. The Minnesota Board of Social Work is continuing to examine the concern of the pass/fail rate of applicants who are foreign-born (outside the United States) and speak English as a second language. The Board's next step might be to pursue a method to collect more specific ethnic data. License applicants have the option of reporting their ethnicity, but a significant percentage (9.68%) do not provide this information. Yet, the Board has qualitative information (from focus groups, Holcomb's Study, 2005) that shows there may be difficulties taking and passing the ASWB examination for applicants from ethnic minority groups who were foreign-born. Even in view of this situation, the Board's mission is to ensure that applicants are able to demonstrate minimum competencies to practice social work. Currently, ASWB has convened a national task force to address this concern. Minnesota, as a member state, is serving on the task force and will continue to work on these issues.

This report can only focus on the number of licensees who are also members of an ethnic minority population. It is statistically impossible, with the current data collection methods, to determine if there is an increased shortage of licensees in specific regions, communities, cities and/or townships, in which there is a high concentration of citizens from ethnic minority populations. The reader is able to look at the Maps in Appendix 3 to visually recognize the number of licensees (LSW, LGSW, LISW and LICSW) whose employment addresses are in Greater and Rural Minnesota and the 11 Metro Counties where there are high concentrations of ethnic minority populations. This issue is of great importance for the Board and the residents of Minnesota.

Table 5.1 presents a comparison of the total number of licensees who identify their ethnicity with the percentage of the total population in the state. Table 5.2 demonstrates the number of licensees per ethnic population.

**Total Number of Licensees Who Identify Their Ethnicity with the Percentage
 Ethnic Population and Percentage of Ethnic Population in Poverty**

Table 5.1

Ethnicity	Sum of all licensees (LSW, LGSW, LISW, and LICSW)	Percentage of population by ethnic group within the state (2000 Census)	Percentage of people of poverty who are also identified as member of a minority ethnic population (Percentage of Ethnicity)
African American	207 (1.98%)	3.0%	27.1%
Asian/Pacific Islander	116 (1.11%)	2.4%	18.9%
Caucasian	8,966 (85.91%)	88.4%	6%
Hispanic	79 (0.75%)	3.0%	20.1%
Multiracial	15 (0.14%)	1.1%	19.7
Native American - Alaskan Native	70 (0.67%)	0.9%	28.6%
Other Ethnicities	Not reported	1.1%	21.4%

The review of the above data clearly shows that there is a lack of social workers who are from minority ethnic populations. Also, the percentage of people of poverty who are also identified as a member of a minority ethnic population enhances the licensee shortages. Often people of poverty, who are dealing with limited basic survival resources, have complex issues that decrease their access to service which may affect their ability to increase their successful societal independence.

TYPE OF LICENSE BY ETHNICITY

Table 5.2

Type of License	Total Number in State	African American	Asian/Pacific Islanders	Caucasian	Hispanic	Multiracial	Native American/Alaskan Native	Did Not Report Ethnicity
LSW	5,108	54	46	4,524	22	6	32	424
LGSW	1,161	58	30	917	23	3	18	112
LISW	732	34	5	594	4	0	5	90
LICSW	3,435	61	35	2,931	30	6	15	357
Total	10,436	207	116	8,966	79	15	70	983

In the review of the data in Chapter Four Findings, Tables 4.5, 4.6, 4.7, and 4.8, the following geographical information is revealed

- * LSWs identified as members of an ethnic minority population:
 - o 120 or 75.00% are in the 11 County Metro area and 40 or 25.00% are in Greater and Rural Minnesota
- * LGSWs identified as members of an ethnic minority population
 - o 119 or 90.15% are in the 11 County Metro area and 13 or 9.85% are in Greater and Rural Minnesota
- * LISWs identified as members of an ethnic minority population
 - o 43 or 89.58% are in the 11 County Metro area and 5 or 10.42% are in Greater and Rural Minnesota
- * LICSWs identified as members of an ethnic minority population
 - o 124 or 84.35% are in the 11 County Metro area and 23 or 15.65% are in Greater and Rural Minnesota

These numbers illustrate the intense need to increase the number of licensees from minority ethnic populations in Greater and Rural Minnesota. It cannot be overlooked that there is also a need to increase the number in the 11 County Metro area. This responsibility is multifaceted and stakeholder groups may consider the development of a strategic plan of action.

Minnesota Child Safety and Permanency

This report covers many fields of practice. For years the U.S. Department of Human Services, Minnesota and County Departments of Human Services, and county commissioners have worked together to reduce the caseload size served by Child Safety and Permanency case workers. This reduction has occurred in all of the 87 counties except 14 in Greater and Rural Minnesota. Of these 14 counties, the largest ratios are in 4 counties (ratios above 45 clients to 1 licensee or non-licensed county worker). See Chapter Four findings for the list of the 14 counties.

School Districts

The shortage of on-site licensed school social workers within the state's school districts is a difficulty that mandates involvement by the state's local school boards, Minnesota Department of Education, residents of the school districts, and the executive and legislative branches of state government. This involvement may also include the Minnesota Department of Human Services, Minnesota Department of Health, and third party reimbursement agencies. This shortage is larger in the public schools in Greater and Rural Minnesota. Yet, in the 11 Metro counties the need appears to be more significant in the private and charter schools. The ratio comparison utilizes 500 students to 1 licensee. Funding for licensed school social workers is often linked with special education students. The recommended ratio is 50 students to 1 licensee for special education students. If this ratio is used, only 12 schools meet this requirement. In 2007 246 school districts did not have an on-site licensed school social worker. Please see Appendix 9 for a complete list of school districts.

Other Fields of Practice

The shortage of licensees working with people with physical and/or cognitive impairments, mental illness, aged 65 and older, living in poverty, and homeless are also areas of concern. However, it is not possible to provide a direct ratio regarding these populations. The Department of Human Services (2007) stated that the overall ratio should be 30 clients to 1 licensee or 15 families to 1 licensee (Heyl, personal communication, 2007).

People with Physical and/or Cognitive Impairments

The Minnesota Department of Human Services has long recognized that people with physical and/or cognitive impairments have been underserved. Minnesota caseload sizes are at a ratio greater than the national average and the U.S. Department of Health and Human Services recommendations. The additional monies needed to reduce the caseload sizes for people with physical or cognitive impairments to a 40 clients to 1 worker would be as follows as of 2005:

Increase in State Allocations:	\$ 8,166,131.00
Average Increase in County Allocation:	\$ 923,970.00
Increase in Federal Allocations:	<u>\$ 9,090,101.00</u>
Total Increase	<u>\$18,180,202.00</u>

Total Number of Individuals: 31,093

Total Increase as of 2005, \$18,180,200.00/Total Number of Individuals 31,093

Total Cost per Individual: \$584.70

It is presumed that there would be little debate that Minnesotans with physical or cognitive impairments deserve the highest quality of services from persons licensed as social workers. Yet, suggested financial support would require significant policy and budgetary initiatives on all fronts (federal, state, local and organizational) to meet the needed levels of service. It should be noted that 60% of the states have implemented programs that meet the recommended caseload size.

People with Mental Illness

It is estimated that the state has 98,000 adults and 75,000 children who suffer from mental illness (1 out of every 29 residents). The recommended ratio of client to worker, for adults with mental illness, is 30 clients to 1 licensee; and the recommended ratio for children with mental illness is 15 clients to 1 licensee.

- There are 69 counties that have a ratio greater than 1,000 residents to 1 licensee.
61 of these counties are in Greater and Rural Minnesota.
- Add the non-licensed county workers to the persons licensed as social workers and there are 21 counties with a ratio greater than 1,000 to 1 licensee.
Only 2 of the 21 counties are in the 11 County Metro area.
- One conclusion is that there are people with mental health concerns who are not receiving services from licensees.
- Another conclusion may be that “caseload sizes are too large to provide best practice techniques”.

People Aged 65 and Older

This report examined the ratio of the population aged 65 and older to licensees. There are 52 counties in Greater and Rural Minnesota that have a ratio of 100 or more people aged 65 or older to 1 licensee. There is no recommended ratio for people aged 65 and older per licensee. Yet, one could apply the same ratio used for other adult categories which is 30 clients to 1 worker. Of these 52 counties, 26 have a ratio greater than 150 to 1, and 7 counties have a ratio greater than 250 to 1. One may assume that not everyone aged 65 and older requires the services of persons licensed as social workers. However, because the licensees in these ratios are employed in many different fields of practice, the above

ratios of 100, 150 or 250 people aged 65 and older are in reality much greater. This statement is also true of the licensees practicing in the 11 Metro counties, including the counties with the largest ratios which are Wright (65 to 1) and Washington (75 to 1). Services may be lacking for Minnesota's aging population, which according to the U.S. Census Bureau, numbered 594,266 in 2000 and is estimated to be 677,270 in 2010 (U.S. Census Bureau, 2000).

People of Poverty

People of poverty have specialized needs that cannot be ignored. Minnesota has a growing number of families who experience generational poverty (Minnesota Department of Demographics, 2007). It is impossible to establish a ratio between the people of poverty to licensees. The U.S. Census Bureau (2000) demonstrated that there were 380,476 Minnesota individuals living in poverty in 2000. Using this total and the Minnesota Department of Human Services recommended caseload size of 30 adult clients to 1 worker, the state would need a total of 12,684 licensees to work with Minnesota residents who are living in poverty. Again, not everyone who is living in poverty requires services from a licensee, and some are currently served by county workers who are not licensed. If services were provided at the recommended caseload size, it may be that the number of people in poverty would decrease in the following categories:

- * Number of children requiring special education
- * Number of children assessed by Child Safety and Permanency workers
- * Number of children and adults receiving mental health services
- * Number of children in foster care
- * Number of children and adults with physical and cognitive impairments
- * Number of adolescents in the juvenile court or corrections system
- * Number of ethnic minority individuals represented in the corrections system

According to the U.S. Department of Health and Human Services, the threshold of poverty for a family of three is \$17,600 per year. Given this threshold and the number of people in poverty in 2000, it is not surprising that Minnesota's families and individuals of poverty are over-represented within the social and human services systems.

People Who Are Homeless

According to the Wilder Research Department (2007) in October 2006, "There were 2,726 children who were homeless with their parents, and 1,951 who were affected by a parent's homelessness" (p.27). The longer a child is exposed to a disruptive environment may create a greater risk for the child to have:

- * difficulty at school
- * mental health issues
- * physical health concerns
- * substance abuse or dependency
- * exposure to human trafficking
- * unemployment as an adult
- * legal problems

It is impossible to empirically state the number of licensees or non-licensed county workers who work with children in Minnesota who are homeless or affected by homelessness. But, one presumes that if the same ratio recommended by the Child Welfare League (11 to 15 children per worker) is applied in Minnesota, the human and social service agencies (public and private) do not have the financial resources to dedicate 312 licensees for this population group.

Cost of Social Work Education and Annual Salary Concerns

As stated earlier, these issues regarding shortages of licensees should not be viewed as the Board's singular responsibility. The cost of living, education, and annual salary (a shared responsibility) are major considerations for people entering into higher education or remaining in social work practice. The annual salary of the licensee with a bachelor's degree would be reduced to about \$17,484 after subtracting the cost of housing and education. This gross annual amount does not include taxes, food, transportation, health care, insurance, clothing, or other necessities of life; and a second means of income is often required.

The individual who enters into a master of social work program is often not compensated accordingly through the social and human services system in Minnesota. An example of this is the lack of differentiation by the Minnesota County Merit System between a bachelor's and master's salary. Although many individuals enter into the practice of social work due to the desire to improve the quality of life for others, social work salaries which are low in comparison to other professions often result in high turn over rates or low number of initial enrollment into the profession.

This financial consideration is not the responsibility of the Minnesota Board of Social Work but rather an overlapping responsibility of the federal, state, and local governments, as well as a function of public and private market issues.

Shortage of Graduates

It is estimated that there will be 2,626 BSW graduates in the next five years (2008-2012), and 1,504 Licensed Social Workers (LSWs) who have discontinued their licenses for a variety of reasons (emeritus, expired, or voluntary terminated). The Minnesota Social Work Programs estimate that there will be 1,720 MSW graduates between 2008-2012. The following totals are the number of master's licensees who have discontinued their licenses: 244 LGSWs, 206 LISWs, and 417 LICSWs between 2002 and 2006. The number of discontinued licensees is 2,308, while the number of estimated graduates is 4,546. One might conclude that there is no shortage of licensees. Yet, there is no way to calculate the number of graduates who do not remain in the state, practice social work, or decide to become licensed. Given the previously mentioned shortages, one can presume

that the estimated number of graduates and the number of individuals who discontinue their licenses is not meeting the needs of the state.

Estimated Minnesota Population Growth and Licensees

The Minnesota Department of Demographics (2007) estimates the state's population will increase by 10% in 2015 with the greatest growth occurring in the Metro counties, South Central, and Southeastern Minnesota. The previously identified shortages demonstrate the greatest lack of licensees is in Greater and Rural Minnesota. The Board of Social Work might consider recommending to the Minnesota Legislative Health and Human Services Committees, Minnesota Department of Human Services, County Human Services Agencies, and other stakeholders to examine alternative means of providing services to areas of Greater and Rural Minnesota with decreasing population growth and including the reimbursement of these alternative means of service delivery.

Shortages: Requires Multifaceted Systematic Plan

The dilemma of shortages of persons licensed as social workers within the state of Minnesota is a complex multifaceted issue and cannot be solved solely by the Minnesota Board of Social Work. Nor is this a recent development, rather this issue has been present for decades. This social and human services setback requires multifaceted systematic plans that involve the clients, Legislature, Governor, consumer advocate organizations, social work education programs, social/human service agencies, and the Minnesota Board of Social Work.

Is the Shortage of Persons Licensed as Social Workers a Dilemma for Minnesota?

Health professionals, such as physicians, nurses, psychologists, and physical therapist have been regulated by state boards for decades. The primary purpose of regulatory boards is the protection of the public from practices that may be considered harmful, unethical, incompetent, or outside the scope of the practitioner's practice. Consumers who work with social work licensees are often requesting services that involve the same issues dealt with by other licensed health professionals. Examples include:

- * A child or vulnerable adult facing abuse or neglect
- * A person 65 or older who does not understand how to use Medicare for their benefits (medication)
- * A person with mental illness who requires the skills to cope with hallucinations,
- * An adolescent who has sought attention or companionship through gang involvement
- * A homeless person who needs services to meet basic needs
- * A student who is struggling with depression
- * An environmental disaster
- * A person with cognitive impairments who is attempting to live in a community safely

These examples just begin to touch on the ways licensees affect clients' lives on a daily basis. Clients who either seek or are forced to work with human and social service agencies are among the most vulnerable and possess some of the most multilayered and complex matters. Minnesota is a progressive state that believes in the "best services for its citizens," which includes the provision of human and social services by licensees who have proven minimum competency and are willing to practice within the profession's licensing standards of practice.

At times, policy makers in Minnesota indicate that counties and the Minnesota Department of Human Services have grievance procedures in place. These grievance procedures deal with the implementation of county or state policies, procedures, and to a limited degree, minimum competencies.

Why Does Minnesota Need Workers with Social Work Degrees?

At times different disciplines, the general public, or other professionals make comments such as: "anyone can practice social work" or "I am a social worker" (but the person does not have a degree in social work). The Council on Social Work Education (CSWE) has established standards which each social work program must meet to be accredited or reaccredited. The curriculum for social workers includes knowledge, skills, and values. Dr. William A. Anderson (2004) of the Social Work Department at Minnesota State University, Mankato did a comparison of the undergraduate social work degree with a degree in psychology or sociology. Table 5.3 demonstrates this comparison. The social work degree provides the education that matches the required knowledge, skills, and values of the social and human service agencies.

Comparison of Bachelors in Social Work to Two "Related" Degrees

Table 5.3

William A. Anderson, MSW, PhD, LISW			
Content areas in accredited social work programs	Presence of required content in Social Work, Psychology & Sociology Degrees:		
	Social Work (a professional program)	Psychology (a liberal arts degree)	Sociology (a liberal arts degree)
1) Knowledge of history & values of social welfare	Extensive coverage forming a foundation for rest of curriculum	Not included	May be mentioned in a "Social Problems" course
2) Knowledge of human development from a social systems perspective	Required coursework in development across the lifecycle, integrated with systems approach	Some coverage in "Developmental Psych" but without study of the social environment	Not included
3) Knowledge of human diversity, racism, & sexism	Required coursework plus inclusion in all skills courses	Not required, possibly an elective in "individual differences"	Brief mention in Introductory course, possibly an elective
4) Knowledge of professional social work values & ethics	Focus on national and state ethical codes and links to practice	Not included (Ethics for Psychologists would be a graduate level topic)	Possible mention of research ethics; no coverage of prof. ethics
5) Social welfare policy analysis skill	Required coursework on welfare policy issues	Not included	Possible mention of policy issues
6) Program eval. & practice research skills & experience	Required coursework on research, with applied skills in evaluation	Lab research and single-subject design; no program evaluation	General research skills but no focus on applied evaluation
7) Intervention skills for working with individuals, families, groups, and communities	Required Methods courses for working with all sizes of client systems with a focus on skills and knowledge building	Generally not covered at the undergraduate level (reserved for graduate training in clinical psychology)	Possible mention of community activism but no social work skills training
8) Supervised field experiences in social work agencies	Required minimum of 440 hours of supervised fieldwork (most do more)	Field experiences are generally not required (esp. in social agencies)	Field experiences are generally not required (esp. in social agencies)

Researcher's Recommendations

The Minnesota Board of Social Work by statute has limited control over the underserved communities served by persons licensed as social workers. Yet, the Board is required to provide information and education as to the depth of the problem.

Therefore, the following are a few of the researcher's recommendations to the Board:

- Board may decide to establish a plan to meet with state stakeholders to provide education on the Board's primary goal to protect the public. (Such as: cultural communities and cultural advocates, advocates, policy-makers, and consumers) Greater and Rural Minnesota and Metro areas should be presented with equal group representation.
 - This plan should include yearly educational workshops provided by both Board staff and Board members.
- Board might consider the distribution of this report to other interested stakeholders such as:
 - Social work educators, social work associations, and consumer groups.
- Board might work with stakeholders to develop a plan to eliminate the state and county social work licensure exceptions to insure that vulnerable populations are provided services by licensed professionals who have demonstrated minimum competencies.
- Board may consider repeating this study in about 10 years for comparison with this baseline data.
- Board may consider educating the general public regarding the roles and responsibilities of social workers. (Social workers are not just CPS workers. Early intervention.)

The state government and human social services organizations also have responsibilities in the development of plans to address this issue. The state government and human social service organizations should consider working with the federal government for:

- The full or partial forgiveness of educational student loans for persons licensed as social workers.
- Third party reimbursement of qualified licensing practice supervision.
- Minnesota Department of Human Services, County Human Services Agencies, and other stakeholders to examine alternative means of providing services to areas of Greater and Rural Minnesota with decreasing population growth and including the reimbursement of these alternative means of service delivery.
- Minnesota Council of Social Work Educators is encouraged to develop a state wide strategic plan to address the shortage of ethnic minority populations entering into social work educational programs.

- Minnesota Council of Social Work Educators is supported by the Board in the development of a dialogue with stakeholders to address the need to increase the number of graduates who are eligible to sit for the license examination.

Conclusion

In conclusion, Minnesota is facing a need to increase the number of persons licensed as social workers. This responsibility falls on many governmental and non-governmental groups. If the increasing ratios of clients to workers or caseload sizes are not addressed in the near future, the human and social service outcomes will not include the provision of “best practice” for clients. The client service delivery system may be reduced to triaging crisis to crisis.

This report has demonstrated that there is a high need for persons licensed as social workers within Minnesota. The greatest need is in Greater and Rural Minnesota. All of the identified fields of practice are facing a shortage of licensees and this need will continue grow. There is also a necessity for licensees in the 11 Metro counties specifically in the fields of aging, poverty, homelessness, corrections, and working with individuals and communities of ethnic minorities.

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APPENDIXES