STATE OF NEVADA

BOARD OF EXAMINERS FOR SOCIAL WORKERS (BESW)

4600 Kietzke Lane, Suite C121, Reno, Nevada 89502
775-688-2555

PUBLIC NOTICE OF BOARD MEETING

9:00 am on Wednesday, August 17, 2022

BESW strives to maintain government transparency and protect public safety. We are offering a virtual option for attendance via Zoom conference. Cameras will be on for the duration of the meeting. Supporting materials will be available electronically at the BESW website: http://socwork.nv.gov/board/Mtgs/.

***NOTE: Per Open Meeting Law, before speaking, please state your full name for the record.**

The Board of Examiners for Social Workers is inviting you to a scheduled Zoom meeting.

Date and Time: August 17, 2022, 09:00 AM Pacific Time (US and Canada).

Invite Link: https://us02web.zoom.us/j/82300370179

Meeting ID: 823 0037 0179

One tap mobile
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Find your local number: https://us02web.zoom.us/u/kbWBJpSZ2u

Please Note: The Board of Examiners for Social Workers may address agenda items out of sequence, combine the agenda items, pull, or remove the agenda items, to aid the efficiency or effectiveness of the meeting or to accommodate persons appearing before the Board. The Board may continue agenda items to the next meeting as needed. (NRS 241.020)

Public comment is welcomed by the Board and will be heard at the beginning of the Board meeting following the Call to Order and Roll and at the end of the agenda prior to the adjournment of the Board meeting. Public comment may be limited to three (3) minutes per person. The Board meeting Chair may allow additional time to be given a speaker as time allows and at his/ her sole discretion. Once all items on the agenda are completed the meeting will adjourn. Prior to the commencement and conclusion of a contested case or a quasi-judicial *proceeding that may affect the due process rights of an individual, the Board may refuse to consider public comment. See NRS 233B.126.*

AGENDA

Items may be taken out of order; Items may be combined for consideration by the public body; Items may be pulled or removed from the agenda at any time; the public body may place reasonable restrictions on the time, place, and manner of public comments, but may not restrict comments based upon viewpoint.

Pursuant to NRS 241.030 the Board may conduct a closed session to consider the character, allegations of misconduct, professional competence, or physical and mental health of a person.

1. **Call to Order, Roll Call.**

2. **Public Comment.**
   Note: No vote may be taken upon a matter raised under this item of the agenda until the matter itself has been specifically included on an agenda as an item upon which action may be taken. (NRS 241.020). Public comment may be limited to three (3) minutes.

3. **Board Operations:**

   A. **Review and Discuss July 20th, 2022, Board Minutes. (For Possible Action).**

   B. **Review and Discuss BESW Licensure Processes and Other Items Regarding Workforce Shortages in Mental Health Professions. (For Discussion Only).**
      i. "Understanding the Challenge of Significant Shortages in All Mental Health Professions" – Updated Report.
      ii. State of Nevada Commission on Behavioral Health Letter to the Governor Approved July 28, 2022.
      iii. Division of Child and Family Services, Nevada Children's Behavioral Health Consortium Meeting Minutes, April 7, 2022, Approved August 4, 2022.
      iv. Post-Graduate Internship Program - 3 Issues for Consideration.

   C. **Board Review of Hearing for Virgilio DeSio, License No. 6200-C. (For Possible Action).**

   D. **Association of Social Work Boards Updates.**

      i. **Stacey Hardy-Chandler, Ph.D., J.D., LCSW, named ASWB's next CEO** – Handout (Informational).
      ii. **Dr. Langston Report from the ASWB Special Meeting of the Online Delegate Assembly**. (Informational).
         - Related Handout: 2022 ASWB Exam Pass Rate Analysis.
         - Findings in Nevada, Deputy Director Sandra Lowery.
      iii. **Online Engaging with ASWB Session on August 18, 2022, for Social Work Licensing Compact Development Updates** - Registration is open to ASWB member Board Members and staff only; no registration fee to attend the sessions.
      iv. **Review and Discuss Selection Attendee at New Board Member Training Session, ASWB Pre- Approval of Dr. Langston for September 15-17, 2022.** (For Possible Action).

v. **Review and Discuss Selection of Delegate for ASWB 2022 Annual Meeting of the Delegate Assembly – November 18-19, 2022, Scottsdale, AZ.** (For Possible Action).
- Serving as a Delegate Handout.

E. Review and Discuss Board Compensation Payment Process. (For Possible Action).

F. Executive Director's Report (Informational).

i. NASW Conference and More Handout; and
ii. Pending Litigation Matter in the United States District Court for the District of Nevada - Case No. 3:20-cv-571-MMD-WG; and
iii. Contract with Lobbyist/ Consultant Flynn Giudici Government Affairs, LLC; and
iv. Future Agenda Items: 1) Address items outlined by previous auditor; 2) Revisiting relinquishments; 3) NRS and NAC changes; (4) Financial Management of Board's Reserves (Checking accounts, Savings accounts, Money market deposit accounts, Certificate of deposit accounts; and etcetera; and
v. Next Board Meeting is 9 a.m. Wednesday, September 21, 2022.

4. Public Comment.
Note: No vote may be taken upon a matter raised under this item of the agenda until the matter itself has been specifically included on an agenda as an item upon which action may be taken. (NRS 241.020). Public comment will be limited to three (3) minutes.

5. Adjournment.

Please contact Karen Oppenlander, LISW at (775) 688-2555 for information regarding the meeting. Supporting materials can be accessed electronically at the BESW website: http://socwork.nv.gov/board/Mtgs//.

This notice has been posted at the office of the Board of Examiners for Social Workers; the Board's Web Site www.socwork.nv.gov; and the State of Nevada's Public Notice Website http://notice.nv.gov.

3A

July Board Meeting Minutes

Understanding the Challenge of Significant Shortages and Other Items Regarding Workforce Shortages in Mental Health Professions

3B-ii

State of Nevada Commission on Behavioral Health Letter to the Governor Approved July 28, 2022

The Honorable Governor Steve Sisolak

Office of the Governor

101 North Carson Street, Suite 1

Carson City, Nevada 89701

June 23, 2022

Dear Governor Sisolak,

In accordance with NRS 433.14, the State of Nevada's Commission on Behavioral Health has prepared an update of Nevada's ranking in the areas of mental and behavioral health along with a summary of the annual reports of the Regional Behavioral Health Policy Boards and Children's Mental Health Consortia. While we are beginning to emerge as a nation, as you and every Nevadan are aware, the COVID-19 pandemic continues to have a profound impact. For Nevada's citizens, both young and old, it has fostered an environment where grief, isolation, loss, and fear has elicited mental health conditions or exacerbated existing ones.

While there is much to be hopeful about in our continued fight against COVID-19, we surmise that the overall ramifications of the pandemic will be long-lasting and will be evidenced by increases in the mental and behavioral health needs of Nevada's citizens. For this reason, the role and work of this Commission, Regional Behavioral Health Policy Boards, and the Children's Mental Health Consortia are vitally important. As you consider programming and critical next steps in the State's ongoing role in the provision of mental and behavioral health services, our hope is that the work summarized here will help guide future decision-making, particularly as critical funding decisions are made.

The COVID-19 pandemic and subsequent shutdowns have been associated with significant increases in mental health symptoms for Americans. CDC data shows younger adults, minorities, essential workers, and unpaid adult caregivers reported having experienced increased substance use and elevated suicidal ideation. While the long-term impact of COVID-19 on mental health remains unknown, it is unlikely that Nevada is fully prepared to address any increase in service demand that is likely to come as a result. Even prior to the COVID-19 pandemic, Nevada consistently ranked poorly with regards to prevalence of mental illness and corresponding access to care. In fact, Mental Health America (https://mhanational.org/) ranks states according to prevalence of mental illness and access to care (higher rankings indicating higher prevalence and lower access to care). In 2022, Nevada again ranked 51st overall, and received an improved ranking of 40th for adults, up from 47th in 2021, but remained with no improvement at 51st for youth. The 2022 MHA report highlighted Nevada as one of three states with the largest improvement ranking (46th to 39th) for youth with private insurance that did not cover mental or emotional problems, a decrease from 12.6%-7.1%. While this is welcome news and its evidence that mental health services are continuing to gain in recognition with insurers, access to care remains a significant challenge in all regions of our state. The data collected for the purpose of these rankings is varied, and comes from a variety of public sources, including from the Nevada Division of Child and Family Services (DCFS) and the Nevada Division of Public Behavioral Health (DPBH). Adult mental health indicators contributing to the ranking

include the following: adults with Any Mental Illness (AMI); adults with substance use disorder in the past year; adults with serious thoughts of suicide; adults with AMI who are uninsured; adults with AMI who did not receive treatment; adults with AMI reporting unmet need; and adults with disability who could not see a doctor due to costs. Youth mental health indicators contributing to the ranking also include the following: youth with at least one Major Depressive Episode (MDE) in the past year; youth with substance use disorder in the past year; youth with severe MDE; youth with MDE who did not receive mental health services; youth with severe MDE who received some consistent treatment; and students identified with emotional disturbance for an Individualized Education Program (IEP). Ultimately, the rankings again demonstrate a great need in Nevada to address the mental and behavioral health needs of its population, and more specifically to address critical access to care issues.

Collectively, the Commission, the Regional Behavioral Health Policy Boards, and Children's Mental Health Consortia are all acutely aware of the challenges documented by Mental Health America regarding the state of mental healthcare in Nevada. The reports of the Nevada Regional Behavioral Health Policy Boards and the Children Mental Health Consortias address both prevalence of mental health disorders as well as access to care in their annual reports and strategic plans. Further, they address the State's need to focus and prioritize the development of a skilled, qualified mental and behavioral health workforce, which includes ensuring Medicaid reimbursement rates are reasonable and encourage provider participation; ensuring adequate crisis response in urban, rural, and frontier areas of the State; increasing access to supportive services, which includes addressing housing, transportation, and the development of competent, reimbursable paraprofessional programs and services, like those that could be offered by community health workers.

Adult Behavioral Health

Northern Region:

NORTHERN REGION PRIORITIES, STRATEGIES, AND RECOMMENDATIONS SUMMARY

The following priorities are presented to include underlying needs and gaps, strategies utilized by the Northern Board, and recommendations from the Northern Board for forward progress.

1. **Regional Board infrastructure development** - Several areas have been identified where additional infrastructure could lead to greater efficiency as the Northern region works to develop a more sophisticated behavioral health system.

   Strategies: Explore Regional Behavioral Health Authorities – In May 2022, the Northern Board established a formal multidisciplinary subcommittee to explore concepts for regional behavioral health authorities and models to increase system efficiency/ The Northern Board developed and submitted a concept paper for Regional Behavioral Health Authorities to DHHS to express their intent. (Please see the Northern Region's white paper of Behavioral Health Authorities at https://nvbh.org/northern-behavioral-health-region/). Sustain Board Support Positions – advocate for sustainable funding for Regional Behavioral Health Coordinator and regional data analyst positions. These positions provide the support necessary for the Board to fulfill duties described in NRS 433.4295. Implement Northern Region Behavioral Health Emergency Operations Plan (BHEOP) – Support local emergency management agencies in formally adopting the regional BHEOP approved by the Board in early 2021. Implement after-actions identified in 2022 regional BHEOP tabletop exercise, including expanding awareness to psychological first aid training.

2. **Affordable and supportive housing and other social determinants of health** - The region's communities are experiencing many individuals who have behavioral health issues and are homeless. These individuals with complex needs deteriorate on the street or become stuck in hospitals or jails for long periods of time with no safe discharge plan available. In addition, the board sees a gap in resources to address social determinants of health. There is no supportive housing aligned with best practice for residents with mental health issues in the region.

   Strategies: The Board established a formal subcommittee to address affordable and supportive housing solutions in January 2022. The Northern Region Behavioral Health Housing Subcommittee established the following recommendations that were adopted formally by the Northern Regional Behavioral Health Policy Board on May 5, 2022 : Advocate for the State to fund regional housing assessments and systems modeling by organizations such as Corporation for Supportive Housing, recommend the Nevada Division of Housing consider equitable distribution of the $500 million Home Means Nevada Housing initiative dedicated to supportive housing to create opportunities for all five behavioral health regions, advocate for sustainable supportive housing, support State and local agencies in the development of 1915i and other applicable home and community-based programs to encourage people-centered services.

3. **Behavioral health workforce with capability to treat adults and youth** - The Northern Region faces significant barriers caused by a lack of behavioral health workforce and difficulties that behavioral health professionals encounter in becoming in-network providers for insurance reimbursement. This gap impedes timely access to treatment and prevents providers from expanding quality services. In addition, the Northern Board recognizes that the community health worker (CHW) and peer recovery support specialists (PRSS) are underutilized in the behavioral health workforce pipeline.

   Strategies: The Northern Board supports a tiered approach for a calibrated mental health system that includes a robust relationship between clinicians, CHWs and PRSSs. Following this model, the Northern Board has been exploring strategies to increase the clinical workforce and expand use of CHWs and PRSSs to bridge the gaps caused by lack of clinical providers. Recommendations: Support local agencies facilitating CHW and PRSS workforce development, expand Medicaid reimbursement to include all behavioral health clinicians as community health worker supervisors, provide incentives for providers in rural areas, evaluate network adequacy and efficiency for insurance company credentialing, support family caregivers through access to reimbursement, respite services, and training across the lifespan.

4. **Development of a sustainable regional crisis response system that integrates existing local crisis stabilization, jail diversion and reentry resources (MOST, FASTT, CIT, and Carson Tahoe Mallory Crisis Center)** - The Northern Region has made significant progress in addressing gaps in crisis response services through the following community-based crisis stabilization, jail diversion and reentry programs: Mobile Outreach Safety Teams (MOST), Forensic Assessment Services Triage Teams (FASTT), Crisis Intervention Team (CIT) Training, and Carson Tahoe's Mallory Crisis Center. (Please see https://nvbh.org/education/ for more information on these programs.) In addition, there is a need to coordinate local infrastructure into the state crisis response system with the implementation of the 988 system.

   Strategies: While progress is being made in obtaining sustainable funding for these programs, the Northern Board continues to hold this as a priority until long term program sustainability is achieved. The Board wrote a position statement on behalf of the region's crisis response system which can be found here on the Statewide Regional Behavioral Health Policy Board's website: https://nvbh.org/northern-behavioral-health-region/. In addition, the Northern Board recommends developing sustainable Medicaid reimbursement rate and other funding sources to

sustain Assertive Community Treatment (ACT) and First Episode Psychosis (FEP) programs, develop 988 infrastructure in coordination with local agencies. Further, the Board supports Certified Community Behavioral Health Centers (CCBHCs) in providing full range of services in coordination with communities.

5. **Increase access to treatment in all levels of care** - Stakeholders in the region identified lack of insurance as a barrier for access to behavioral health care. Furthermore, there is significant concern about access to care for youth and adults who have insurance. While there is no quantitative data on this, there are many stakeholder reports of struggling to obtain outpatient appointments for youth and adults. They also report not having adequate access to intensive outpatient treatment for youth and inpatient treatment for youth as many youths are waiting in hospitals for acute psychiatric treatment. Notable gaps in the region are the lack of intensive in-home services, crisis stabilization centers, and respite care for youth.

   Strategies: In exploring access to care issues for individuals who are under-insured or lack insurance, the Northern Board identified some opportunities to connect uninsured individuals with care, including the youth trauma recovery grant and the region's Certified Community Behavioral Health Centers (CCBHCs). The Northern Board is planning to continue to learn more about the topic including solutions for underinsured individuals and increasing use of CCBHCs. The Northern Board is also interested in exploring other models of care including peer drop-in centers, living room models, respite care, and community support centers.

6. **Develop services to support continuity of care (i.e., continuation of medication/ service connection with community health worker)** - For years, stakeholders in the Northern Region have identified issues with continuity of care across the continuum. There are barriers in linkages to care that include lack of formalized referral systems, lack of coordination and communication, and limited provider capacity.

   Strategies: The Northern Board is very interested in utilizing community health workers to address challenges in continuity of care for individuals with behavioral health issues. The Board recommends formal agreements between CHWs and various existing programs such as Nevada Healthlink, OpenBeds, and hospitals. The Northern Board also plans to identify other strategies, such as peers, to support discharge planning and continuity of care in the region and investigate structural solutions to strengthen warm hand offs.

Rural Region:

Recommendations to the Commission on Behavioral Health:

I. Increase investments in Nevada Medicaid reimbursement for behavioral health services.

   Ongoing business closures and other restrictions related to controlling the spread of COVID-19 in Nevada heavily impacted state budgets, the need for behavioral health services by Nevadans covered by Medicaid have been more dire than ever. Improving investments in these services now may help to mitigate more long-term negative effects to population mental health and substance use outcomes across the state in the wake of the COVID-19 pandemic.

II. Increase resources and program choices to address the needs of high-risk populations, including youth, the elderly, and ethnic or racial minority groups. Specific populations had been seeing greater issues related to behavioral health in Nevada previous to the COVID-19 pandemic, much of which has been exacerbated during the pandemic response. These groups include the elderly, children, adolescents, and young adults of all racial or ethnic groups, as well as BIPOC communities specifically. Programs and policies to address these needs must focus on being culturally competent (or moreover, culturally respectful) and age appropriate (including use of technology).

III. Support programs that assist and support service members, veterans, and their families (SMVF) in a way that is competent to military culture.

IV. Support programs and funding that would increase the number of behavioral health providers across the state of Nevada.

V. Support behavioral health transportation solutions and pilot programs.

Data Highlights:

- All counties in the Rural Region have inadequate local availability of licensed Alcohol and Drug Counselors, Clinical Alcohol and Drug Counselors, and Certified Problem Gambling Counselors.
- All counties in the Rural Region have inadequate local availability of Licensed Marriage and Family Therapists and Licensed Clinical Professional Counselors.
- There are no licensed psychiatrists located in any counties included in the Rural Region.
- There is only one licensed psychologist located within the Rural Region, in Elko County.
- There are 29 Licensed Clinical Social Workers located within the Rural Region; 20 of which are in Elko County.

Behavioral health concerns related to COVID-19:

- Increased mental health crisis in hospital emergency departments.
- Increased alcohol and substance use
- Increased intentional overdoses.
- Increased stress and burnout in front-line workers
- Increased depression and suicidality among youth
- Increased isolation among home-bound and geographically isolated persons.

Clark County Region:

This summary has been prepared with data from 2021 provided by the Clark Regional Behavioral Health Policy Board (CRBHPB). The data collection period covers January through December 2021.

Due to the continued impact of COVID-19, the Board met virtually five times through web-based video conferencing, with additional accessibility through teleconferencing, in compliance with NRS to accomplish its mission this year. Accordingly, the Board has also determined to continue video and teleconferencing until further notice.

The COVID-19 public health crisis and interrelated events resulted in the Board maintaining its previous top four priorities from those identified in 2021 and emphasizing recovery. However, for 2022, the Board also voted to add a fifth priority to address behavioral health and wrap-around services for individuals experiencing homelessness.

The Clark Regional Policy Board continues to embrace a data-driven approach to identifying the region's behavioral health needs and system gaps. In a review of the data, workforce-related issues, with cluster aspects of recruitment and retention, significantly influence the first three priorities. This is unchanged from their previous report and is consistent with public comments of stakeholders statewide made during regular Commission Meetings. Therefore, the Board and the Commission on Behavioral Health believe the below identified recommendations are a top priority for the Clark region:

- Mental health oversight agency and workforce development issues.
- Dedicated funding for crisis services for children and adults.

- Residential treatment services for youth.
- Increasing collaboration on the spectrum of substance misuse and its relation to mental health.
- Identify wrap-around services for individuals experiencing homelessness and mental health crisis.

Clark County represents the largest county by population in Nevada. Therefore, the following data was collected and analyzed to understand better the impact of the priority recommendations submitted by the Board:

- Clark County population 2,226,715
- Approximately 73% of the whole state of Nevada
- 15.1% of the population is 65 and over
- 56% of the population is an ethnic minority
- Young adults and children make up almost half the entire population
- An estimated 20% of the population experience ten or more poor mental health days and categorize themselves as having unfavorable mental health
- Significant increase in unintentional or undetermined overdose-related deaths for youth under eighteen followed closely by young adults.
- Significant need for inpatient and outpatient beds that are left unmet
- Clark County, on average, has 21 child and adolescent psychiatrists per 100,00; the national average is 89.
- Alcohol and substance misuse continue to rise
- Clark County coroner data attributes 219 deaths to fentanyl overdose

Workforce Development for prevention and intervention services for youth and adults continues to be a priority for Southern Nevada, as it remains below the national average of providers per capita. The Board recommended the following:

- DHHS and DPBH review the allocation of funds to meet the identified needs for the Clark Region.
- Address the region's counselor-to-patient ratio by attracting counselors from out of state.
- Mainstream the application process for a behavioral health professional to become licensed.
- Review the Medicaid reimbursement rate and processing time to align with more competitive states.
- Add incentives for providers who serve high-risk populations and utilize peer support specialists.

The need for continued and expanded crisis services in Clark remains a priority. The Board, encouraged by the Commission on Behavioral Health, supports increasing the community's access to and availability of comprehensive crisis support, especially for those efforts that reduce over-reliance on emergency rooms, hospitals, and the criminal justice system. Still, in Clark County, only one mobile crisis unit exists, which serves only one zip code located in Downtown Las Vegas and responds to thousands of calls annually. In addition, the Department of Health & Human Services Division of Child & Family Services provides one mobile crisis team (MCRT) for youth and families in crisis.

The Board identified the Crisis Now model, which utilizes a non-hospital like an environment to provide urgent behavioral health services, as an evidenced-based good practice to serve the community better. This model creates a home-like environment for individuals that need services that are not restrictive and provides clinical and medical services with added peer specialists. The Crisis Now model, in conjunction with the Crisis Intervention Team (CIT) model, can safely and effectively provide needed crisis services that divert an individual from emergency rooms, hospital admissions, and jails.

The Board, DHHS, and DPBH should review, develop, and implement a plan for working with community partners to model Crisis Now services. Crisis services with adequately trained staff and good options for behavioral health treatment and follow-up can reduce the number of emergency room visits. The average number of patients waiting in emergency rooms for Behavioral Health Services continues to rise yearly. In 2021 data from the U.S. Labor Statistics rated Nevada second in the nation for the highest number of workers quitting jobs. Many health care professionals are experiencing high burnout and long hours with little incentives. Other professions have offered remote work, but this is not the case

for in-person medical staff. The shortage of staff and increased emergency rooms can leave a patient not receiving adequate behavioral health care or limited options for follow-up. Crisis care can help an individual get on the right track while in crisis.

Regarding residential treatment services for youth, there is little change concerning data and costs associated with the placement of youth into treatment centers. In the 2021 report, a 12-month analysis revealed over $7,000,000 was spent on out-of-state placements despite a decrease in the monthly cost of treatment. This amount was more than what Nevada paid for in-state residential treatment during the same reporting period. Part of the Clark County Children's Mental Health Consortium's 10-year plan calls for reducing the reliance on out-of-state and out-of-community placements for services or treatment of youth with Serious Emotional Disturbance (SED). Compounding the ability of the CCCMHC to reach this goal is the fact that the Clark County Department of Family Services is experiencing staff reductions while encountering children and families with higher needs of care. This has resulted in children not having the support or services available to provide services adequately.

The Clark Regional Behavioral Health Policy Board and the Clark County Children's Mental Health Consortium, supported by the Commission, suggest creating more intensive community-based services to enhance the existing system of care. While the ideal situation is for a child(ren) to remain with families and caregivers, increased collaboration and funding options for local and state services will need to align with the severe needs of children who require a higher level of care to stay safe to themselves and within their community.

The National Institute on Drug Abuse recognizes that about half of individuals who develop substance abuse disorders are also diagnosed with mental disorders and vice versa. As such, the Board understands and acknowledges the need to address substance abuse and misuse to address behavioral health concerns more effectively, as these issues are often co-occurring. Therefore, the Commission encourages the Board's desire to build bridges connecting prevention, treatment, and recovery providers to mental health professionals to create innovative solutions and system change.

The Clark Regional Behavioral Health Policy Board, supported by the Commission, supports efforts to improve public education and awareness of substance misuse and prevention. Due to prejudice or discrimination, many individuals are unwilling to seek mental health and substance misuse treatment. Breaking down biases through education encourages individuals to meet with health care professionals and openly discuss treatment options, recovery support, and connections to services. In addition to a treatment option, prevention has long-lasting economic benefits and averts injuries, disabilities, and deaths caused by misuse. The U.S. Surgeon General's office reports that evidence-based intervention returns $58 for every $1 spent.

The return on investment could have significant implications for public safety and criminal justice system costs. In a 2021 study by Applied Analysis, the increased demands of the growing community and the lack of available beds for both substance abuse and mental health issues are bombarding the system. On average, the Clark County Detention Center (CCDC) processes 70,000 inmates yearly, with 30 percent of that population experiencing a mental health need. In conjunction with substance misuse, the large volume of inmates makes it nearly impossible to provide comprehensive treatment while in custody. Identifying issues while in custody may be the only opportunity for linking someone to a diversion program that would better suit their needs versus imprisonment. Often, individuals serve their time and are released with little understanding of an action plan, therefore having a higher likelihood of repeating the cycle. The Board will continue monitoring public health trends like this to make effective current and relevant recommendations.

Washoe County Region:

Given the unprecedented and historic times we are living in with the Covid 19 pandemic, the coming year(s) may be dramatically different, and the strategies may pose potential fiscal, programmatic, and logistical challenges. The Board continues to note that Nevada remains at the bottom of many national indices for behavioral health care and recommends the support for the adult behavioral health issues that were prioritized for 2021 and are summarized below:

- Crisis Response/Stabilization
- Equitable Response to Substance Misuse
- Behavioral Health Emergency Response
- Diversity and Inclusion
- Mental and Behavioral Needs of Children
- Behavioral Health Workforce

Crisis Response/Stabilization: The WRBHPB recognized the need for crisis response and stabilization in Washoe County, individuals and families experiencing a behavioral health crisis need to be supported by a crisis response system that provides a continuum of services to stabilize and engage anyone in crisis and provide the appropriate, integrated treatment to address the problem that led to the crisis. A robust crisis response system ensures that every person in crisis receives the right response in the right place every time.

Strategy and Progress

A number of developments at the national level and within Nevada were focus around addressing behavioral health crisis and preventing suicides. The implementation of the new 988 as the three-digit call line for anyone experiencing a behavioral health crisis or suicidality. The 988 number went live across the country on July 16, 2022, which will lead to the enhanced/continued development of a crisis response system for Washoe region. The core elements of the crisis response system include a statewide crisis call center to manage the 988-crisis line, deployment and utilization of mobile crisis teams, and physical crisis stabilization centers.

The Washoe County Health District (WCHD) contracted with Social Entrepreneurs, Inc. (SEI) to support the implementation of a behavioral health crisis response system in the Washoe County Region including the City of Reno, City of Sparks, and Washoe County. The project's success depends upon the active involvement of key stakeholders, including those with lived experience, to design the state's first comprehensive crisis response system to address critical behavioral health needs of the residents of Washoe County. Stakeholders have been recruited in six areas, including a leadership Council of policymakers and a Technical Advisory Committee (TAC) of human services and finance professionals. In addition, four subcommittees composed of subject matter experts have been formed, as recommended by the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Guidelines for Behavioral Health Crisis Care. These components are required for a functional, coordinated, and comprehensive response to behavioral health crises and align with the project's subcommittees.

Equitable Focus on Substance Misuse: The WRBHPB recognized that efforts were lacking when addressing citizens with co-occurring disorders (mental health and substance misuse). Mental illness and substance use problems and illnesses seldom occurs in isolation, and they frequently accompany each other, as well as substantial number of general medical issues.

Strategy and Progress

The Board's contact with community stakeholders has identified the concern that the focus of the programs, funding, and policy creates inequity between mental illness and substance use problems. Understanding that the two are often co-occurring, the Board realized a need to work to ensure inclusion and collaboration with all sectors of behavioral health. The Board acknowledge and views the passage of SB69 as a successful completion of this priority area, however the Board will continue its support of the inclusion and focus on substance abuse issues within the region.

Behavioral Health Response: Before, During, and After a Crisis/Disaster/Health Crisis:

All disasters and emergencies have a behavioral health component. Following disasters, behavioral health problems may range from transitory distress followed by return to pre-exposure levels to the emergence of new disorders including Post Traumatic Stress Disorder (PTSD), anxiety, or depression. The disaster may also lead to the worsening of pre-existing conditions like Serious Mental Illness (SMI) in adults, Severe Emotional Disturbance (SED) in children, and co-occurring Substance Use Disorders (SUD). Awareness has grown in understanding that all who experience a disaster are affected to

varying degrees, individually and collectively. It is not uncommon for those affected (both victims and responders) to report disturbing feelings of grief, sadness, anxiety, and anger. The psychological effects of the disaster may be immediate or manifest months or years after the disaster. When a disaster occurs, normal day-to-day behavioral health services must continue in addition to the potential immediate and extended surge demand caused by the disaster. It is helpful if county behavioral health agencies pre-identify behavioral health responders from both the public (directly operated facilities) and private sectors that have disaster behavioral health qualifications, skill sets and training as part of regional health coalition activities. By identifying capabilities in advance, resources may be assigned so that the appropriate level of clinical support or intervention is provided at the incident site or other community setting.

Strategy and Progress

Discussion continues with the County Emergency Manager's office around the inclusion of the draft Washoe County Regional Behavioral Health Emergency Response Plan Annex with the Washoe County Regional Emergency Operations Plan. While the current health crisis provided lessons learned for moving forward in emergency and disaster planning, it also precluded the ability to exercise the plan given the restrictions and prevention strategies in place. We look forward to working with the State and other regions in the exercising of response plans.

Nevada Resilience Project (NRP): The Crisis Counseling Assistance and Training Program (CCP), rebranded in Nevada as the Resilience Project, is a short-term disaster relief grant for states, U.S. territories, and federally recognized tribes. The Resilience Project serves to provide early and immediate behavioral health support, triage, intervention, and referral of services in response to the impacts of COVID-19 on Nevada's population understanding that early triage, intervention, and referral to services can reduce the risk of mental health disorders for those impacted by COVID-19. The WRBH Coordinator currently provides high-level supervision and oversight to the Washoe team of Nevada Resilience Ambassadors (NRP). Resilience Ambassadors provide education, information, counseling, and resource navigation while promoting healthy coping, empowerment, and resilience. Resilience Ambassadors can provide support and connection to resources over the phone, through text and video-chat, or face to face.

They are able to offer bi-lingual access to services; assistance navigating to needed resources in the community; help to reduce stress, build coping skills, and develop a resilience plan. The effort is a collaboration between the State of Nevada (providing the current funding), the WCHD (providing daily Covid "positive" lists), and Washoe County HSA/Regional Coordinator providing high level supervision of ambassadors. The success of this project is substantial. The fact that every individual who is reporting positive for COVID-19 has or will be offered an opportunity to speak to a crisis counselor and obtain referrals for services as needed, is not only significant but potentially unprecedented for a disaster/event of this magnitude.

The Community Health Improvement Plan (CHIP), developed by the Washoe County Health District is a plan of action to address local conditions that are contributing to or causing poor health in Washoe County. Behavioral health was seen as a top concern cited by the community and is one that greatly suffers from lack of adequate resources and available workforce. The WRBHPB supports the efforts taken for the successful implementation of the CHIP.

Diversity and Inclusion

The behavioral health needs of minority communities have been historically and disproportionately underserved. Providers need to be sensitive to cultural issues and equipped with the necessary language skills that facilitate and promote effective service delivery. The proportion of behavioral health providers from diverse groups generally does not represent the proportion of those various diverse groups in the United States.

Strategy/Progress

Following SAMHSA's commitment to addressing these behavioral health workforce disparities, WRBHPB, seeks to identify and promote the effective retention strategies for prevention, treatment, and recovery support providers and providers who are or who serve members of racial, gender, and ethnic minority populations or other minority groups such as military members, veterans, and their families; lesbian, gay, bisexual, and transgender (LGBT) individuals; and American

Indian/Alaska Native tribal members. WRBHPB will continue to welcome presentations and education, studying the cultural attributes that affect our ability to reach and serve our community members.

Behavioral Health Workforce

Nationally, there is more demand for behavioral health (mental health and substance use) treatment than workforce capacity to deliver services which impacts timely access to treatment and prevents providers from expanding quality services. Regionally, the pandemic stressed an already overwhelmed behavioral health workforce. The region is fortunate to have many highly competent and committed professionals working hard to deliver behavioral health services, but barriers to educational attainment, professional recruitment, and long-term retention have been included in discussions around workforce development. The WRBHPB continues to support the study and discussion on how Nevada, and Washoe County can affect change to this growing need. The passage of SB69, which acknowledges the role peers can play in the workforce was a positive step.

Workforce Recommendations

The Commission is thankful for Governor Sisolak's attendance of the Healthcare Provider Summit on April 19, 2022. It was a great opportunity to meet with so many colleagues in the behavioral health field to discuss life and our work through the pandemic. It was heartening to hear how we were able to get through the pandemic together and explore ways to improve access to behavioral health services in our state.

One theme that was often heard during the summit was that there is a need to increase and build our behavioral health workforce and specifically licensed providers that are regulated by several different licensing boards. Each discipline (psychologists, nurses, social workers, marriage & family therapists, clinical professional counselors, and drug & Alcohol counselors) is working under their own board of examiners. It has been proposed in that these boards unite under a single board – this suggestion is alluring, but likely introduces several complications. Another solution that is more feasible is the boards aligning their guidelines to make the licensing of new providers more streamlined. If the process for licensure is easier to navigate Nevada is more likely to attract providers to our state. One example we heard during the summit is that a licensed nurse from out of state can apply for a temporary license in Nevada and be approved to work within just a few days – the same process for a licensed marriage and family therapist from out of state can take 3 months or more. Nevada's various boards of examiners should be sharing strategies to encourage and develop a licensed behavioral health workforce. The biggest opportunities we see for collaborating amongst the boards are in the areas of license reciprocity with providers moving to Nevada from out of state and supervision on new professionals seeking licensure in Nevada.

Regarding reciprocity – Nevada will continue to struggle with behavioral health workforce unless we make the process easier for fully licensed and experienced providers moving from out of state to obtain a license in Nevada. In this area it appears that the Board of Nursing in Nevada has been the most successful in providing out of state applicants a "temporary" license to practice in Nevada in just a few days until background checks and other administrative processes are cleared for full licensure in Nevada. Other state boards should look towards the nursing boards policies in this area. Additionally, there are several interstate compacts for licensing reciprocity in various behavioral health fields that Nevada should consider joining to increase the number of providers licensed in the state for behavioral health services.

Regarding supervision – there are two opportunities in Nevada to improve access to new providers seeking high quality supervision towards licensure. First is to standardize the training/process to become a supervisor in a given discipline. This process is often convoluted or daunting to professionals that would otherwise qualify to supervise state interns, but do not do so because the process is confusing. In this area the board of examiners for drug and alcohol counselors seems to be most successful in offering a standardized training program through state sponsored CASAT to meet the qualifications to supervise interns in Nevada. Other state boards should consider a standardized and easily accessible training to certify supervisors in their discipline.

Another innovative suggestion not mentioned in the recap is the use of Telesupervision. There are advantages that the Telesupervision Services may provide. Our State Licensing Boards are the appropriate regulators to oversee and develop

these services. All around the world, Telesupervision services are being developed and implemented.

Telesupervision, also known as e-supervision, is defined as the use of video conferencing technologies to supervise graduate students or assistants remotely. Supervisors can utilize video conferencing technologies to meet with students to discuss their objectives, assignments, and caseload, and to provide necessary and timely feedback for effective supervision.

What we have learned from the delivery and productivity of telehealth services during the pandemic shows the viability of telehealth services and the opportunity to develop high-quality Telesupervision in our state. Many states face similar challenges, and have developed or are developing Telesupervision, and they are able to eliminate the logistical problems and hardships that limit the development of high-quality providers and services. The advantages of Telehealth and Telemedicine can be realized with Telesupervision. The Boards can develop protocols to establish clear expectations and goals for Telesupervision and tailor these as each Board determines appropriate and consistent with their professional standards. They can embed Telesupervision into a sound supervisory model to develop high quality training and services. They can formulate plans to manage technical problems. The supervisors in our state will be able to use technology in supervision once the policies and procedures are in place for ethical practice of tele-psychology and digital communications. Telesupervision offers an opportunity to overcome distance, access and time and develop high quality supervision and support the development of our provider workforce.

https://telehealth.org/telesupervision
https://pubmed.ncbi.nlm.nih.gov/30589439
https://psycnet.apa.org/fulltext/2020-39749-016.pdf

Substance Abuse and Gambling in Nevada

In relation to Nevada's substance abuse concerns, there is an overarching need for increased need for qualified professionals to increase capacity and quality of services. The COVID-19 pandemic stressed an already overwhelmed and understaffed behavioral health field, including substance abuse treatment providers. The recent passing of SB69 in the 81st legislative session will assist with ensuring that Peer Recovery Support Specialists are adequately trained and able to provide quality services. Also, adding substance misuse prevention education curriculum to schools will help to educate young Nevada's about the dangers of substance use earlier in life.

Mental Health America ranks states on a basis on 15 criteria which includes but is not limited to: Adults with Substance Use Disorder in the Past Year and Youth with Substance Use Disorder in the Past Year. While the above measures are not a complete picture of the mental health system, they do provide a strong foundation for understanding the prevalence of mental health concerns, as well as issues of access to insurance and treatment, particularly as that access varies among the states. Related to adults in the reports through Mental health America, Nevada Ranks 40th, up two spots since last year. However, Nevada remains 51st when it comes to youth meeting the listed criteria. Nevada also remains ranked 51st overall regarding mental health care in the United States. Specifically in relation to substance use, Nevada ranks 45th for adults with substance use disorder in the past year, a regression from 40th last year, for youth Nevada declined to 49th from 47th the previous year.

The Clark County Regional Behavioral Health Policy Board highlights a priority of increasing collaboration on the spectrum of substance misuse and its relation to mental health. To create change around behavioral health and improve the lives of Clark County residents. substance misuse and abuse must be part of the discussion. The state must work to build a bridge that connects prevention, treatment, and recovery providers to mental health professionals to create innovative solutions and systems change. The Clark County Regional Behavioral Health Policy Board recommends supporting efforts to improve public education and awareness for substance misuse prevention and breaking down biases through education. Prevention has long-lasting economic benefits and averts injuries, disabilities, and deaths caused by misuse.

The Northern Regional Behavioral Health Policy Board highlights increasing workforce. Nevada faces significant barriers caused by a lack of behavioral health workforce and difficulties that behavioral health professionals encounter in becoming in-network providers for insurance reimbursement. The Northern Regional Behavioral Health Policy Board recommends:

- Increase reimbursement rates for all behavioral health professions where there is a low ratio of active providers to population to attract more to the workforce,
- Develop and expand additional incentives for practitioners providing services in rural counties. (e.g., Expand application time window and streamline process to complete HRSA loan forgiveness application as a provider agency and provider; provide housing stipends, etcetera)
- Support policy change by the Department of Insurance that simplifies the insurance paneling process for behavioral health clinicians.

As noted above, the Washoe Regional Behavioral Health Policy Board highlights equitable focus on substance misuse and continued to support efforts around addressing this issue for both children and adults. To be noted the Washoe Regional Behavioral Health Policy Board reported on the methamphetamine and stimulant surveillance 20202, in which methamphetamine related deaths in Nevada per 100,000residents rose from 4.4 in 2011, to in 2020. The Board also reported on the Opioid surveillance reporting in Nevada opioid related emergency department encounters increased by 96% from 2010 to 2020 and deaths increased by 24% in the same timeframe.

The Rural Regional Behavioral Health Policy Board reiterated workforce development and improved reimbursement as common priorities. Some ideas presented to bolster workforce in behavioral health include:

- Tuition reimbursement for providers serving within designated provider shortage areas;
- Tuition reimbursement or scholarship opportunities for new providers serving disadvantaged populations, including persons of lower socio-economic status and/or persons of color who are underserved in their respective communities;
- Increased reimbursement for behavioral health services, particularly for persons covered by Nevada Medicaid in Fee-For-Service areas, specifically rural and frontier Nevada;
- incentives for providers specializing in the treatment of children, the elderly, and other high-risk populations; and
- support policy changes that expand the ability of interns to access completely remote supervision, expansion of the number of internship sites available, and to expedite licensure processes.

A unique priority for the Rural Board is transportation: while transportation to and from all types of treatment has been a priority of the Board in previous years, the situation has remained dire for many communities. Unfortunately, other efforts to improve transportation to and home from services has largely proved fruitless; these options are either cost prohibitive or not realistic for consumers or are cost prohibitive for potential transportation providers. The Rural RBHPB prioritizes both novel and evidence-based practices in resolving transportation challenges, so long as proposed solutions are centered around the needs of user.

In relation to Problem gambling services in Nevada, recently the Reno Center for Problem Gambling closed, leaving one less facility where individuals can receive treatment for program gambling assistance, fortunately clients were able to be absorbed by other community partners. The pandemic affected gambling throughout the state and Problem gambling providers saw a slight decline in service requests over the last two year, however, are anticipating an increase in services as gaming establishments are open and individuals are returning to old behaviors. According to UNLV's report on problem gambling a total of 364 Nevada residents received problem gambling services in FY2021. In FY21, there was a 23% decline in outpatient enrollments and a 33% decline in residential enrollments. The ongoing Covid-19 pandemic has severely impacted programs. All clinics quickly adapted to the crisis and began offering telehealth services in addition to face-to-face services to support their clients' needs, but they continue to face challenges. On average, the treatment population are single white men, around 45 years old. The treatment population is not representative of the overall Nevada population and tends to be more white, less educated, with lower household income. Most of the treatment

population seeking services have a DSM-5 score indicating severe gambling disorder and are seeking treatment for the first time. Around 40% of clients who were discharged in FY21 were discharged after successfully completing 75% of their treatment goals, which is a good indicator of the effectiveness of Nevada's treatment system as well as the positive post-treatment follow up.

Children's Behavioral Health

In October 2021, the US Surgeon General declared a State of Emergency in child and adolescent mental health. Between March and October 2020, the percentage of emergency department visits nationwide for children ages 5-11 rose 24% and for children 12-17 rose 34%. There was a greater than 50% increase in suspected suicide attempts amongst girls aged 12-17 presenting to the emergency department in early 2021 compared to 2019.

These above numbers represent national trends. These concerns are heightened in our state, which sadly consistently is ranked 51st in children's mental health metrics by Mental Health America (mhnational.org). The core areas in which our state struggles include access to care and fiscal support/insurance coverage for necessary care. These issues are addressed by our state's three regional children's mental health consortia annual reports, highlights of which are summarized below.

Clark County Region:

Clark County's regional group identifies four priority areas: mobile crisis intervention services, expansion of family peer to peer support, implementation of the Building Bridges model to support transition of youth back to our community from higher level of care treatment facilities, and an expanded service/care array to mitigate the need for crisis care. Projected costs and specific details for these recommendations are found within the ten-year plan report submitted by the Clark County Children's Mental Health Consortium.

Rural Region:

The Rural Regional report includes updated statistics pertinent to their region. Of significance, 100% of the rural population in Nevada reside in a federally designated health professions shortage area (HPSA). The four priorities identified for 2022 include: creation of a website with up-to-date local resources, promotion of an awareness and de-stigmatizing campaign, support for community-wide early intervention training as well as crisis support, and a push to increase their group's influence on mental health policy creation.

Washoe County Region:

Washoe County's consortia has two legislative recommendations: to fund the infrastructure to support and maintain local programs benefitting youth and families, as well as promotion of programs to respond to the local mental health crisis. The WRBHPB continues to support those regional partners that are working towards the enhancement and improvement of access to mental health care for families and children.

In summary, all three consortia have similar recommendations: expansion of services as well as expansion of the currently available service array to best support youth and families, to identify issues before they rise to the level of a crisis, and to support crisis services in the community.

In closing, the Commission, the Regional Health Policy Boards, and the Children's Mental Health Consortia remain committed to improving the mental and behavioral health systems in Nevada. We are committed to improving the services that exist and augmenting them to include a more robust system of care that can better meet the needs of all Nevadans. We encourage the State to consider the priorities summarized in this letter and that have been developed to address the mental and behavioral health service needs in our rural, urban, and frontier communities.

Respectfully submitted,

Braden Schrag

Chair, Commission on Behavioral Health State of Nevada

CC:

Arvin Arpario, RN
Jasmine Cooper
Lisa Durette, M.D.
Daniel Ficalora, LCPC
Gregory Giron, Psy.D.
Natasha Mosby, LCSW
Lisa Ruiz-Lee

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Division of Child and Family Services, Nevada Children's Behavioral Health Consortium Meeting Minutes, April 7, 2022, Approved August 4, 2022

Nevada Children's Behavioral Health Consortium
Meeting Minutes
April 7, 2022

All members participated via Lifesize technology (video or audio)

MEMBERS PRESENT:
Charlene Frost – Nevada PEP
Dan Musgrove – Clark County Children's Mental Health Consortium
Ellen Richardson-Adams – Division of Public and Behavioral Health
Jacquelyn Kleinedler – Washoe County Children's Mental Health Consortium
Karen Taycher – Nevada PEP
Katherine Louden – Washoe County School District
Lisa Linning – Clark County Department of Family Services
Melissa Washabaugh – Rural Children's Mental Health Consortium
Michelle Sandoval – Division of Public and Behavioral Health
Sarah Dearborn – Division of Health Care Financing and Policy

MEMBERS ABSENT:
Alexa Rodriguez – Clark County Department of Juvenile Justice
Braden Schrag – Commission on Behavioral Health
Cara Paoli – Washoe County Human Services Agency
Cindy Pitlock – Department of Child and Family Services
Dena Schmidt – Aging and Disabilities Services Division
Jennifer Bevacqua – Eagle Quest (Group Home Provider)
Lawanda Jones – Substance Abuse Prevention and Treatment Agency
Sandy Arguello – Koinonia Family Services

STAFF AND GUESTS:
Amna Khawaja – Division of Child and Family Services
Antonio Gudino – Division of Health Care Financing and Policy
Beverly Burton – Division of Child and Family Services
David Ollsen – Medicaid Pharmacy Care and Assist Unit
Deidre Manley – Division of Child and Family Services
Eileen Hough – Department of Health and Human Services
Gwendolyn Greene – Renaissance Behavioral Health
Hannah Keenan – Enterprise Psychiatric Residential Treatment Facility
Janelle Cuenca – University of Nevada
Jennifer Ahn – Aging and Disability Services

Jessica Flood Abrass – Nevada Rural Hospital Partners
Joelle McNutt – Nevada Board of Examiners
Kary Wilder – Division of Child and Family Services
Kristen Rivas – Division of Child and Family Services
Marcel Brown – Division of Healthcare Financing and Policy
Rhonda Lawrence – Division of Child and Family Services
Robert Weires – Clark County Schools
Samantha Cohen – Division of Child and Family Services
Shannon Hill – Division of Child and Family Services
Tiffany Judd – Guest
William Wyss – Division of Child and Family Services

1. Call to Order, Roll Call, Introductions

Ellen Richardson-Adams, Commission on Behavioral Health Chair, called the meeting to order at 2:02 p.m. Kristen Rivas, Division of Child and Family Services, conducted roll call and quorum was established.

2. Public Comment

There was no public comment.

3. Approval of the February 3, 2021, Meeting Minutes

MOTION: Dr. Lisa Linning made a motion to accept the minutes from the February 3, 2021 meeting.
SECOND: Dan Musgrove
VOTE: Motion passed unanimously with no opposition or abstention.

4. For Information Only. Announcements – *All Members*

Charlene Frost announced Nevada PEP is moving from "awareness" to "acceptance", and with acceptance, they hope to see more action with children's mental health and children's mental health services. Children's Mental Health Acceptance Day is May 5th. The Clark County Mental Health Consortium is holding the Annual Summit on May 2nd and 3rd. Activities and a Twitter Chat are planned. She encouraged everyone to follow Nevada PEP on Twitter, Facebook, and Instagram, and visit the Youth M.O.V.E. Nevada website.

5. For Information Only. Regional Consortia Ten-Year Strategic Plan Updates – *Dan Musgrove (Clark County Children's Mental Health Consortium), Jacquelyn Kleinedler (Washoe County Children's Mental Health Consortium), Melissa Washabaugh (Rural Children's Mental Health Consortium)*

Clark County Children's Mental Health Consortium (CCCMHC) – Dan Musgrove, former Chair, summarized the Consortium's 2021 Status Report and 2023 Vision for Success. The Vision

has six main goals: 1. Addressing the highest needs, 2. Comprehensive service array for all, 3. No wrong door to services, 4. Prevention and early intervention in mental health, 5. Raise awareness and support for children's mental health, and 6. Locally managed system of care. The report provided an overview of progress on the top four service priorities of the Consortium: 1. Sustainable funding for the Mobile Crisis Response Team (MCRT), 2. Family peer-to-peer support expansion, 3. Fully implement the Building Bridges Model of Care to support youth and families transitioning from residential care back into the community, 4. More service array options so youth and families can access care at earlier stages to reduce the need for crisis service intervention. Budgetary requests supporting these goals and projects were made to the legislature. Quality residential care and the devasting impact of the COVID-19 pandemic on families and children continue to be challenging. The Department of Justice investigation is still in progress with work ongoing to identify opportunities for improvement. There is a group focusing on crisis work in Las Vegas. Mr. Musgrove emphasized that requests from CCMHC will also be beneficial to the entire state. There is an Interim Finance Committee meeting scheduled for May which will have several American Rescue Plan Act (ARPA) requests scheduled for review with hopefully some explanation and much-needed discussion on important issues.

The 5th Annual Southern Nevada Summit on Children's Mental Health is May 2nd and 3rd. This is a virtual event. Attendee cost is $15.00 and CEU credits are available. Mr. Musgrove encouraged everyone to sign up and join.

Jacqueline Kleinedler asked about the new CCMHC Chairperson. Mr. Musgrove informed everyone that Amanda Haboush-Deloye is the new Consortium Chair. Ms. Richardson thanked Mr. Musgrove for all his contributions in his former role.

Washoe County Children's Mental Health Consortium (WCCMHC) – Jacquelyn Kleinedler, Chair, reported long terms goals are: 1. Increase access to compassionate care in the least restrictive environment, 2. Decrease and/or buffer children and youth's exposure to toxic stress, and 3. Increase child, youth, and family access to positive community-based experiences. Details of relevant systemic factors across the State and in communities were highlighted including the housing crisis in Washoe County causing evictions and the Covid-19 pandemic. The report discussed the Surgeon General's Advisory on Mental Health, mental health providers and services, and Medicaid and health insurance barriers for youth and families. WCCMHC has a dedicated agenda item called Family Voice and the report summarized themes discussed throughout the year (education, bullying, youth suicide, substance abuse, and overall health and access to compassionate care). Families and providers were involved in those discussions and even though statistical data lags behind by a year or two, when the Consortium hears from families, they receive valuable current anecdotal data.

One of the Consortium's strengths lies in collaboration with 22 community partner agencies that were unrelenting in 2021 in efforts to maintain programs, activities, and standards of care for youth and families. Partner achievements and activities for successful community impact were highlighted. Specific budget requests were made for: 1. Commit funding, infrastructure and legislative support to maintain and expand existing programs and services in Washoe County (24x7 MCRT support), and 2. Promote innovative programs to respond effectively to the ongoing

and increasing youth mental health crisis (intensive, in-home crisis stabilization). The report included 14 discrete accomplishments across agencies. Examples included (publishing dynamic listings of resources on the website, a letter to the Nevada Department of Education (NDE) asking for easing of mandated educational requirements to support both student and mental health, and distribution of a community mental health newsletter. In 2022, 17 activities are planned with multiple community partners (one example is monitoring data reports from Children's Cabinet and the school district for signs of suicide screening for 7th graders). She referred everyone to the handout for additional details. Ms. Frost thanked Ms. Kleinedler for her passion and open discussions. Ms. Kleinedler said as the Chair of WCCMHC she encouraged participation from providers, partner agencies and guests to attend meetings, talk about concerns, and volunteer.

Rural Children's Mental Health Consortium (RCMHC) – Melissa Washabaugh, Chair, provided an overview of the RCMHC Service Priorities Report. The report was delayed and they are still working on the final version. The Consortium's five priorities were: 1. Creation of a comprehensive website, 2. Awareness and de-stigmatizing messaging, 3. Support/encourage training at the community level, 4. Increase the consortium's influence on mental health policy creation, and 5. Increase access to evidence-based and evidence-informed mental health supports and service in rural communities. Statistics on the status of children's mental health in rural Nevada showed challenges these regions face due to wide geographical areas separating healthcare facilities, high rates of uninsured/under-insured, limited access to higher level services, and healthcare provider shortages. These challenges were increased by the COVID-19 pandemic and the recent closure of a psychiatric inpatient facility in Washoe County which served children in crisis throughout much of rural Nevada. Mobile Crisis Response services are stepping in to help fill some of these gaps. Collaborative projects are underway and will continue with key partners (Nevada PEP, Nevada System of Care, Youth M.O.V.E. Nevada, and DCFS.

6. For Information Only. Mobile Crisis Update – *Andrew Freeman (Division of Child and Family Services)*

Tabled. Mr. Freeman was not in attendance.

7. For Possible Action. Division of Child and Family Services Update – *Dr. Cindy Pitlock (Administrator, Division of Child and Family Services), Dr. Megan Freeman (Children's Behavioral Health Authority, Health and Human Services)*

a. Impact of West Hills Hospital Closure on the Community Update
b. Retention/Retainable Rates Update
c. Legislative/Fiscal Updates

Tabled. Dr. Pitlock and Dr. Megan Freeman were not available due to a conflict with the Interim Finance Committee meeting.

8. For Information Only. DCFS Planning and Evaluation Unit (PEU) – FY2020-2021 Desert Willow Treatment Center (DWTC), Division of Child and Family Services (DCFS) Presentation – *Dr. Jackie Wade (Deputy Administrator, Residential Services, Division of Child and Family Services)*

Tabled. Dr. Wade was not available due to a conflict with the Interim Finance Committee meeting.

9. For Information Only. Workforce Development Initiatives Presentation – *Rhonda Lawrence (Clinical Program Manager II, DCFS)*

Ms. Lawrence announced that ARPA funds through partnering with the Children's Cabinet were passed today to establish an Infant Mental Health Association to allow for an infant and early childhood endorsement for Nevada, making Nevada the 32nd state in the nation to receive this endorsement. The Association will include all professionals (home educators, home visiting nurses, academics, mentors, supervisors, clinicians, and early intervention specialists) working in the childhood space to receive an endorsement for socio-emotional development, as well as provide an associative network. The endorsement will also improve the ability to receive Substance Abuse and Mental Health Services Administration (SAMSA) grants and help increase workforce through training offerings for evidence-based practices. They have asked for two more cohorts of parent-child psychotherapy, which is the dialectic parent/child evidence-based treatment for children (birth to six). Ms. Lawrence is working on a project which includes Clark County and Carson to expand the Infant-Toddler Court Program, Safe Babies Court Team (a specialty family court program for 0-3). Community parent-child psychotherapy providers are required to stand up these family court programs. These initiatives are intertwined and encompassing of system and community partners.

A system briefing was provided in August to all DCFS with the goal of providing children and families equitable access to diverse and culturally informed, licensed mental health professionals who maintain professional competency to provide a broad array of community based mental health services and evidence-based treatment in children and family's communities. They have asked for ARPA funding for two public service DCFS interns. This state job classification allows a pre-graduate to receive a salary for part-time work while fulfilling hours required for a graduate degree (licensed Clinical Social Work, Master of Social Work, Master of Counseling Psychology). Ms. Lawrence put forward a budget enhancement request to fund ten positions at Nevada Child and Adolescent Services (NNCAS), five positions in both the North and South. They currently have two interns from UNR Marriage and Family Therapy (MFT) and Child-Parent Psychotherapy (CPC) programs who are learning System of Care values of mental health service provision with children, youth and families. Interns are being trained in dialectical and focused models of treatment, to understand meaningful behavior modification treatment by looking at children's needs and strengths through deep engagement with families. She is hoping to hire the interns post-graduation and is hopeful they can take their values and training out into the community.

NNCAS has a child and adolescent psychiatric program with the UNR School of Medicine, funded through the Children's Mental Health Block Grant and the Washoe County Human Services Agency. The psychiatric clinic is staffed with UNR Fellows and is open one afternoon per week to children, ages 0 – 17, with diagnoses of Serious Emotional Disturbance (SED), which is one of the requirements. A board-certified child and adolescent psychiatrist attending physician is onsite to supervise. Ms. Lawrence would like to see this program implemented as a model

throughout Nevada. Telehealth services are offered, providing services to near-located rural families. An APRN, who is in her final program at UNR also works with NNCAS.

A post-graduate intern currently working with Ms. Lawrence is preparing a survey of the states of California, Utah, Arizona, Oregon, Colorado and Nevada to specifically look at MFT and CPP Boards of Examiners who are in charge of licensing qualified mental health professionals. One barrier is that there are many clinical supervisors in Clark and Washoe counties, but few in rural Nevada. A Nevada-approved MFT/CPC Clinical Supervisor license is required to supervise interns to prevent them from having to pay out-of-pocket for required clinical supervision. The comparative survey of state licensing boards and what they require shows that it appears Nevada's requirements are much more stringent and involved than other states and is something that needs consideration. Ms. Lawrence questioned if the high bar to become a certified clinical supervisor is helpful in terms of quality and workforce development and was concerned it may be making it difficult to become a mental health professional (due to the high costs of paying for clinical supervision and the high housing costs interns are experiencing).

The Health Resources and Services Administration (HRSA) loan re-payment program currently certifies sites deemed to be 'service-shortage' areas. This means licensed clinicians at certified sites can apply to receive a cash payment to apply to student loans, with a requirement for the clinician to remain employed at the clinic for two years. Community partners can also become registered with the program to provide this incentive to prospective hires. Ms. Lawrence would like to see the program maintained but has learned HRSA has decertified a high percentage of sites in the nation, post-COVID-19. She is concerned some of Nevada's sites will be decertified during this current children's mental health crisis.

Ms. Lawrence feels the Consortium can have deeper engagement with licensing boards to network and attend meetings to learn and work together to develop a qualified licensed mental health workforce. Licensing boards could provide reports to the Consortium with numbers of licensed and pre-licensed interns for each license category and available licensed clinical supervisors, as well as provide surveys showing how many licensed professionals are actually providing services (including who and where those services are being provided, and how they are being paid and reimbursed). Deeper engagement with universities, community colleges, and online graduate programs whose students are living in Nevada (Walden or Capella) is also another area of opportunity.

Another area of opportunity is to have deeper engagement with middle and high school students, to be talking with them about mental health issues. Ms. Lawrence felt young people are very much in touch with mental health issues and have curiosity and energy about the issues they face. She feels there is a real opportunity to speak with them about the potential of joining this field as a career. Pathways to do so through college and graduate programs are very daunting. Needs for bi-lingual and bi-cultural trained professionals who come from diverse backgrounds are great and potential youth need mentors and guidance to show the way and how to acquire resources. The goal would be to engage with UNR and UNLV to partner in first-generation student programs and scholarship/grant opportunities to fund students continuing their education beyond high school, and then from there into graduate school.

Ms. Lawrence summarized these areas of opportunity as potential goals for the Consortium to assist in expanding the children's mental health workforce. Dr. Linning asked if Ms. Lawrence could provide guidance to follow up and ensure Clark County is HRSA-certified as a service-shortage area. Ms. Lawrence will send the HRSA DCFS office contact information to anyone who would like to apply or check certification status.

Ms. Taycher thanked Ms. Lawrence for her passion and the work she is doing to increase and improve Nevada's workforce. Ms. Richardson commented she was excited to hear about the endorsement and plans to start early and provide families another level of early childhood (birth to age 8) support. Ms. Sandoval appreciated Ms. Lawrence's partnership efforts to bring training services out to rural regions. Ms. Lawrence also mentioned that with this grant they will be able to push out more infant and early childhood mental health consultation, which is an important upstream program seeking to identify and help find families and children as early as possible through pre-schools and childcares. They often work with pre-schools and childcares to understand needs of the children they are educating and caring for. This is part of an evidence-based model of quality early childhood. They will be able to bring on four more early childhood mental health consultants to be utilized in Elko and Ely.

10. For Information Only. Regional School-Based Health Centers Update – *Jennifer Lords (Rural School Districts), Katherine Louden (Washoe County Schools), Robert Weires (Clark County Schools)*

Rural School Districts – Jennifer Lords presented updates on several rural county school districts and will forward a copy of her presentation to Ms. Wilder for distribution. The Carson School District is a Project Aware Grantee and is working to build clinical school systems within a Multi-Tiered System and Support (MTSS) framework. Tier 1 is universal support (services given to all students), Tier 2 is services delivered to increasing needs (20% of students will access additional services in small groups), and Tier 3 is special supports (3%-5% of students will receiving individual supports). Carson has staffed 13 school counselors at their middle and high schools and has 12 school social workers and safe-school professionals. A clinical social worker has just been hired. They have a Memorandum of Understanding for Tier 3 services with community providers that includes some assistance through UNR who has provided training in motivational interviewing to all school counselors and social workers. A significant number of mental and behavioral health trainings were presented to students and staff over the last years (Signs of Suicide, Youth Mental Health First Aid, Safe-Talk, Safe-Voice, Positive School Climate, and Social-Emotional Learning Training-SEL). A multi-day training event was held in December (Resilience, Self-Care, and Supporting Students in Trauma).

Churchill County District is working to increase offerings for school behavioral health. The number of safe-school professionals was increased and there are now safe-school professionals working at each school level (elementary, middle and high school). A clinical intern is providing Tier 3 services and they are hosting UNR interns who provide Tier 3 counseling services. Tier 3 services are also being provided through partnership with the Community Prevention Coalition to give service access at school. The district health plan is also providing access to mental health support for staff. With the pandemic, increasing demands for staff supports are becoming critical

and work is underway to bring in additional staff support focused on well-being and self-care. A shared position is hosted with the Prevention Coalition for the Too Good for Drugs program, as well as offering Mindfulness Training for students.

Douglas County School District has staffed school counselor positions at each school and now has three full-time social workers. Installation of vape detectors was initiated to address vaping concerns with substance abuse. SEL training is provided to middle school staff, as well as a training program called Tools Not Rules. School counselors are providing Suicide Prevention Training and the Columbia Suicide Screener for assessing suicide risk was recently adopted. All school counselors, social workers, psychologists, and secondary administrators are trained in the Clark County School District Threat Assessment program. Michelle Trujillo and Tracy Fisher from the NDE Office of Safe and Respectful Learning provided additional SEL training for students and staff. The Moxy Up grant is being utilized to provide after school care for foster-involved children and host partnerships with several agencies for Tier 3 counseling and services, including suicide and crisis screening.

Humboldt County School District is a former Project-Aware grantee and is now staffed with seven school counselors and six safe-schools professionals. They work in partnership with communities and schools to host five community and school workers onsite, with a coordinator working in the district. Signs of Suicide Training is provided annually for all 7th graders and Second Step SEL Training, Safe-Voice Training, and Youth Mental Health First Aid Safekeeping (all staff certified with updates every three years) are offered. Partnerships for supports are in place with the Family Support Center, Frontier Community Coalition, and the Boys and Girls Clubs. The district hosts the Food Bank of Northern Nevada onsite so schools and community members can come to the food bank at the district office. Telehealth partnerships are established with Ilumna Telehealth and UNLV for Tier 3 services and an agreement with a Humboldt General Hospital physician is also established to provide physician services to students at school, as well as providing Mindful Training for staff.

Lander County Schools have increased staff to include three masters-level social workers and one licensed clinical social worker intern. Clinical services are offered onsite in partnership with Reno Behavioral Health and the Trauma Recovery Grant on Mondays. One school counselor, a nurse, and a health assistant are now working within behavioral health needs. Mindfulness Training for staff and financial assistance for staff participating in wellness and self-care activities were offered. The Leader in Me Training (Covey Foundation) which focuses on building growth mindset and leadership skills in students, was provided. A school psychologist was hired who is building an Autism Diagnostic Observation Schedule (ADOS) team for increasing autism screening and diagnosis. A crisis prevention and intervention trainer and a wellness coordinator were hired for staff and training was provided (Recognizing Substance Use and Building School Climate in Adversity). Vape detectors were installed.

Lyon County School District now has 22 school counselors and one clinical social worker, as well as two clinical social work interns who are working in schools via community partnerships. Safe-schools professionals are now in all attendance areas and are rolling out training for school resource officers in mental health needs of students. They are providing trauma-informed training for all staff. Second Step SEL curriculum for K-8 and Restorative Justice Practices Training for 9th through 12th graders are being delivered. The district is working through monthly collaborative

teams with Juvenile Services and DCFS about shared caseloads and Carson Tahoe Behavioral Health is providing suicide screening for Dayton schools. They have also been heavily utilizing the Trauma Recovery Grant to provide Tier 3 services to students who are intersecting with trauma experiences and who are uninsured or under-insured. An Anxiety Screener was delivered and they are able to refer students to external support. Some sites are offering Mindfulness Training for teachers and they have partnerships for other tiered services including clinical level interventions.

Pershing County has a multi-tiered system of support through their previous Project Aware Grant and has maintained those changes in their district with recovery dollars. They are providing tiered support through a Memorandum of Understanding (MOU) with Zephyr Wellness. An online virtual resource center for school, local, and national support options for students was created and parents can access their student's screening results. A student strengths assessment is being done three times a year to identify study needs in a growth mindset model and parents, teachers, and student mental health staff can access results of students in their care and identify goals and needs which can be shared to ensure services students are receiving at school correlate with services they are receiving in therapy to ensure wrap-around, holistic care. A partnership was established with Frontier Community Coalition and the Youth Team (a peer prevention group which has produced substance abuse videos streaming on social media to prevent marijuana and vaping use). Partnerships are also established with Juvenile Probation and their hospital APRN for psychiatric services. They are also working to increase partnerships with tribal authorities.

Storey County is building out school health services with two school counselors, two Safe-Schools professionals, and a part-time clinical social work intern. Their health aide is also a paramedic, which has been a support in crisis scenarios. Tiered support is being utilized and Career Readiness and SEL training is provided to all Freshmen students. A project is underway to increase youth voice for behavioral health through peer support via their leadership and Student Council. Support for staff is offered through regional professional development support and the Employee Wellness Program.

White Pine County has an employee community health worker, a school social worker, two school counselors, and a contracted LCSW. District-wide student support team meetings are hosted with admins to collaborate on their system and the needs of students and families. They are working to revamp policy for Tier 1 services and are using The Leader in Need training for student social-emotional curriculum. School climate surveys are used to determine how to align with SEL competency action items. Partnerships are established with the Pace Coalition, Boys and Girls Clubs, Juvenile Services, and DCFS. The district recently participated in a SOC listening event about community partnerships.

Ms. Lord reported work is ongoing with Medicaid for funding that will be ending which is shoring-up many school-based health positions across the state. Districts with current Medicaid contracts are Washoe, Humboldt, Esmeralda, Churchill, Lyon, Nye, and Clark. Billing systems are being built so schools can access Medicaid dollars for students who qualify. This will help sustain school-based health positions across the state. One of the challenges is getting initial funding for electronic health records required for getting billing done which will allow interventions to be monitored with fidelity for all students to ensure they are getting quality services.

Ms. Taycher commented that the presentation provided great information, but was difficult to follow, and she hoped Ms. Lord could share the written version. Ms. Lord will forward the presentation to Kary Wilder and Kristen Rivas so it can be shared with the group. Jacqueline Kleinedler appreciated getting a comprehensive overview of what was happening in the rural school districts and said she was looking forward to helping identify and support gaps in services going forward.

Washoe County Schools– Kathryn Louden provided updates and reported they are working on Safe Voice, Handle with Care, and Signs for Suicide, and are implementing many model-exemplary processes with socio-emotional learning. The Washoe County Children's Mental Health Consortium has connected Ms. Louden to resources, support and assistance, which has improved offerings to district students. She was grateful for this partnership and also appreciated Ms. Lawrence's presentation and her role as a resource to the district. The district has a Safe and Healthy Schools Commission which provides recommendations to the Board of Trustees with several people on the Board who are behavioral and mental health experts.

Washoe County has 193 school counselors (69 elementary, 56 middle school, 68 high school), 12 MSW-level school social workers (17 allocations), 58 Safe-School professional allocations, and several positions remain unfilled. They are implementing co-located mental health supports in 25 school sites through partnerships, which includes several Project Aware schools and are part of the statewide Project Aware collaboration. The district has 45.2 school psychologists and 47.7 nurses for over 105 school sites. There is a new administrative-level mental health professional position for licensed clinical social workers and marriage and family therapists. More mental health professional positions will be added next year to serve high schools. Job descriptions are being developed for bridge work to bring in interns to expand the district workforce. Telehealth services are being expanded and plans were presented to the Board of Trustees for both medical and mental telehealth. New family resource centers are being added, a new provider was obtained for IEPs, and they are in conversations with the state to improve Medicaid services and Medicaid billing.

The district is participating in opportunities to provide better services through a Centers for Disease Control grant, school climate surveys, and participation in studies. They participated in the Collaborative for Innovation and Improvement Network (COIN) and are engaging in the school health quality assessment through Safe System (https://safesystem.com) through the National Center for School Mental Health, which allows implementation of continuous improvement processes. Support is received from the state through different departments (DCFS and the Office of Safe and Respectful Learning Environments) who have provided connections to various valuable resources that were previously unknown (Mental Health Technology Transfer Center).

Challenges exist with tracking down and supporting children in transition (CIT), especially unaccompanied minors, and through the Intervention Department they are receiving a grant which will help the district go to weekly motels and do more intervention and outreach in partnership with other organizations and teams.

In the north, school social work professionals and marriage and family therapists are honoring the loss of Dr. Eric Albers, University of Nevada Social Work, which is heavy on their hearts.

Ms. Taycher thanked Ms. Louden and commented she is happy to hear they are participating in the Transfer Center as she is on the Advisory Board and glad to know Nevada is participating.

Clark County Schools – Robert Weires reported that traditionally Clark County has focused on Tier 2 and Tier 3 levels of crisis interventions and has well-established suicide intervention protocols. The Columbia Screener is used and staff are trained on a regular basis (counselors, social workers, nurses) for first responder intervention at the school level. They are active Safe Voice members and have had a special initiative over the last two years through the pandemic to introduce socio-emotional screening through Panorama Surveys across schools. A multi-disciplinary leadership/Tier 2 problem-solving team dedicated to mental health is under development. As a large district, they have performed well delivering Tier 3 services and provide additional supports for schools in relation to targeted threats assessments through their crisis response teams. They struggle with providing Tier 1 support to at-risk students and are starting to make progress, while experiencing growing pains. Work is underway to determine an appropriate socio-emotional learning curriculum for schools this year. Telehealth is starting to roll out for half of the schools through Hazel Health for medical services and Hazel Heart for mental/behavioral health. PM Pediatrics will be providing services to other schools. Trauma-informed Care Practices training is planned in the fall for school-based teams, specialists, counselors, social workers, psychologists, etc. They currently have 166 licensed psychologists and 210 social workers and safe specialists combined in the Wraparound Services department. Additional social worker positions are anticipated to be approved in the near future. There are currently approximately 700 counselors and 220+ school nurses across 370 schools. They are working on the same issues as Washoe County Schools and the Rural District, along with the current major challenge of building infrastructure relative to social-emotional learning and mental health.

Lori Baumann (Clark County School District Health Services Coordinator) reported that the Hazel Heart mental telehealth program is live at 157 schools. The PM Pediatrics telehealth program is currently live in 40 schools and students can get referred by an initiator (with parental permission) to receive weekly care with a provider. The telehealth programs are also setting up case management to hopefully set students up for additional follow-up care as needed. The physical Hazel Health program is live in 14 schools in health offices for students to get online with a provider. PM Pediatric telehealth services will also be offered soon in the health offices. The United Citizens Foundation is currently live in five schools and will be expanding to additional schools in the next year. The Family Support Center opens August 1st and will offer physical and behavioral health services, job search resources, and Medicaid application assistance. Nevada Eye Care is in two schools and provides free eyecare and glasses to students, in addition to their mobile unit which travels to other schools in the district. Charlene Frost asked about Hazel Heart working with other providers and Ms. Bauman responded that they are working to get other providers outside of school if that was the need.

Ms. Taycher asked if the items in the updates from Robert Weirs and Kathryn Louden could be provided to Jennifer Lords. Ms. Lord put her contact information in the Chat.

Ms. Taycher asked about efforts to provide data on utilization and outcomes to determine the success of these program and determine how many children receive benefits. Ms. Baumann said Clark County does a mid-year review and an annual report with this information. She said Hazel Health is providing weekly updates to Wraparound Services as to how many students were

referred, how many received follow-up care, weekly appointments, etc. She can provide the information. Ms. Richardson asked about timeframes for the mid-year review and annual report. Ms. Baumann said they are done in January and July and then provided to the school boards. Ms. Taycher said that would be helpful and also asked about the other districts and how they are thinking about processes for NDE to collect certain pieces of data for monitoring and ensuring program success. Jennifer Lords said this is a project for NDE to pull existing data sources together and there is a need for electronic medical records (EMR) to be in place to pull required reports and assess progress. There is no universal EMR software or process throughout the state and some districts are still using Microsoft Excel spreadsheets. They are working to figure out how to get data into a systematic easy-to-use solution throughout Nevada, but right now the process is to compile data by hand. Mr. Weires said there are additional reporting requirements for some districts by the legislature this past session regarding the SOS program and number of kids involved in discipline. There are reporting systems directly to NDE which may be a data source available to the Consortium. Ms. Taycher asked Ms. Lords to advocate at NDE to show these supports are helping children and that investment is needed.

Ms. Lords shared that Pershing County referrals to Tier 3 clinical support were above 20%, compared to an expected distribution of 3-5%. As they put their Management Process System programming into place, they saw this changed to 80% of students receiving Tier 1 support, 20% at Tier 2, and then 3-5% at Tier 3. This showed that implementation of this systematic practice successfully caused Tier 3 clinical support to decrease since needs are being met at lower levels. They continue working with UNR and the counties to implement this program to shore up school health systems across Tiers in order to see this distribution fall into expected parameters. Pershing County's data supports the fact that through this implementation, initial focus is on Tier 3 and over time this shifts within expected parameters with the bulk of serves provided at lower levels. Ms. Louden said that since not all data sources are aligned across the state with different initiatives, this is one of their big projects. Mr. Weires also commented that the pandemic and severe staffing issues have impacted their baseline and Clark County is now well-oriented, but still in a 'growing-pains' stage.

Ms. Richardson thanked everyone for their extensive updates.

11. For Information Only. Medicaid Update and Changes – *Sarah Dearborn, Division of Health Care Financing and Policy (DHCFP)*

General Medicaid Update – Ms. Dearborn reported State Plan Amendment (SPA) for the Children's Health Insurance Program (CHIP) was approved on March 29th. This SPA is to align and describe all behavioral health benefits available to children who have Nevada Checkup.

Additionally, SPA 21-009 related to the removal of neurotherapy services for the treatment of a mental health diagnosis has been withdrawn. Through several discussions with the Centers for Medicare and Medicaid Services (CMS), it was determined the biofeedback and neurotherapy provision would be considered a maintenance of effort violation of the requirements of Section 9817 of the American Recovery Act of 2021. This would put the State's 9817 Enhanced Home and Community based Federal Medical Assistance Percentage (FMAP) funding at risk. The SPA was withdrawn until these services can be reconsidered for limitation at the end of the Home and

Community Based Services ARPA period which ends in April 2024. Associated with that SPA, the policy for neurotherapy services was eliminated from Chapter 400 of the Medicaid Services Manual (MSM) and they have reverted that back to Chapter 400 policy that was approved at the March 18th Public Hearing, so those services are available to be provided and performed.

The most current SPA submitted is in regard to crisis stabilization centers. This SPA defines the daily rate for stabilization centers. New policy was proposed to be included in MSM Chapter 400 for this service. The process is underway with CMS to get the rate policy approved and providers enrolled as crisis stabilization centers.

At the February Interim Finance Committee Meeting, Nevada Medicaid included in the Home and Community-Based ARPA quarterly spending plan, a request for funds to procure a consultant to develop a comprehensive plan to improve Medicaid mental health services for children. The consultant will look at SPA and Medicaid service policies and identify routes for services for mental health for children. There are no dates yet for public feedback and Ms. Dearborn will notify the Consortium membership.

The Applied Behavioral Analysis (ABA) quarterly report has been posted to the Division of Healthcare and Financing public website.

The Medical Programs Unit posted a public workshop around changes to the Medicaid Telehealth Services Policy (MSM Manual, Chapter 3400). The changes will align with Senate Bill 5 to allow for audio-only services outside the declared public health emergency and also support patient parity. She encouraged everyone to review the proposed draft changes.

Two planning grants are underway (Mobile Crisis Planning and Support Act Planning). The Mobile Crisis Planning Grant is a year-long grant which goes through September 2022. Fact-finding sessions are being held with current providers of mobile crisis services to gather as much detail as possible on recommendations to make to current policy, as well as the current SPA. With this opportunity, many states will be able to do a SPA amendment or possibly a waiver to get mobile crisis services within Medicaid and changes to the MSM manual. Once mobile crisis teams that align with statute are established, the State will be able to collect an 85% enhanced FMAP for a three-year period for qualifying mobile crisis services.

The Support Act Planning Grant is focused on increasing substance use treatment provider capacity. Getting the 1115 Substance Abuse Disorder application approved is in progress. The application was submitted in November 2021, and they are engaged in conversations with CMS which recommended putting the application back out for an additional 30-day public comment period at the end of April. Ms. Dearborn will give an update at the June NCBHC meeting. CMH likes to see public involvement and feedback on policy and Ms. Dearborn asked everyone to participate and contribute. Related to that, CMS encouraged development of a dedicated 1115 webpage for public information distribution. They are working on the Substance Abuse Disorder Databook, and it will be available for the public to review.

The 1915(i) Program is targeted to youth in specialized foster care with ten providers (six providers in Clark County and four in Washoe County). They are holding bi-weekly meetings with Juvenile Justice, DCFS, and County Child Welfare programs. She has also engaged Medicaid's fiscal agent to assist working through billing issues. Char Frost asked if the Behavioral Health Technical Assistant had been hired yet for this and who it may be? Ms. Dearborn said that it may need to out as a request for proposal (RFP) process and she was not aware of the timeline.

Medicaid Formulary Request – Ms. Dearborn asked for more specific information to define what the Consortium was looking for on this topic. She invited members of the Medicaid Pharmacy Unit to attend the meeting to help answer questions. Jacquelyn Kleinedler reported the concern is how different Medicaid providers have different formularies and when children are bumped to a new provider, there are significant negative impacts. This happens often enough to cause medication disruptions which cause behavioral and mental health concerns. David Ollsen with the Medicaid Pharmacy Care and Assist Unit explained there are non-preferred and preferred medications on the list and this situation occurs when patients have a prior authorization on a non-preferred drug or move from managed care to non-managed care. They've been internally discussing grandfathering people in as a policy for fee-for-service. He said he could not speak to how the managed care organizations (MCOs) operate their businesses, however, there is a possible solution which could include an advocacy for a single or unified Preferred Drug List (PDL) for the State. Those determinations of what are preferred, or non-preferred drugs could be made at the meetings (Silver State Scripts Board Meetings) and would have to become part of the MCO contracts. Another potential solution would be to create a 'carve-out' for the Division of Financing Health Care and Policy to manage the pharmacy benefit for the entire state. Antonio Guidino, Division of Health Care Financing and Policy (DHCFP) stated there were policies in place for continuity of care which provide for continuation of medications and recommended anyone interested to contact him directly to set it up.

Ms. Kleinedler asked what it would take for the Consortium to advocate for a solution. She also asked if either of the solutions discussed would require legislative action. Mr. Ollsen said legislation would help and would be required for the 'carve-out' option. Ms. Kleinedler reported the Washoe County Policy Board is currently holding meetings to consider bill drafts to put forward to the legislation. She asked if this is an area the Consortium thinks is worth exploring as an add-on to a bill draft or if there are other ways to advocate for these solutions to occur, then this could be considered when it becomes an action item at the next meeting. She will invite Dr. Jose Cucalon, a pediatrician in Washoe County, to the next meeting. He works with Medicaid patients and has seen this happen very frequently. Ms. Frost reported the Southern Region Medication Policy Board is actively looking for a bill to sponsor and this may be a good candidate. Jessica Flood reported the Northern Board is also reforming and looking for legislative bills. Ms. Food suggested Ms. Kleinedler personally present this idea to the Board. Ms. Kleinedler said she is not the most informed person about the topic. It was decided to discuss this item at the June meeting.

12. For Possible Action. Make Recommendations for Agenda Items for the Next Meeting – *All Members*

- Medicaid formulary policy changes
- Updates from Regional Medication Policy Boards regarding legislative bill drafts

13. Public Comment. *No action may be taken upon a matter raised during a period devoted to comments by the general public until the matter itself has been specifically included on an agenda as an item upon which action may be taken.*

Jessica Flood reported that she and Michelle Sandoval have been working on four Mental Health Crisis Hold videos: one for the adult process and one for the youth process (Spanish and English). The statewide Mental Health Crisis Hold group has participated in this project. They are looking for a vibrant and articulate Spanish-speaking clinician to participate and would like suggestions emailed to Jessica Flood (jessica@nhrp.org) or Michelle Sandoval (mvsandoval@health.nv.gov).

14. Adjournment. *Ellen Richardson-Adams, Chair*

Ellen Richardson-Adams adjourned the meeting at 4:35 p.m.

Post-Graduate Internship Program - 3 Issues for Consideration.

Post-Graduate Internship Program - 3 Issues for Consideration

1. The Board is being asked by the Rural Regional Behavioral Health Board to remove the existing requirement for an onsite licensed mental health professional when the clinical supervisor is off-site.
    a. This onsite supervision is both administrative and to provide immediate assistance in an emergency to protect both the intern and the clinical supervisor when the clinical supervisor is an off-site supervisor.
    b. This has been a Board requirement for more than 20 years and is in place to prevent an intern from being left alone at a site without any clinical backup.
    c. The attached policy has draft language that would allow for the reduction to telephone / video access to the onsite supervisor once the intern has completed 1000 clinical hours, 500 non-clinical hours and 50 hours of supervision IF the clinical supervisor agrees. This is the point at which an intern can request exam approval.

2. The Board has a policy of closing an approved internship site when a Medicaid sanction is granted against the site or if there is a regulatory or accreditation sanctions against the site.
    a. The policy has been broadened to say a sanction by any payor source, not simply Medicaid.
    b. If an agency gets into trouble with payors, regulatory or accreditation entities, the Board has not believed it appropriate to have it open as teaching location for post-graduate interns until the terms of the sanction are met and restrictions are removed.

3. A new issue has arisen regarding the allowance for a post-graduate clinical internship to be completed solely with remote practice. The Board is being asked to weigh in on whether they believe that this constitutes a comprehensive internship.
    a. During COVID, all internships moved to remote platforms. With the removal of the Emergency Directive, agencies are generally doing a blend of in-person treatment and remote treatment.
    b. Board staff checked with the VA, DPBH Rural Clinics and several private agencies to determine their current practice model. None of them are doing remote only treatment, most are doing a hybrid model.

State of Nevada
Board of Examiners for Social Workers
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POST-GRADUATE CLINICAL INTERNSHIP PROGRAM

CLINICAL SOCIAL WORK means the application of methods, principles and techniques of case work, group work, community organization, administration, planning, consultation, research and psychotherapeutic methods and techniques to persons, families and groups to help in the diagnosis and treatment of mental and emotional conditions. (NRS 641B.030)

INTERN means an applicant for licensure as an independent (LISW) or clinical (LCSW) social worker via a post-graduate internship. The applicant is currently licensed in Nevada as a LMSW license but has not yet completed the 3000 hours of supervised postgraduate experience and 104 hours of supervision necessary for a licensure in Nevada as a LISW or LCSW. An intern is in the process of completing the requirements for their advanced license under an approved **Internship Program** of supervised practice. (NAC 641B.035)

Internship Policy – Related NACs and Expectations

Clinical Social Work Internship: Performance of supervised, postgraduate social work in Nevada.
An applicant for licensure as a clinical social worker must complete an internship program consisting of not less than 3, 000 hours of supervised, postgraduate social work and 104 hours of supervision. Except as otherwise provided, the required work must be:

(a) Undertaken in a program that is approved by the board before the applicant begins the program. The program must include, without limitation:
  (1) An examination, if deemed necessary by the board;
  (2) An appropriate setting, as determined by the board;
  (3) Supervision of the applicant by a supervisor who has been approved by the board; and
  (4) A plan of supervision that has been approved by the board.
(b) Completed not earlier than 2 years or later than 3 years after the board approves the program. For good cause, the board will grant a specific extension of this period.
(c) Conducted pursuant to the requirements and standards set forth by the board. For good cause, the board will withdraw its approval of a particular program.

At least 2,000 hours of the supervised, postgraduate clinical social work required by must be in the area of psychotherapeutic methods and techniques to person, families and groups to help in the diagnosis and treatment of mental and emotional conditions. The remaining hours may be completed in other areas of clinical social work. [NAC641B.150 (1,2)]

PSYCHOTHERAPEUTIC METHODS and TECHNIQUES Defined
The methods of treatment that use a specialized, formal interaction between a clinical social worker and a client in which a therapeutic relationship is established and maintained to:

- Understand unconscious processes and intrapersonal, interpersonal and psychosocial dynamics; and,
- Diagnose and treat mental, emotional and behavioral disorders, conditions and addictions. (NAC 641.057)

At the successful completion of a post-graduate clinical internship, the licensee must be able to demonstrate

A. The ability to assess, diagnose, and treat mental and emotional conditions

- Comprehensive psychosocial assessment including knowledge and utilization of Mental Status Exams (MSE)
- Determination of diagnosis, i.e., use of the DSM
- Development of treatment plans with specific goals
- Various clinical intervention approaches
- Competence in individual, family and group psychotherapies
- Document and review of treatment outcomes
- Knowledge of psychopharmacology
- Knowledge of addictions and the related clinical interventions
- Suicidal/homicidal evaluations and interventions
- Abuse/neglect evaluations and interventions
- Experience with a range of clientele

B. The skills and professional conduct necessary for continuing competency

- Thorough understanding of the NRS / NAC related to Social Work practice in Nevada.
- Establish professional clinical relationships – initiating and sustaining a worker/client relationship based in social work standards of professional conduct that strengthens the client.
- Appropriate "use of self" with clients and colleagues – the separation of personal issues from professional responsibility and relationships
- Commitment to the social work profession and services to clientele
- Application of social work values and ethics
- Knowledge and application of human behavior and the social environment
- Recognize and reinforce the client's prerogative of self-determination
- Utilize supervision for critical review of practice

C. Concepts relating to risk and safety issues

- Uses safety policies procedures to protect clients and licensee.
- Demonstrates the ability to assess and then function safely in emergency situations.
- Consistent use of safety and risk assessments
- Understanding the steps for mandated reporting and mandated action.
- Competence in initiating civil commitments (legal hold).
- Assessment of the intern's readiness for competent autonomous practice in relation to such safety and risk factors.

Internship Policy - Site Approval

A post-graduate internship can only be completed at a **site** approved by the Board.

In the **Site Application**, the Board requires an agency, seeking to become an approved site, to provide information regarding the following –

- Proof of agency NPI and TIN numbers, state licensure for the agency (must be licensed in NV for a period of not less than one year before consideration as a site).
- Identification of payor sources utilized by the agency, including insurance vendors, contracts, etc. and a description of how billing for services is done.
- A narrative explanation of the target client population served by the agency, types of therapy services provided, psychometric testing used, and typical issues / diagnoses treated.
- The job description and / or detailed contract for a post-graduate internship position. The **site** has the burden of demonstrating that the position constitutes clinical social work and is appropriate to provide psychotherapeutic methods and techniques.

- Organizational chart and list of the clinical complement of staff at the agency.
- Plan to provide supervision for post-graduate interns, onsite and / or offsite.
- Clinical policies
- Safety policies
- A blank client chart.

The **site** will submit an application which is reviewed by the staff and / or board member overseeing the Post-Graduate Internship Program. Once approved, the site must be agree to an onsite Board review at any time. The site must give permission for the intern's **clinical supervisor** to observe the practice of the **intern** and to review the documentation of the **intern** if the **clinical supervisor** is not employed by, or contracted with, the site (see Access Letter).

If a **site** is found to no longer meet the requirements as described above, the Board may terminate the **site** as a location for post-graduate internships. If the **site** does not have an onsite licensed mental health professional, the Board may terminate the **site** as a location for post-graduate internships. If the **site** receives a sanction by a payor source, regulatory or accreditation body, then the **site** will be closed until the terms of the sanction are met. In any of these scenarios, the Board will give **site**, **clinical supervisor** and **intern** 30 days to facilitate the transfer or closure of cases to minimize possible adverse effects on the client.

Internship Policy – Program and Application

An ***Internship Program*** is defined as the contract between a Licensed Master Social Worker (LMSW) or **intern**, a Board approved **clinical supervisor** and a Board approved **site** (agency). Licensees interested in a post-graduate clinical internship will apply to the Board for approval prior to engaging in any direct practice with clients. The applicant may only practice at a Board approved site, pursuant to NAC 641B.150.

The application is broken down into two parts, the **Intern** will apply for their LCSW / LISW license and will provide information about the proposed clinical site(s). Once the licensee's application is approved, the **clinical supervisor** will complete the supervision contract, specifying the period of the contract and any reimbursement paid by the intern / site. An application is not considered complete until both parts are submitted and approved. If the **intern** needs to make changes to their approved internship (leaving a site, adding a site, or changing their clinical supervisor), they will complete a **partial application** then the **clinical supervisor** will complete an updated contract.

The approved **site** must be in an agency that has a defined mental health / clinical program in place that would be appropriate for the educational needs of an internship. The site's approved job description / contract must be submitted with the internship application. Interns can only practice under Board approved job descriptions / contracts. Once approved, **any changes of position / job at the site must be approved by the Board in advance.** A new job description must be submitted with a request for an internship change. This change must be approved by the Board for the internship to remain active.

If the intern's **clinical supervisor** is **off-site** (not employed by or contracted with the site), then the site must designate a Nevada **licensed on-site mental health professional** (MD, APRN, PhD, MFT, or CPC) that will serve to provide administrative supervision and can assist in a clinical emergency. The on-site mental health professional must coordinate with the Board approved **clinical supervisor** regarding the intern's practice. The clinical leadership of the **site** will complete an Access Letter which the **intern** will submit providing permission for access.

An intern may not engage in direct practice with clients unless the clinical supervisor or licensed on-site mental health professional is on-site and available for immediate consultation. After the intern has completed 1000 clinical hours, 500 non-clinical hours and 50 hours of supervision, the licensed on-site mental health professional may be available for immediate consultation indirectly, e.g., the use of cellular phones, video conferencing, etc., if the **clinical supervisor** is agreeable. Since the practice of the intern is under the **clinical supervisor's** license, it is up to him/her to determine if the intern is ready for more independent practice.

Internship Policy – Program and Supervision

Per NAC 641B.160 the **clinical supervisor** is responsible for the practice of social work by the **intern**. This is managed in part by supervision meetings. The **clinical supervisor** is expected to meet with the intern individually, for not less than one hour per week. The Board also allows for 24 hours of group supervision, provided that the **clinical supervisor** is present at the group. The minimum number of hours of supervision required for completion of a post-graduate internship is 104 hours. While it is preferred that supervision occur on a face-to-face basis, the Board will allow supervision to occur using telecommunication technologies.

Additionally, **Clinical supervisors** are expected to analyze the performance of the **intern**. This is done through the supervision meetings, via direct observation the practice of the intern (in person, video conferencing or recorded sessions) and by a review of the documentation by the intern (assessments, treatment plans, progress notes and discharge summaries).

Documentation of each supervision meeting must be kept by the **clinical supervisor** and will be submitted to the Board upon request. These records must be kept for a period of five years after the closure of the supervision contract.

Internship Policy – Reporting

Once an internship is approved, the **intern** will begin to track their hours using a Board created **spreadsheet**. Each month, hours calculated from the spreadsheet are given to the **clinical supervisor**. The hours will be included in the six-month **progress report**. The reporting period are determined at the point of initial approval and will not change throughout the internship. This report will be reviewed and approved by the Board. Approval of hours is not a guarantee.

The Board may **refuse to accept a progress report or final report** submitted, if the report, (a) does not satisfy the reporting requirements for the forms provided by the Board; (b) does not include such additional information concerning the internship as requested by the Board; or (c) is received by the Board after the date on which the report is due. If the Board refuses to accept a progress report or final report, the Board will disallow credit for all hours of internship as reported on the report.

Internship Policy – Exam and Completion of Internship

Once an **intern** has completed 1000 hours of clinical practice, 500 hours of non-clinical practice and 50 hours of supervision, (s)he is eligible to request exam approval. The form is available on the website and is emailed to the Board. The intern must take and pass the exam prior to completion of both their hours and the minimum of 24 months of practice. **An internship is considered complete when the intern has 24 months of practice, 2000 hours of clinical practice, 1000 hours of non-clinical practice and 104 hours of supervision and has passed the clinical exam.** While an internship is granted for up to 3 years, this is an allowance for interns who are not practicing fulltime. Once an intern has completed the required hours and 24 months of practice, the internship, itself is completed. If the intern has not taken and passed their exam by that point, the internship will be closed, and the intern will need to apply for a new internship. Hours will be banked once a new internship is approved.

Adopted January, 1997; Amended March, 1999; Amended January, 2000; amended February 2016; amended August 2022

3C

Board Review of Hearing for Virgilio DeSio, License No. 6200-C. (For Possible Action).

Stacey Hardy-Chandler, Ph.D., J.D., LCSW, named ASWB's next CEO

ASWB
Association of Social Work Boards

Leadership

June 9, 2022

Stacey Hardy-Chandler, Ph.D., J.D., LCSW, named ASWB's next CEO

Tags: Board of Directors CEO

Stacey Hardy-Chandler, Ph.D., J.D., LCSW

ASWB President Roxroy Reid of New Mexico announced that the Board of Directors has unanimously voted to accept Stacey Hardy-Chandler, Ph.D., J.D., LCSW, as ASWB's new CEO following a national search. ASWB's Search Committee noted that Hardy-Chandler stood out among a robust pool of highly qualified applicants. "In addition to her impressive resume and leadership skills," said Reid, "she is deeply committed to the social work profession, equity, and social justice."

Hardy-Chandler received her master's in social welfare from the University of California, Los Angeles, her doctorate in clinical psychology from the California School of Professional Psychology (Alliant International), and her Juris Doctor from the University of Nevada, Las Vegas William S. Boyd School of Law. She will complete a Postgraduate Diploma in Organisational Leadership this year at Oxford University Saïd Business School. She is currently licensed as an LCSW in Nevada and Virginia.

Her social work career spans more than 30 years and includes providing mental health services to diverse client populations, serving as director of field education for the University of Nevada, Las Vegas School of Social Work and George Mason University Department of Social Work in Virginia, and most recently serving as director of the Center for Children and Families for the City of Alexandria.

Professional honors include National Association of Counties and Virginia Association of Counties Achievement Awards; National Association of Social Workers – Nevada Chapter Social Worker of the Year Award; and University of Nevada, Las Vegas Innovation Award for development of the Advanced Graduate Certificate, Forensic Social Work.

Hardy-Chandler's start date will be July 6.

3D – ii

2022 ASWB Exam Pass Rate Analysis

2019 and 2020 North American Pass Rates

2019 and 2022 Nevada Pass Rates

2022 ASWB Exam Pass Rate Analysis

FINAL REPORT

To the social work community:

At the core of the social work profession is the ability to acknowledge and honor individuals, not in isolation, but as part of their families and communities. This work—and the ability of social workers to lead change—is built on the foundation of professional standards, legally defined in regulation, that ensure competent and ethical practice. In this way, social work serves as a light for society. It is only natural that the Association of Social Work Boards remains true to its values by leading change within the profession. ASWB plays a key role in supporting and serving the social work community to advance safe, competent, and ethical practices to strengthen public protection. One important way we do this is by developing and maintaining social work licensing examinations that meet rigorous standards, ensuring that they are relevant and reflective of current social work practice.

Now, as part of our commitment to fair and uniform exams for all, ASWB is offering additional insight for our profession. For the first time, ASWB is sharing an in-depth analysis of pass rate data for the social work licensing exams, based on demographic information self-reported by test-takers. We have invested in gathering and analyzing these data through a collaboration with our partners at Human Resources Research Organization, a psychometric consulting firm. We are publishing the findings as part of the association's commitment to participating in data-driven conversations around diversity, equity, and inclusion.

This report, the *2022 ASWB Exam Pass Rate Analysis,* is an important starting point in a collective process to better help all test-takers be equally prepared for success on the examinations. By establishing a baseline, these data will enable a conversation about how the profession collectively gets from where we are now to where we want to be. In this new analysis, we observe that pass rates for some demographic groups are lower than for others, highlighting the need to identify potential steps that ASWB can take to address these differences while adhering to the public protection mandate that guides its mission.

ASWB continues to refine its exam development processes and is taking actions that will enhance its already validated examination program, including:

- Continuing to evaluate all aspects of the licensing exam development process, beginning with an in-depth review of item generation, and then implementing a comprehensive, user-centered investigation of test-takers' experiences
- Offering a collection of free resources designed for social work educators to help them understand the exams and candidate performance so they can better prepare their students for the exams and to increase access to exam resources
- Bringing a greater diversity of voices into the exam creation process through the Social Work Workforce Coalition
- Hosting community input sessions to expand the range of perspectives involved in the creation of the next iteration of the exams
- Launching the Social Work Census, an in-depth survey of social workers, to better understand who today's social work practitioners are and what they do

These actions, like this report, represent initial steps that reflect social work values and uphold ASWB's mission to protect the public from harm. The association looks forward to supporting all test-takers in their journey toward licensure and remains committed to serving its member boards by

investing in identifying and enhancing opportunities for social workers to obtain and maintain licensure.

We invite all interested members of the profession to join ASWB on this journey. It is in the power of our collective action that meaningful change can truly take hold.

In partnership,

Roxroy A. Reid, Ph.D., LCSW

Roxroy A. Reid, MSW, Ph.D., LCSW
President

Stacey Hardy-Chandler, PhD, JD, LCSW

Stacey Hardy-Chandler, Ph.D., J.D., LCSW
Chief Executive Officer

August 2022

ASWB Exam Pass Rate Analysis

FINAL REPORT

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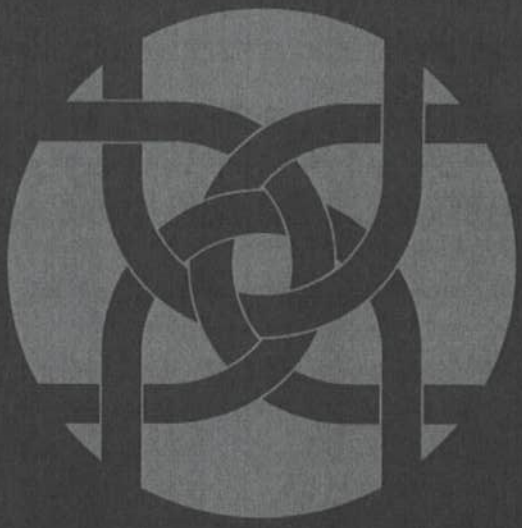


INTRODUCTION

Founded in 1979, the Association of Social Work Boards is the nonprofit organization composed of the social work regulatory boards and colleges of all 50 U.S. states, the District of Columbia, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and all 10 Canadian provinces. ASWB provides support and services to the social work regulatory community to advance safe, competent, and ethical practices to strengthen public protection. As a part of that work, ASWB develops and maintains the social work licensing examinations that are used to test a social worker's competence to practice ethically and safely. In 2021, ASWB administered 66,982 exams to licensure applicants at test centers worldwide.

Regulatory boards and colleges use the exam, along with requirements such as a degree from an accredited social work educational program and supervised experience, to help make licensing decisions. ASWB has processes in place to ensure the exams remain relevant and reflective of current social work practice and follow industry standards for validity and reliability.

On November 9, 2021, ASWB's Board of Directors made the decision to gather, analyze, and release performance data for its examinations as part of an effort to integrate data equity principles into ASWB's work. These principles include providing access to the data found in this report, ensuring reporting is clear and accessible, and working to include more stakeholder voices in future data collection.

The Board's decision also reflects a desire to contribute to the larger conversation about diversity, equity, and inclusion. This report serves as a preliminary step in informing potential actions that ASWB and the social work community can take to address differences in pass rates for different groups while still adhering to the public protection mandate that guides ASWB's mission.

The *2022 Analysis of ASWB Examination Pass Rates: Final Report* is organized into three major sections:

- **Methodology** details the methods, procedures, and decision criteria that the independent team of researchers and psychometricians at Human Resources Research Organization (HumRRO) used to organize and analyze ASWB's exam performance data.
- **Findings** presents data on the population and performance of test-takers from each of the five exams ASWB administers—Clinical, Masters, Bachelors, Associate, and Advanced Generalist. Refer to Appendix A for more on how each exam category is defined. These data reflect both aggregate counts and pass rates, as well as counts and pass rates broken out by demographic group.
- **Discussion** summarizes inferences suggested by the findings across all exams. It discusses their impact on the profession and how they inform potential future initiatives and research.

METHODOLOGY

METHODOLOGY

This report includes findings from the analysis of test-taker performance data across ASWB's five exams (Clinical, Masters, Bachelors, Associate, and Advanced Generalist) administered between 2011 and 2021, with a particular focus on two time periods: 2011 to 2021 and 2018 to 2021.

By reviewing exam participation and pass rates between 2011 and 2021, the report provides an approximately 10-year period to evaluate changes across time. This metric captures the number of test-takers who have passed the exam between 2011 and 2012 and establishes a robust baseline for comparison to data in future reports.

Data are also presented for the four-year period from 2018 to 2021 to correspond with the current exam blueprint. This blueprint is based on the examination content outlines developed through a survey of the profession as reported in the *2017 Analysis of the Practice of Social Work*. The introduction of a new exam blueprint can result in slight changes to exam content. Focusing on test-takers between 2018 and 2021 allows for more direct comparisons across similar testing experiences.

Data formatting and analysis

Several preparatory steps were conducted before beginning the analyses. First, raw data for all the exams needed to be converted into a usable format. Before processing, raw data were organized by exam administration and therefore included multiple administration instances for some test-takers (i.e., test-takers who had attempted an exam more than once were present multiple times within the same dataset). To address this, analysts developed indicators in the dataset for each test-taker's first attempt, last attempt within a year, and most recent attempt over the 10-year period so that each test-taker was counted only once in the analysis.

Second, it was necessary to identify and define the focal variables for categorizing test-takers for the purposes of analysis. Focal variables, in this context, largely refer to demographic characteristics such as gender, race/ethnicity, age, and primary language. These variables also include other indicators, such as the state or province where test-takers were approved to take the exam and the school from which test-takers earned a social work degree (Note: State/Province and school analyses are available at aswb.org and are not included as part of this report.) When computing rates for demographic groups, individuals were aggregated based on their self-reported demographic information. For some categories, the decision was made to combine subgroups that have traditionally been grouped for analytical purposes and to ensure a sufficient sample size for reporting purposes. For example, test-takers who reported "Puerto Rican" as their race/ethnicity were included as part of the "Hispanic/Latino" group for analyses. Test-taker age was another variable that had to be defined and computed; this was achieved by subtracting test-takers' birth year from their exam administration year.

Once all focal variables were defined and incorporated into the datasets, participation counts and pass rates could be computed for each exam. In general, participation counts were computed by obtaining frequencies of administrations, whereas pass rates were computed by obtaining the pass-fail status for each test-taker by administration. The participation counts and pass rates were calculated for subsets of the data by constraining the data based on (a) the exam attempt indicators previously created and (b) exam year. This way, an individual test-taker would be counted only once when computing each statistic.

Participation counts and pass rates for the various demographic groups were calculated by filtering the data according to the focal variable(s) of interest. For instance, when computing the pass rates for different race/ethnicity categories, the data were first filtered by exam attempt (i.e., first-time vs. repeat) and year or time period, where applicable, and then organized according to the test-takers' race/ethnicity category. The resultant pass rate reflects the percentage of those test-takers within each group who passed the exam the first time they took it or who eventually passed the exam during the target time period.

When computing participation counts and pass rates for intersecting demographic groups (race/ethnicity by gender and race/ethnicity by age), data were first separated by race/ethnicity and then counts and pass rates were computed for either gender or age within each race/ethnicity category.

Participant counts

Two types of participant counts were calculated for this report. Each type of participant count is described in greater detail below:

- **First-time** participation counts reflect the number of test-takers who took an exam for the first time during the target time period regardless of whether they passed the exam. Every test-taker is accounted for only once in the dataset and only for the first exam attempt.
- **Eventual** participant counts reflect the number of test-takers who took the exam over a target time period, but takes into account only test-takers' most recent attempt within that period. For example, a test-taker may have taken the exam multiple times between 2018 and 2021, with the final attempt occurring in 2021. Only the most recent attempt in 2021, however, would be included in the eventual count for the time period between 2018 and 2021. This number reflects the number of test-takers who took the exam, not the number of examinations administered.

Pass rates

Two types of pass rates were calculated for this report. Each type of pass rate is described in greater detail below:

- **First-time** pass rates reflect the percentage of test-takers who took an exam for the first time during the target time period and passed the exam.
- **Eventual** pass rates reflect the percentage of test-takers, both repeat and first-time, who tested during the target time period and eventually passed the exam. For those test-takers who took the exam more than once during the target time period (i.e., repeat test-takers), only the most recent attempt is included in the analysis. For example, a test-taker may have taken the exam multiple times between 2018 and 2021, eventually passing in 2021. Only the most recent attempt in 2021, however, would be included in the calculation of the eventual pass rate for the time period between 2018 and 2021.

Additional considerations

There are additional considerations that are important to note here before proceeding to a presentation of the findings. First, despite two types of outcomes being computed for the purposes of this report (i.e., first-time and eventual), more emphasis will be placed on the presentation of first-time participant counts and pass rates than eventual counts and pass rates. This decision was guided by the fact that findings corresponding with test-takers' first attempts, despite being lower overall for all groups, reflect the most methodologically "clean" data. This, in turn, allows for the most equivalent comparisons across groups because every test-taker in the dataset, regardless of how many exam attempts, attempted an exam at least once. In contrast, the analyses for eventual counts and pass rates are more methodologically "noisy" because of their inclusion of test-takers' "most recent attempt," which can vary widely from test-taker to test-taker. Thus, findings related to counts and pass rates for these types of outcomes are likely to be influenced not only by variation in the number of times test-takers may have attempted an exam, but also by extraneous factors (e.g., practice effects, changes in mood/anxiety with repeated attempts, increases in length of time since graduation), which can accumulate over repeated attempts and affect performance in non-systematic ways. Eventual counts and pass rates are still helpful in that they highlight how many individuals eventually pass the exam regardless of number of attempts. For making the most direct comparisons, however, particularly with respect to how demographic groups are performing on the exam, findings related to test-takers' first attempts are easier to interpret. The exception to this is findings for the Associate and Advanced Generalist exams, which will largely focus on eventual pass rates because of the low sample sizes for those exams.

Second, when interpreting the findings presented in this report, it is important to keep in mind the limitations of the available data. The demographic variables depicted in the findings are based on self-reporting and limited by the response options available to each test-taker at the time of exam administration. The options may not reflect the various ways that individuals identify and describe themselves. This is particularly the case for categories related to gender and race/ethnicity. While some categories currently include response options that allow the test-taker to fill in a response, these options were introduced more recently into registration forms and were therefore not consistently available to all test-takers during the target time periods. One demographic variable reported by test-takers is primary language, which they indicate when registering for the exam. The social work licensing exams are currently offered only in English. Some jurisdictions allow special arrangements for test-takers who indicate that English is not their primary language; these may include extra time on the exam and the use of one or two dictionaries. The findings reported are based on self-reporting of primary language, however, not on the use of special arrangements.

Finally, the current dataset reflects low sample sizes associated with some demographic groups, such as test-takers from historically marginalized racial/ethnic communities (e.g., Native American/Indigenous peoples), test-takers in higher age categories, and test-takers whose primary language is not English. Small samples were also an issue for the Advanced Generalist and Associate exams regardless of demographic group. Although sample sizes are included for all reported findings to help inform and guide comparisons, it is recommended that findings for groups with small sample sizes (less than 50 test-takers) be interpreted with caution. To protect the privacy of individual test-takers, findings are not reported for samples where the number of test-takers is less than 10.

INTERPRETING FIGURES

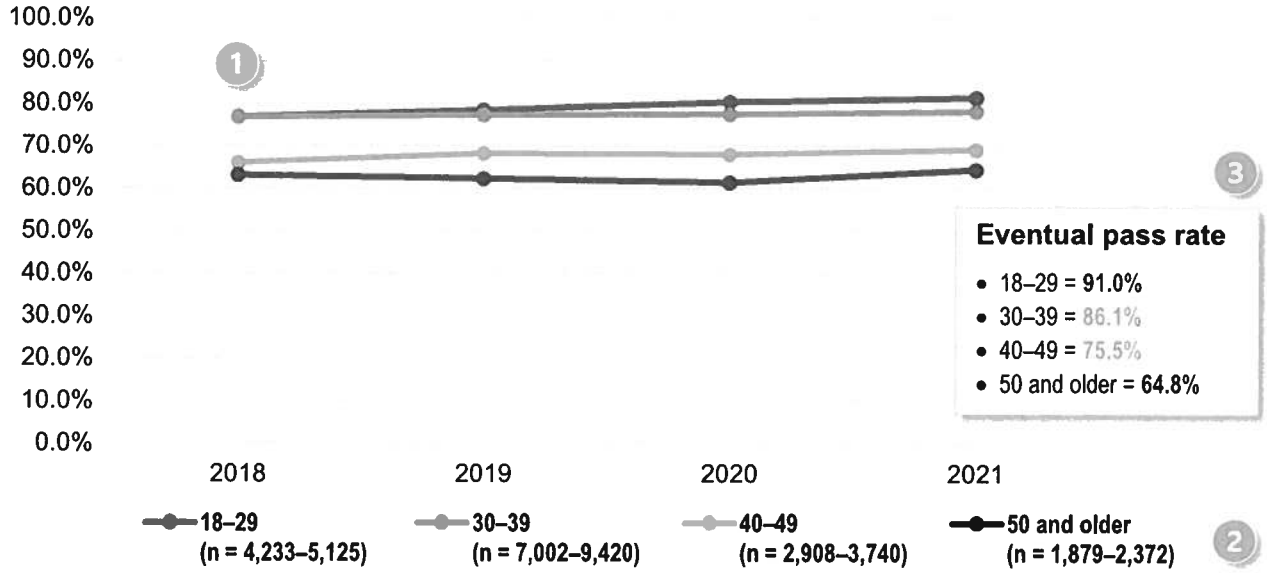
INTERPRETING FIGURES

To help guide readers in interpreting the figures presented in this report, examples are provided below.

Line graphs

In this report, line graphs are used to depict trends in pass rates across time, either from 2011 to 2021 or from 2018 to 2021, depending on the exam. Several pieces of information are incorporated into each line graph, designated here by a number in an orange circle.

Figure A. 2018–2021 Clinical exam first-time pass rates by year and eventual pass rates by age



1. **First-time pass rates** are reported on a year-by-year basis for the target time period using individual lines to represent different demographic subgroups. The lines are presented to reflect longitudinal trends over the target time period. First-time pass rates by year, where applicable, are provided in supplementary tables in the appendices.

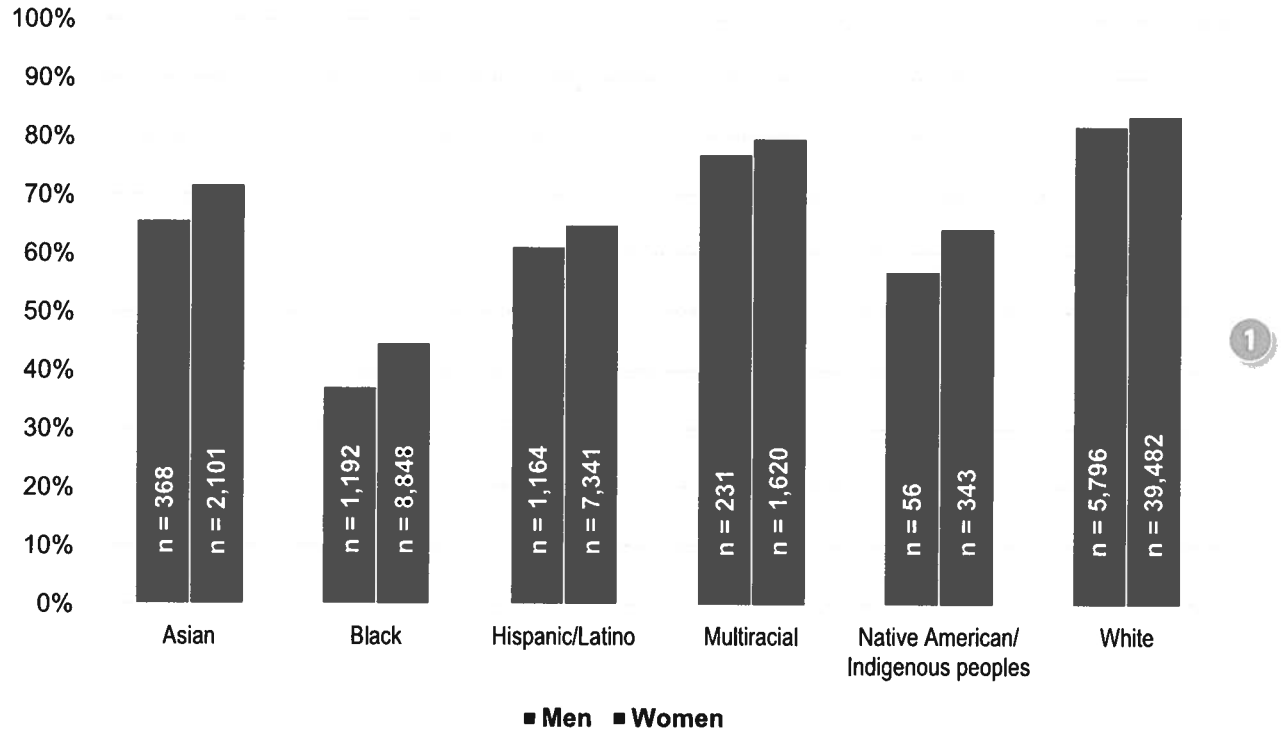
2. **The legend** provides information about which demographic subgroups are represented in the graph. Alongside each subgroup is a range, which reflects the number of test-takers from each subgroup who took the exam during the target time period. For example, "n=4,233–5,125" below "18–29" means that the annual number of first-time test-takers in that age category between 2018 and 2021 ranged from 4,233 to 5,125. These ranges are given to provide context for interpreting the graph, particularly in cases where the sample sizes are low, which could show more volatility in longitudinal trends.

3. **Eventual pass rates** are reported for test-takers in a call-out box to the right of the graph. These pass rates reflect the most recent exam attempt by test-takers over the target time period. In the example above, an eventual pass rate of 91 percent for test-takers in the 18–29 age category means that, for test-takers in that age category who took the exam between 2018 and 2021, 91 percent eventually passed the exam. This includes both first-time and repeat test-takers.

Bar charts

In this report, bar charts are used to depict aggregated pass rates within a target time period. Pass rates featured in bar charts may reflect either first-time or eventual pass rates and are aggregated from either 2011 to 2021 or 2018 to 2021, depending on the sample size of the test-taker population. Eventual pass rates and 10-year aggregates are typically reported when test-taker populations are small. Bar charts are also used to report on intersectional findings. Refer to the figure title to determine which pass rate and target time period are being reported.

Figure B. 2018–2021 Clinical exam first-time pass rates by race/ethnicity and gender



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1 **Bar charts** feature the sample size of each demographic subgroup superimposed on the bars themselves. These sample sizes reflect the total number of test-takers who took the exam within the target time period. These samples could reflect either the total number of first-time test-takers within a target time period or the total number of eventual test-takers (i.e., first-time and repeat) within a target time period. Refer to the figure title to determine which sample is being referenced in the chart.

CLINICAL EXAM FINDINGS

CLINICAL EXAM FINDINGS

Test-taker population

Test-taker population overall

Between 2011 and 2021, the number of Clinical exam first-time test-takers has steadily increased from 9,100 test-takers in 2011 to 20,657 test-takers in 2021 (a 127 percent increase). The slight drop in the number of test-takers in 2020 to 16,801 was likely caused by the start of the COVID-19 pandemic and associated restrictions that reduced capacity in testing centers to accommodate social distancing.

Table 1. 2011–2021 number of Clinical exam first-time test-takers

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Total test-takers	9,100	9,604	10,879	12,217	13,044	14,007	16,095	16,022	17,207	16,801	20,657

Test-taker population by race/ethnicity

From 2011 to 2021, white test-takers made up the largest proportion of Clinical exam first-time test-takers, comprising approximately 75 percent in 2011, but decreasing to 63 percent by 2021.

This decrease in the proportion of white first-time test-takers corresponded with an increase in the overall proportion of first-time test-takers from historically marginalized communities, which grew from 20.6 percent in 2011 to 34.5 percent in 2021. (Note: For the purposes of this report, "historically marginalized communities" includes test-takers who reported their race/ethnicity as Asian, Black, Hispanic/Latino, multiracial, and Native American/Indigenous peoples.) The largest increase in the proportion of first-time test-takers was observed for Hispanic/Latino test-takers, which grew 8 percent from 2011 to 2021.

Table 2. 2011–2021 number of Clinical exam first-time test-takers by race/ethnicity

Race/ Ethnicity	In 2011	Proportion of test-takers	In 2021	Proportion of test-takers	Total 2011–2021	Proportion increase/ decrease 2011–2021
Asian	162	2%	768	4%	4,805	+2%
Black	1,079	12%	2,932	14%	20,858	+2%
Hispanic/Latino	466	5%	2,726	13%	14,988	+8%
Multiracial	119	1%	576	3%	3,423	+2%
Native American/ Indigenous peoples	57	1%	115	1%	911	0%
White	6,855	75%	12,977	63%	105,758	-12%
Total	9,100	--	20,657	--	155,633	--

Note. Percentages may not total 100 percent because test-takers who selected options such as Prefer not to say or filled in their own identifiers were excluded from this analysis. These options were not available to test-takers at all points during the target time period. ASWB has altered the response options available on the exam registration forms and will continue to evaluate these options to ensure test-takers may accurately respond.

Test-taker population by gender

The number of individuals taking the Clinical exam more than doubled from 2011 to 2021, but the proportion of men and women taking the exam remained approximately the same, with women making up a larger proportion (87 percent) compared to men (13 percent).

Table 3. 2011–2021 number of Clinical exam first-time test-takers by gender

Gender	In 2011	Proportion of test-takers	In 2021	Proportion of test-takers	Total 2011–2021	Proportion increase/ decrease 2011–2021
Men	1,212	13%	2,618	13%	20,586	0%
Women	7,888	87%	18,007	87%	134,969	0%
Total	9,100	--	20,657	--	155,633	--

Note. Data shown may not reflect all test-takers because those who selected options such as *Prefer not to say* or filled in their own identifiers were excluded from this analysis. These options were not available to test-takers at all points during the target time period. ASWB has altered the response options available on the exam registration forms and will continue to evaluate these options to ensure test-takers may accurately respond.

Pass rates

The sections that follow provide findings related to first-time and eventual pass rates for individuals taking the Clinical exam. Figures show first-time pass rate trends, as well as eventual pass rates aggregated over the target time period. Refer to Methodology for more information on the distinction between first-time and eventual pass rates.

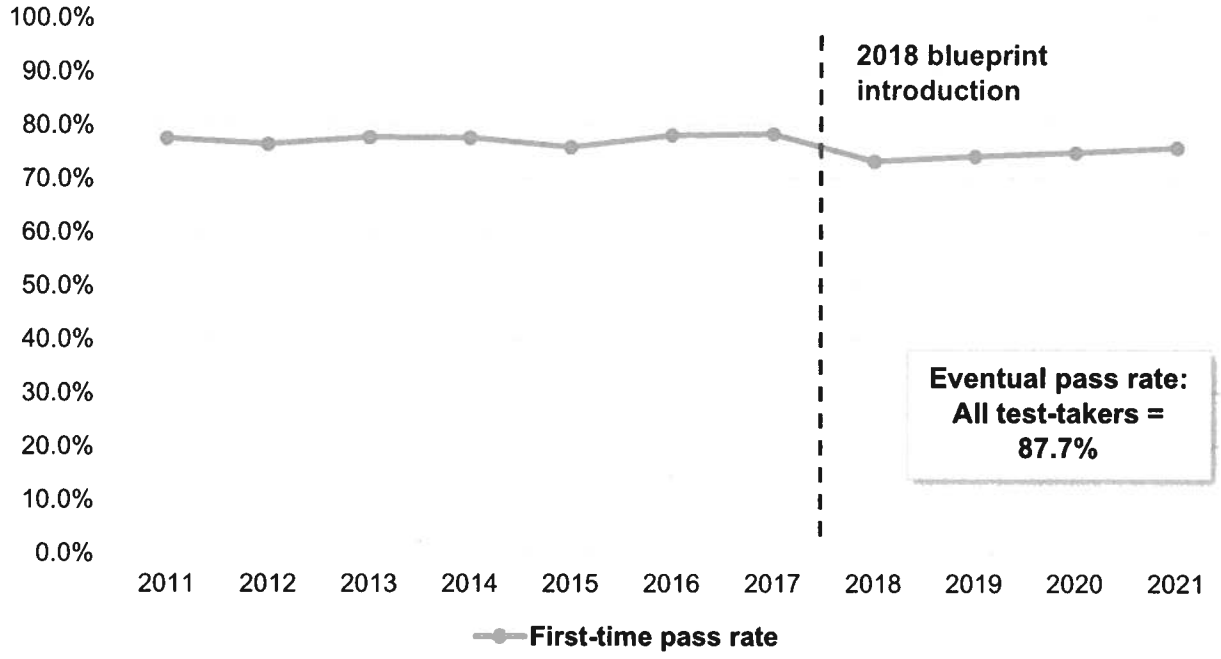
First-time pass rate numbers by year are not reported in the figures below but can be found in Appendix B.

First-time and eventual pass rates

From 2011 to 2021, most test-takers (76.1 percent) passed the Clinical exam on their first attempt. Refer to Table B1 in Appendix B for first-time pass rate numbers by year. When taking into account the number of test-takers who passed the exam regardless of whether it was their first or a subsequent attempt (i.e., eventual pass rate), even more test-takers (87.7 percent) passed the Clinical exam during this time period.

First-time pass rates decreased slightly (~5 percent) between 2017 and 2018. This decrease most likely occurred because of the introduction of a new exam blueprint. Refer to Methodology for more information on exam blueprints.

Figure 1. 2011–2021 Clinical exam first-time pass rates by year and eventual pass rate



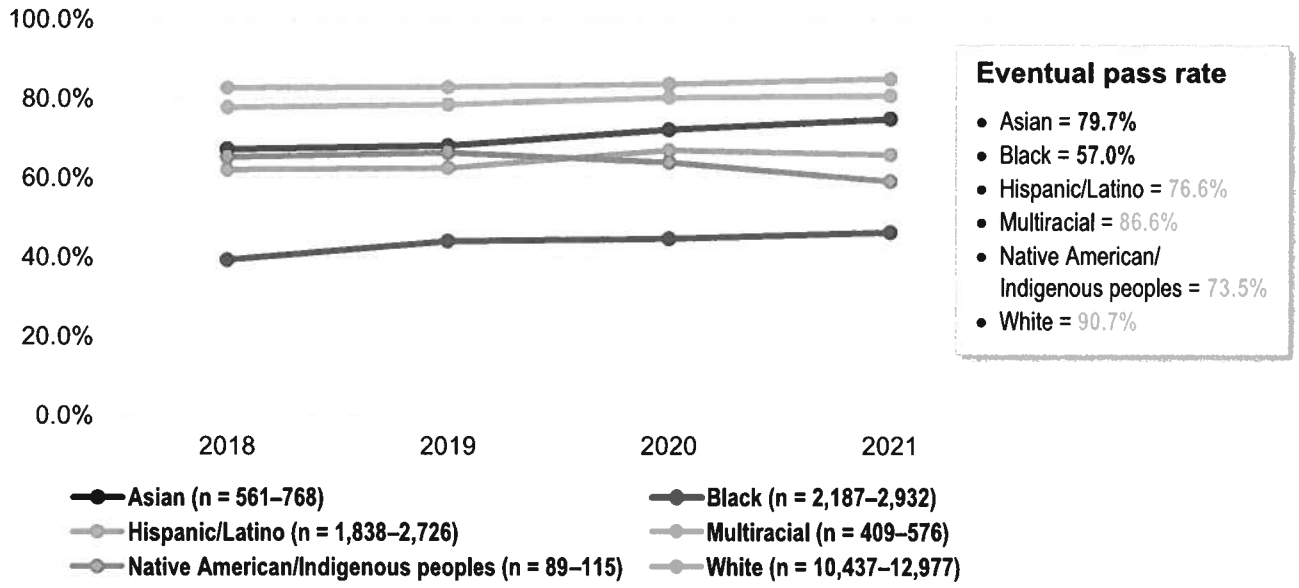
Pass rates by race/ethnicity

When considering the Clinical exam performance of test-takers by race/ethnicity, first-time pass rates have historically been highest for white test-takers, averaging 83.9 percent during the 2018–2021 time period, followed by multiracial (79.9 percent), Asian (72 percent), Hispanic/Latino (65.1 percent), Native American/Indigenous peoples (62.9 percent), and Black (45 percent) test-takers. Refer to Table B2 in Appendix B for first-time pass rate numbers by year. Eventual pass rates were higher overall across all race/ethnicity groups but demonstrated the same pattern as described for first-time pass rates.

By comparison, first-time pass rates for white test-takers have remained relatively stable during the four-year period, increasing 2.3 percent between 2018 and 2021. Black test-takers displayed some of the most significant growth in first-time pass rates, increasing 7 percent from 2018 to 2021. Asian test-takers also demonstrated a substantial increase (7.6 percent) in pass rates during this same time period; however, the number of Asian test-takers was notably smaller than the number of Black test-takers, so comparisons between these two groups may be difficult. Pass rates grew slightly for Hispanic/Latino and multiracial test-takers between 2018 and 2021, increasing by approximately 4 percent and 3 percent respectively.

Native American/Indigenous peoples test-takers showed a decrease of 6 percent in first-time pass rates between 2018 and 2021. This finding should be interpreted with caution because the relatively small sample size of this population may reflect more variation in pass rates from year to year compared to groups with larger sample sizes.

Figure 2. 2018–2021 Clinical exam first-time pass rates by year and eventual pass rates by race/ethnicity

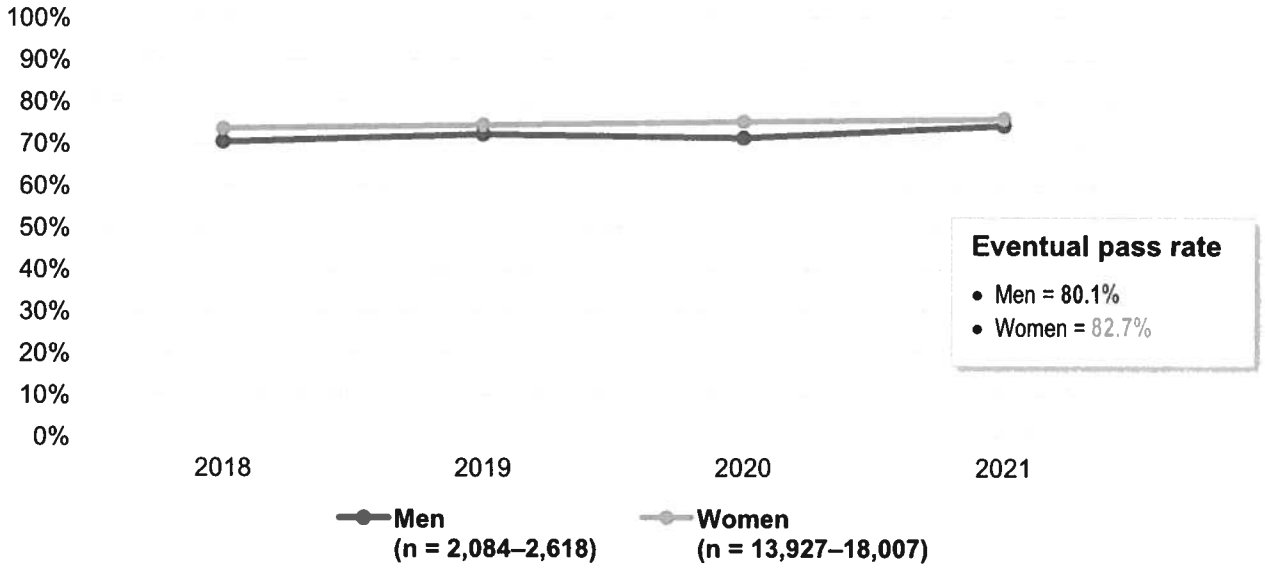


Note. Data shown may not reflect all test-takers because those who selected options such as *Prefer not to say* or filled in their own identifiers were excluded from this analysis. These options were not available to test-takers at all points during the target time period. ASWB has altered the response options available on the exam registration forms and will continue to evaluate these options to ensure test-takers may accurately respond.

Pass rates by gender

Reviewing Clinical exam performance by gender, pass rates were slightly higher for women than for men. This was the case for each year from 2018 to 2021, as well as when averaging across the four-year time period, for which the first-time pass rate was 75.3 percent for women and 72.8 percent for men. Refer to Table B3 in Appendix B for first-time pass rate numbers by year. Eventual pass rates were higher overall for both women and men but demonstrated the same pattern as described for first-time pass rates.

Figure 3. 2018–2021 Clinical exam first-time pass rates by year and eventual pass rates by gender

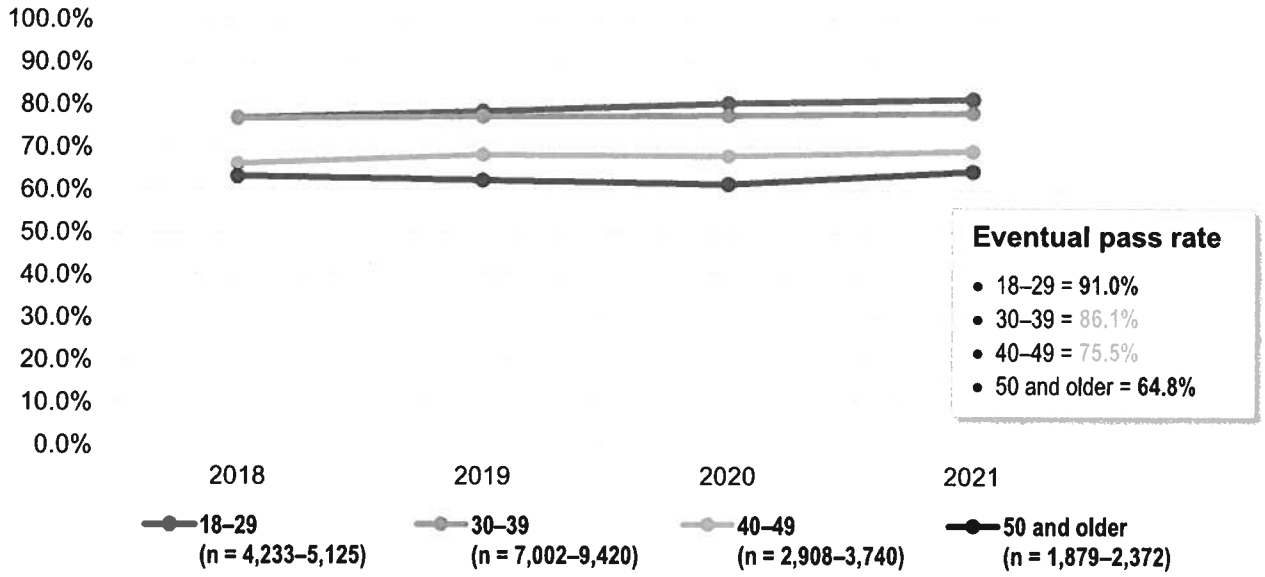


Note. Data shown may not reflect all test-takers because those who selected options such as *Prefer not to say* or filled in their own identifiers were excluded from this analysis. These options were not available to test-takers at all points during the target time period. ASWB has altered the response options available on the exam registration forms and will continue to evaluate these options to ensure test-takers may accurately respond.

Pass rates by age

Reviewing Clinical exam performance by age, pass rates were higher for test-takers in lower age categories than for higher age categories. Averaging across 2018 to 2021, the first-time pass rate was 80.1 percent for test-takers between the ages of 18 and 29, 77.7 percent for those between the ages of 30 and 39, 68.5 percent for those between the ages of 40 and 49, and 62.8 percent for those 50 years and older. Refer to Table B4 in Appendix B for first-time pass rate numbers by year. Eventual pass rates were higher across all age categories but demonstrated the same pattern as described for first-time pass rates.

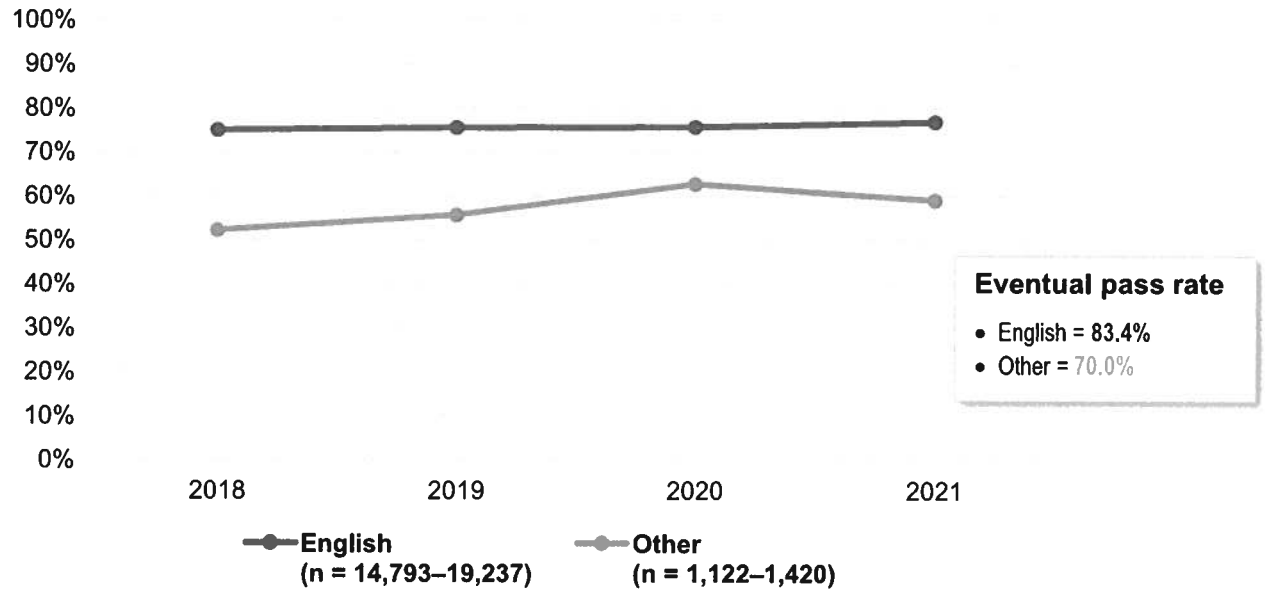
Figure 4. 2018–2021 Clinical exam first-time pass rates by year and eventual pass rates by age



Pass rates by primary language

Reviewing Clinical exam performance by primary language, pass rates were higher for test-takers who indicated their primary language was English than for those who indicated their primary language was not English. This trend was observed for first-time pass rates by individual year from 2018 to 2021, and over the four-year time period, in which the first-time pass rate was 76.2 percent for test-takers whose primary language was English and 59.1 percent for those whose primary language was not English. Refer to Table B5 in Appendix B for first-time pass rate numbers by year. Eventual pass rates were higher overall for both groups of test-takers but demonstrated the same pattern as described for first-time pass rates.

Figure 5. 2018–2021 Clinical exam first-time pass rates by year and eventual pass rates by primary language

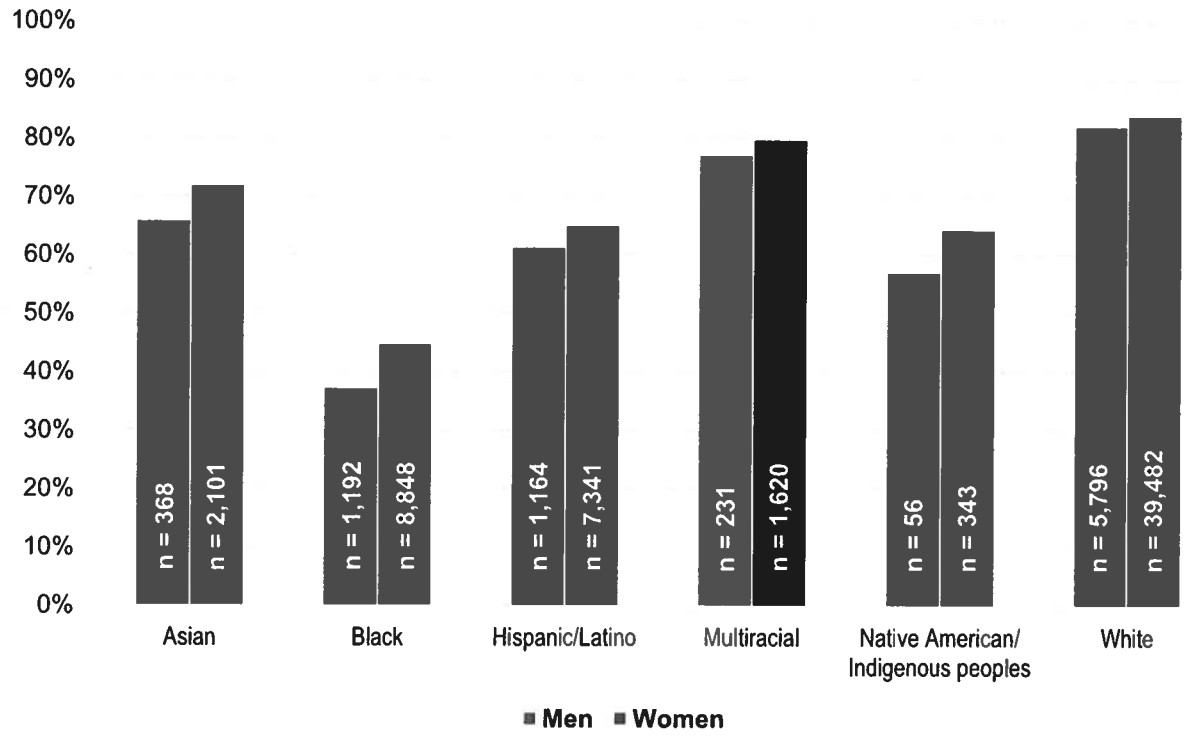


Pass rates by race/ethnicity and gender

Across all race/ethnicity subgroups, women had slightly higher first-time pass rates on the Clinical exam than men. Averaging across 2018 to 2021, the smallest difference in first-time pass rates between genders was observed for white test-takers (1.8 percent). The largest gender differences were observed for Black, Native American/Indigenous peoples, and Asian test-takers, with first-time pass rates for female test-takers being 7.5, 7.3, and 6.1 percent higher, respectively, than the first-time pass rates for male test-takers.

Overall, the patterns observed across gender and race/ethnicity were consistent with the general race/ethnicity findings for first-time pass rates on the Clinical exam, with the highest pass rates occurring for white test-takers and the lowest occurring for Black test-takers regardless of gender. Refer to Table B6 in Appendix B for first-time pass rate numbers by year.

Figure 6. 2018–2021 Clinical exam first-time pass rates by race/ethnicity and gender



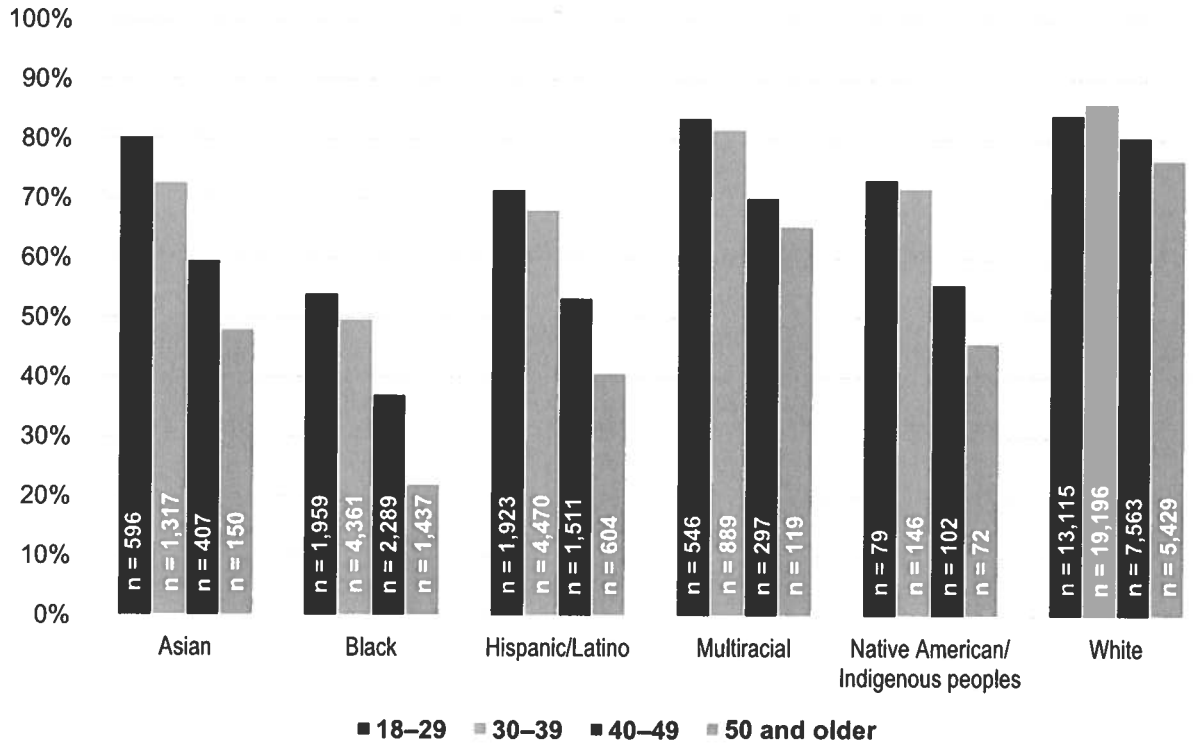
Note. Data shown may not reflect all test-takers because those who selected options such as *Prefer not to say* or filled in their own identifiers were excluded from this analysis. These options were not available to test-takers at all points during the target time period. ASWB has altered the response options available on the exam registration forms and will continue to evaluate these options to ensure test-takers may accurately respond.

Pass rates by race/ethnicity and age

Across most race/ethnicity subgroups, test-takers in the youngest age category (18 to 29 years old) had the highest first-time pass rates on the Clinical exam compared to test-takers in other age categories. The exception to this trend was for white test-takers between 30 and 39 years old; this group had a higher first-time pass rate (86.2 percent) than white test-takers in other age categories.

Within race/ethnicity subgroups, first-time pass rates mostly decreased as age categories increased, with the largest differences among age categories consistently occurring between test-takers who were 18 to 29 years old and test-takers who were 50 years and older. Refer to Table B7 in Appendix B for first-time pass rate numbers by year. The smallest difference in first-time pass rates between these two age categories was observed for white test-takers (7.5 percent), while the largest differences between these categories were observed for Asian (32.4 percent) and Black test-takers (32.2 percent).

Figure 7. 2018–2021 Clinical exam first-time pass rates by race/ethnicity and age



Note. Data shown may not reflect all test-takers because those who selected options such as *Prefer not to say* or filled in their own identifiers were excluded from this analysis. These options were not available to test-takers at all points during the target time period. ASWB has altered the response options available on the exam registration forms and will continue to evaluate these options to ensure test-takers may accurately respond.

MASTERS EXAM FINDINGS

MASTERS EXAM FINDINGS

Test-taker population

Test-taker population overall

Between 2011 and 2021, the number of Masters exam first-time test-takers has steadily increased from 11,260 in 2011 to 21,650 in 2021 (a 92 percent increase). The slight drop in the number of test-takers in 2020 to 16,716 was likely caused by the start of the COVID-19 pandemic and associated restrictions that reduced capacity in testing centers to accommodate social distancing.

Table 4. 2011–2021 number of Masters exam first-time test-takers

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Total test-takers	11,260	12,732	13,110	14,184	15,214	15,496	16,884	16,812	18,231	16,716	21,650

Test-taker population by race/ethnicity

From 2011 to 2021, white test-takers made up largest proportion of Masters exam first-time test-takers, comprising approximately 69 percent in 2011, but decreasing to 57 percent by 2021.

This decrease in the proportion of white first-time test-takers corresponded with an increase in the overall proportion of first-time test-takers from historically marginalized communities, which grew from 27.4 percent in 2011 to 39.1 percent in 2021. (Note: For the purposes of this report, "historically marginalized communities" includes test-takers who reported their race/ethnicity as Asian, Black, Hispanic/Latino, multiracial, and Native American/Indigenous peoples.) The largest increase in the proportion of first-time test-takers was observed for Hispanic/Latino test-takers, which grew 6 percent from 2011 to 2021.

Table 5. 2011–2021 number of Masters exam first-time test-takers by race/ethnicity

Race/ Ethnicity	In 2011	Proportion of test-takers	In 2021	Proportion of test-takers	Total 2011–2021	Proportion increase/ decrease 2011–2021
Asian	351	3%	754	3%	5,510	0%
Black	1,686	15%	4,225	20%	30,646	+5%
Hispanic/Latino	782	7%	2,752	13%	17,093	+6%
Multiracial	202	2%	585	3%	3,959	+1%
Native American/ Indigenous peoples	66	1%	136	1%	947	0%
White	7,747	69%	12,423	57%	108,550	-12%
Total	11,260	--	21,650	--	172,289	--

Note. Percentages may not total 100 percent because test-takers who selected options such as *Prefer not to say* or filled in their own identifiers were excluded from this analysis. These options were not available to test-takers at all points during the target time period. ASWB has altered the response options available on the exam registration forms and will continue to evaluate these options to ensure test-takers may accurately respond.

Test-taker population by gender

The number of individuals taking the Masters exam approximately doubled from 2011 to 2021, but the proportion of men and women taking the exam remained relatively the same, with women comprising 87.5 percent and men 12.5 percent.

Table 6. 2011–2021 number of Masters exam first-time test-takers by gender

Gender	In 2011	Proportion of test-takers	In 2021	Proportion of test-takers	Total 2011–2021	Proportion increase/ decrease 2011–2021
Men	1,448	13%	2,593	12%	21,604	-1%
Women	9,809	87%	19,040	88%	150,613	+1%
Total	11,260	--	21,650	--	172,289	--

Note. Data shown may not reflect all test-takers because those who selected options such as *Prefer not to say* or filled in their own identifiers were excluded from this analysis. These options were not available to test-takers at all points during the target time period. ASWB has altered the response options available on the exam registration forms and will continue to evaluate these options to ensure test-takers may accurately respond.

Pass rates

The sections that follow provide findings for first-time and eventual pass rates for individuals taking the Masters exam. Figures provide information related to first-time pass rate trends, as well as eventual pass rates aggregated over the target time period. Refer to Methodology for more information on the distinction between first-time and eventual pass rates.

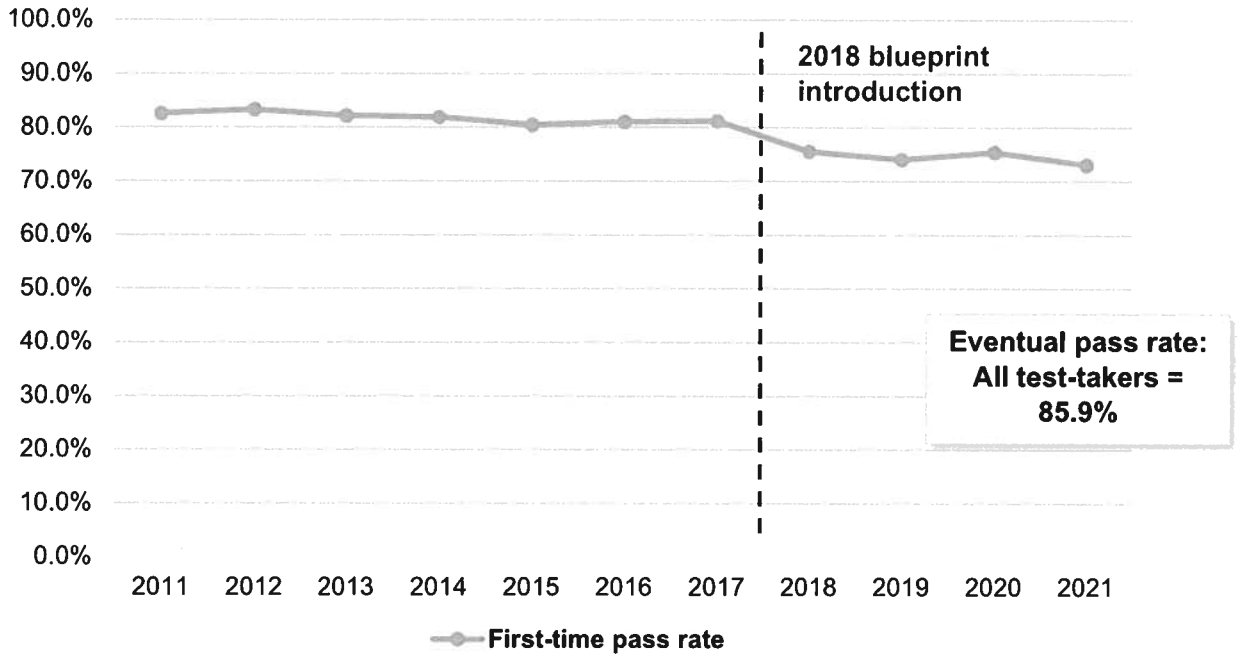
First-time pass rate numbers by year are not reported in the figures below but can be found in Appendix C.

First-time and eventual pass rates

From 2011 to 2021, most test-takers (78.5 percent) passed the Masters exam on their first attempt. Refer to Table C1 in Appendix C for first-time pass rate numbers by year. When taking into account the number of test-takers who passed the exam regardless of whether it was their first or a subsequent attempt (i.e., eventual pass rate), even more test-takers (85.9 percent) passed the Masters exam during this time period.

First-time pass rates decreased slightly (~6 percent) between 2017 and 2018. This is most likely because of the introduction of a new exam blueprint. Refer to Methodology for more information on exam blueprints.

Figure 8. 2011–2021 Masters exam first-time pass rates by year and eventual pass rate

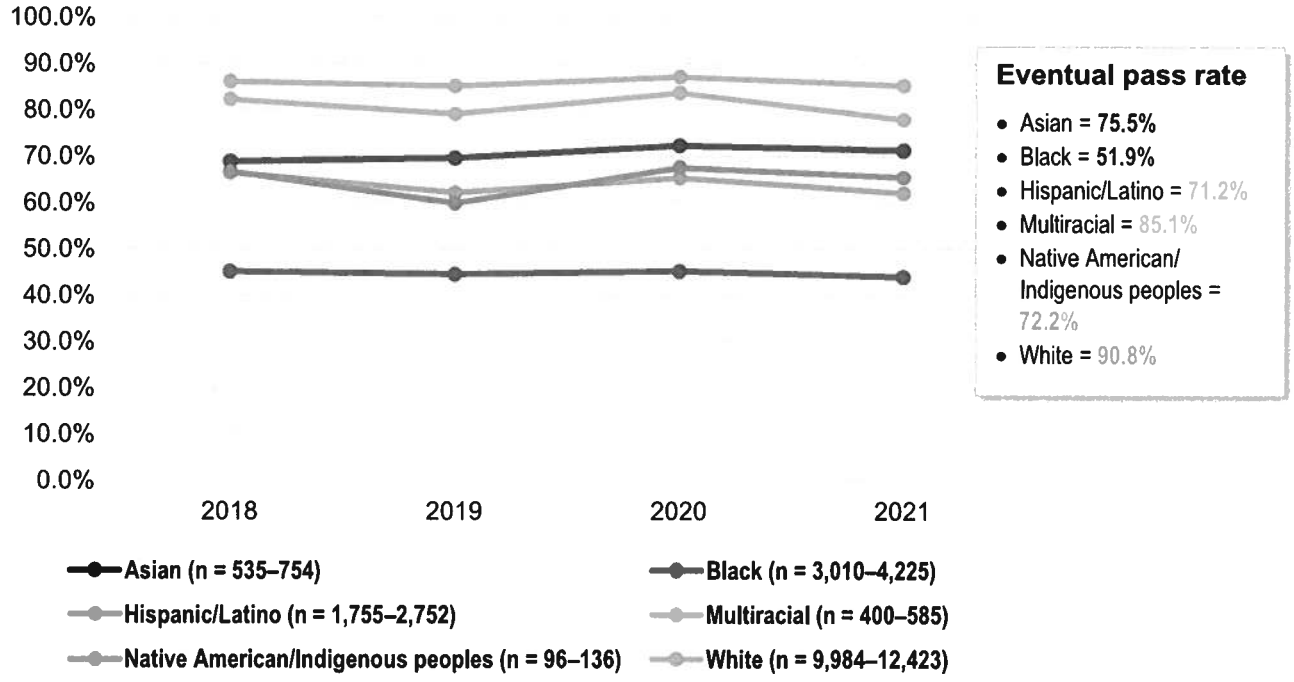


Pass rates by race/ethnicity

When considering the Masters exam performance of test-takers by race/ethnicity, first-time pass rates have historically been highest for white test-takers, averaging 85.8 percent during the 2018–2021 time period, followed by multiracial (80 percent), Asian (71 percent), Native American/Indigenous peoples (64.4 percent), Hispanic/Latino (63 percent), and Black (44.5 percent) test-takers. Refer to Table C2 in Appendix C for first-time pass rate numbers by year. Eventual pass rates were higher overall across all race/ethnicity groups but demonstrated the same pattern as described for first-time pass rates.

First-time pass rates have also remained relatively stable from 2018 to 2021 for several race/ethnicity groups, decreasing less than 1 percent for white test-takers, 1.1 percent for Black test-takers, and 1.3 percent for Native American/Indigenous peoples test-takers. The largest decrease in first-time pass rates was observed for test-takers identifying as Hispanic/Latino or multiracial, with pass rates decreasing 4.4 percent from 2018 to 2021 for both groups. In contrast, Asian test-takers showed a 2.4 percent increase in first-time pass rates from 2018 to 2021.

Figure 9. 2018–2021 Masters exam first-time pass rates by year and eventual pass rates by race/ethnicity

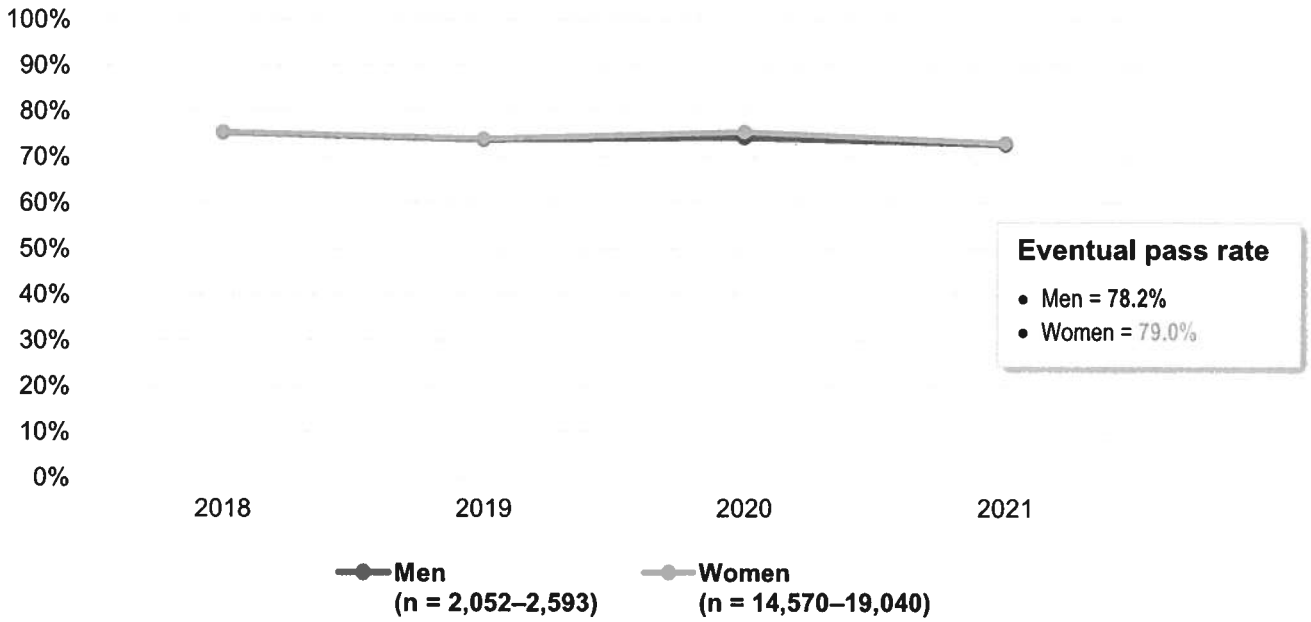


Note. Data shown may not reflect all test-takers because those who selected options such as *Prefer not to say* or filled in their own identifiers were excluded from this analysis. These options were not available to test-takers at all points during the target time period. ASWB has altered the response options available on the exam registration forms and will continue to evaluate these options to ensure test-takers may accurately respond.

Pass rates by gender

Reviewing Masters exam performance by gender, pass rates were slightly higher for women than for men. This included pass rates by individual year from 2018 to 2021, as well as the four-year average of first-time pass rates, which was 74.1 percent for women and 73.5 percent for men. Refer to Table C3 in Appendix C for first-time pass rate numbers by year. Eventual pass rates were higher overall for both women and men but demonstrated the same pattern as described for first-time pass rates.

Figure 10. 2018–2021 Masters exam first-time pass rates by year and eventual pass rates by gender

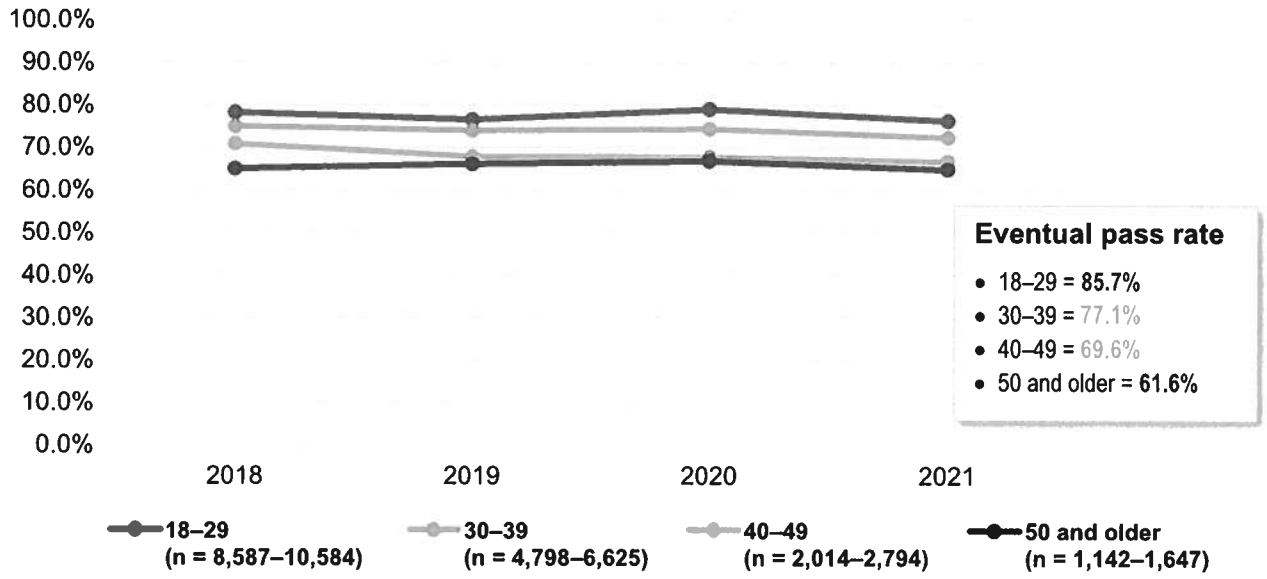


Note. Data shown may not reflect all test-takers because those who selected options such as *Prefer not to say* or filled in their own identifiers were excluded from this analysis. These options were not available to test-takers at all points during the target time period. ASWB has altered the response options available on the exam registration forms and will continue to evaluate these options to ensure test-takers may accurately respond.

Pass rates by age

Reviewing Masters exam performance by age, pass rates were higher for test-takers in lower age categories than in higher age categories. Averaging across 2018 to 2021, the first-time pass rate was 77.2 percent for test-takers between the ages of 18 and 29, 73.4 percent for those between 30 and 39, 67.4 percent for those between 40 and 49, and 65.8 percent for those 50 years and older. Refer to Table C4 in Appendix C for first-time pass rate numbers by year. Eventual pass rates were higher across all age categories but demonstrated the same pattern as described for first-time pass rates.

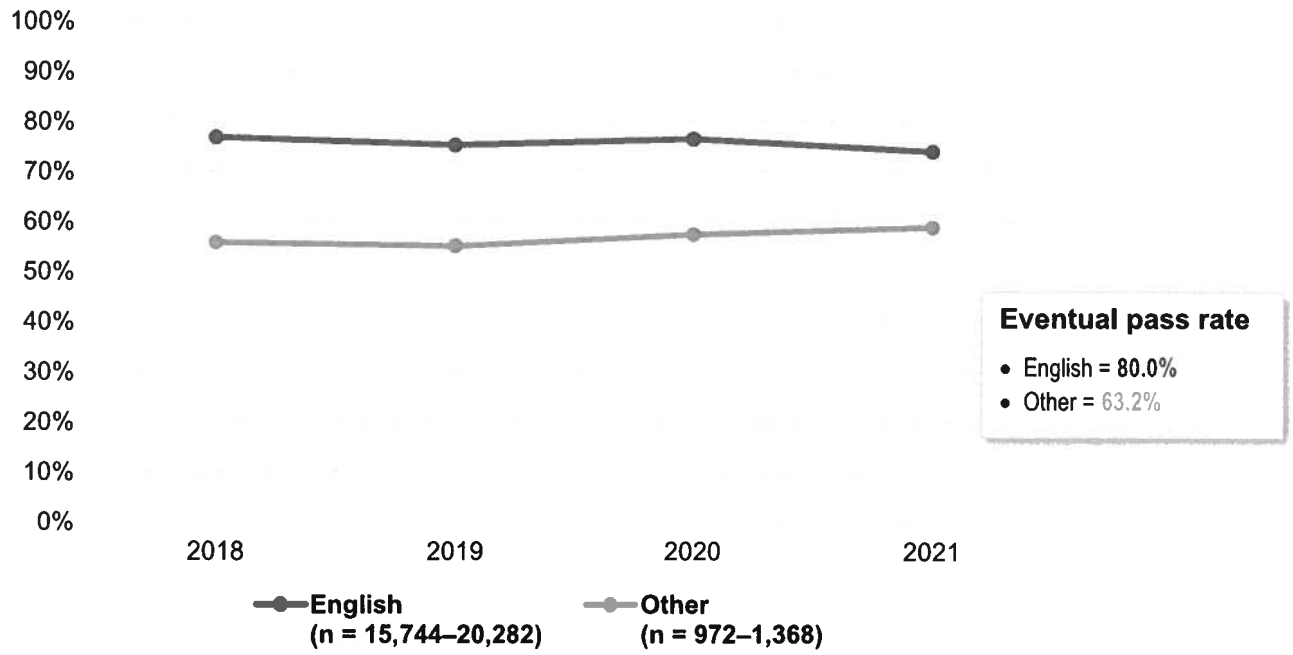
Figure 11. 2018–2021 Masters exam first-time pass rates by year and eventual pass rates by age



Pass rates by primary language

Reviewing Masters exam performance by primary language, pass rates were higher for test-takers who indicated their primary language was English than for those who indicated their primary language was not English. This trend was observed for first-time pass rates by individual year from 2018 to 2021, as well as the average across the four-year time period, for which the first-time pass rate was 75.1 percent for test-takers whose primary language was English and 57.2 percent for those whose primary language was not English. Refer to Table C5 in Appendix C for first-time pass rate numbers by year. Eventual pass rates were higher overall for both groups of test-takers but demonstrated the same pattern as described for first-time pass rates.

Figure 12. 2018–2021 Masters exam first-time pass rates by year and eventual pass rates by primary language



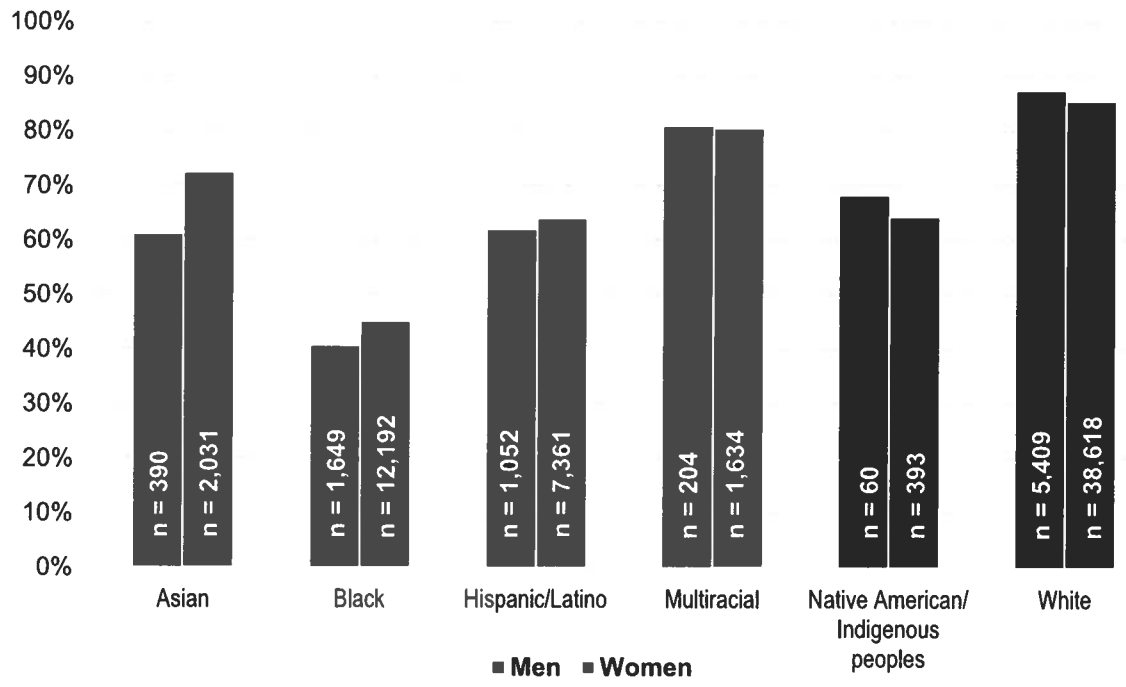
Pass rates by race/ethnicity and gender

From 2018 to 2021, women who identified as Asian, Black, and Hispanic/Latino had higher first-time pass rates on the Masters exam than men. For other race/ethnicity groups (i.e., multiracial, Native American/Indigenous peoples, and white), men had slightly higher pass rates than women.

Averaging across 2018 to 2021, the smallest difference in first-time pass rates between genders was observed for multiracial test-takers (less than 1 percent). The largest gender difference was observed for Asian test-takers, with the first-time pass rate for women being 11.4 percent higher than that for men. For both Black and Hispanic/Latino test-takers, first-time pass rates for women were 4.5 percent and 2 percent higher, respectively, than first-time pass rates for men. For Native American/Indigenous peoples and white test-takers, first-time pass rates for men were 4 percent and 2 percent higher, respectively, than first-time pass rates for women.

Overall, the patterns observed across gender and race/ethnicity were consistent with the general race/ethnicity findings for first-time pass rates on the Masters exam, with the highest pass rates occurring for white test-takers and the lowest occurring for Black test-takers regardless of gender. Refer to Table C6 in Appendix C for first-time pass rate numbers by year.

Figure 13. 2018–2021 Masters exam first-time pass rates by race/ethnicity and gender



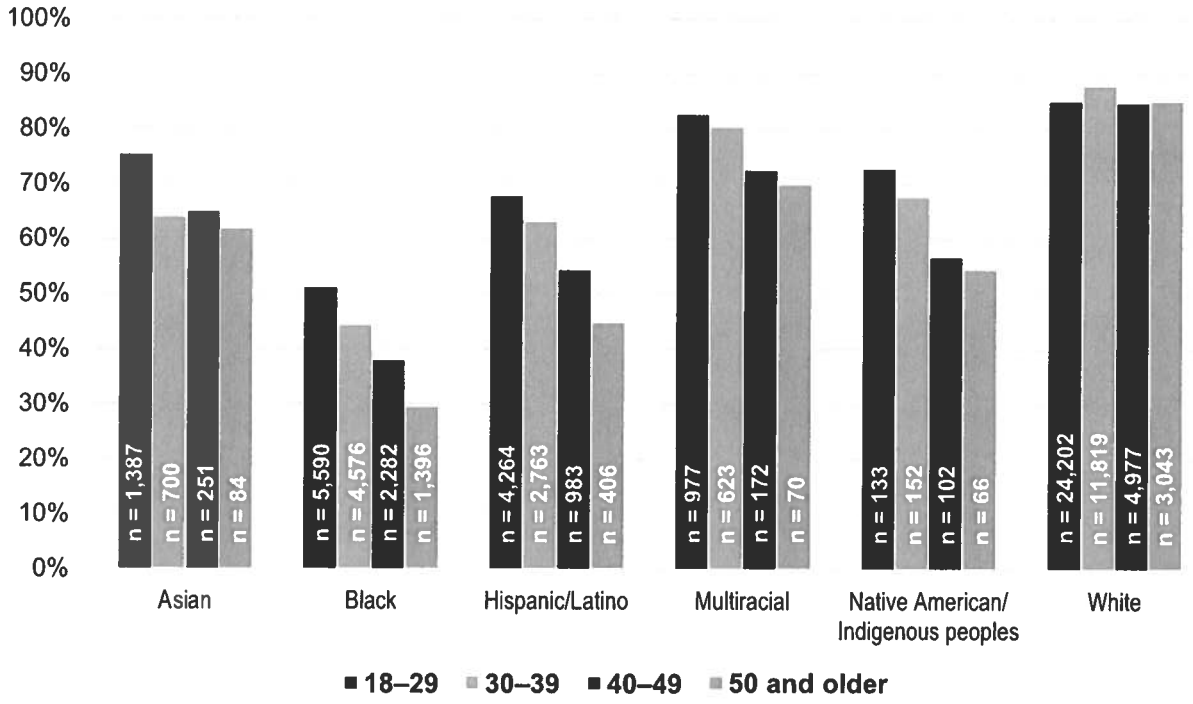
Note. Data shown may not reflect all test-takers because those who selected options such as *Prefer not to say* or filled in their own identifiers were excluded from this analysis. These options were not available to test-takers at all points during the target time period. ASWB has altered the response options available on the exam registration forms and will continue to evaluate these options to ensure test-takers may accurately respond.

Pass rates by race/ethnicity and age

Across most race/ethnicity subgroups, test-takers in the youngest age category (18 to 29 years old) had the highest first-time pass rates on the Masters exam compared to test-takers in other age categories. The exception to this trend was for white test-takers between 30 and 39 years old; this group had a higher first-time pass rate (88 percent) than white test-takers in other age categories.

Within race/ethnicity subgroups, first-time pass rates mostly decreased as age categories increased, with the largest differences among age categories predominantly occurring between test-takers who were 18 to 29 years old and those 50 and older. Refer to Table C7 in Appendix C for first-time pass rate numbers by year. The smallest difference in first-time pass rates between these two age categories was observed for white test-takers (less than 1 percent), while the largest differences between these categories were observed for Hispanic/Latino (23.1 percent) and Black test-takers (21.8 percent).

Figure 14. 2018–2021 Masters exam first-time pass rates by race/ethnicity and age



Note. Data shown may not reflect all test-takers because those who selected options such as *Prefer not to say* or filled in their own identifiers were excluded from this analysis. These options were not available to test-takers at all points during the target time period. ASWB has altered the response options available on the exam registration forms and will continue to evaluate these options to ensure test-takers may accurately respond.

BACHELORS EXAM FINDINGS

BACHELORS EXAM FINDINGS

Test-taker population

Test-taker population overall

Between 2011 and 2021, the number of Bachelors exam first-time test-takers increased slightly from 3,164 test-takers in 2011 to 3,494 test-takers in 2021 (a 10.4 percent increase). The slight drop in the number of test-takers in 2020 to 2,709 was likely caused by the start of the COVID-19 pandemic and associated restrictions that reduced capacity in testing centers to accommodate social distancing.

Table 7. 2011–2021 number of Bachelors exam first-time test-takers

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Total test-takers	3,164	3,251	3,595	3,873	4,083	4,113	4,462	3,711	3,583	2,709	3,494

Test-taker population by race/ethnicity

From 2011 to 2021, white test-takers made up the largest proportion of Bachelors exam first-time test-takers, comprising approximately 73 percent of the test-taker population in 2011, but decreasing to 69 percent by 2021.

This decrease in the proportion of white first-time test-takers corresponded with an increase in the overall proportion of first-time test-takers from historically marginalized communities, which grew from 25.1 percent in 2011 to 27.9 percent in 2021. (Note: For the purposes of this report, "historically marginalized communities" includes test-takers who reported their race/ethnicity as Asian, Black, Hispanic/Latino, multiracial, and Native American/Indigenous peoples.)

Table 8. 2011–2021 number of Bachelors exam first-time test-takers by race/ethnicity

Race/Ethnicity	In 2011	Proportion of test-takers	In 2021	Proportion of test-takers	Total 2011–2021	Proportion increase/ decrease 2011–2021
Asian	55	2%	97	3%	793	+1%
Black	515	16%	446	13%	5,614	-3%
Hispanic/Latino	174	6%	293	8%	2,634	+2%
Multiracial	36	1%	100	3%	710	+2%
Native American/ Indigenous peoples	15	1%	40	1%	313	0%
White	2,308	73%	2,406	69%	28,968	-4%
Total	3,164	--	3,494	--	40,038	--

Note. Percentages may not total 100 percent because test-takers who selected options such as *Prefer not to say* or filled in their own identifiers were excluded from this analysis. These options were not available to test-takers at all points during the target time period. ASWB has altered the response options available on the exam registration forms and will continue to evaluate these options to ensure test-takers may accurately respond.

Test-taker population by gender

The number of individuals taking the Bachelors exam slightly increased from 2011 to 2021, but the proportion of men and women taking the exam has remained approximately the same, with women making up 90.5 percent compared to 9.4 percent for men.

Table 9. 2011–2021 number of Bachelors exam first-time test-takers by gender

Gender	In 2011	Proportion of test-takers	In 2021	Proportion of test-takers	Total 2011–2021	Proportion increase/ decrease 2011–2021
Men	300	9%	327	9%	3,995	0%
Women	2,862	91%	3,166	91%	36,026	0%
Total	3,164	--	3,494	--	40,038	--

Note. Data shown may not reflect all test-takers because those who selected options such as *Prefer not to say* or filled in their own identifiers were excluded from this analysis. These options were not available to test-takers at all points during the target time period. ASWB has altered the response options available on the exam registration forms and will continue to evaluate these options to ensure test-takers may accurately respond.

Pass rates

The sections that follow provide findings related to first-time and eventual pass rates for individuals taking the Bachelors exam. Figures provide information related to first-time pass rate trends, as well as eventual pass rates aggregated over the target time period. Refer to Methodology for more information on the distinction between first-time and eventual pass rates.

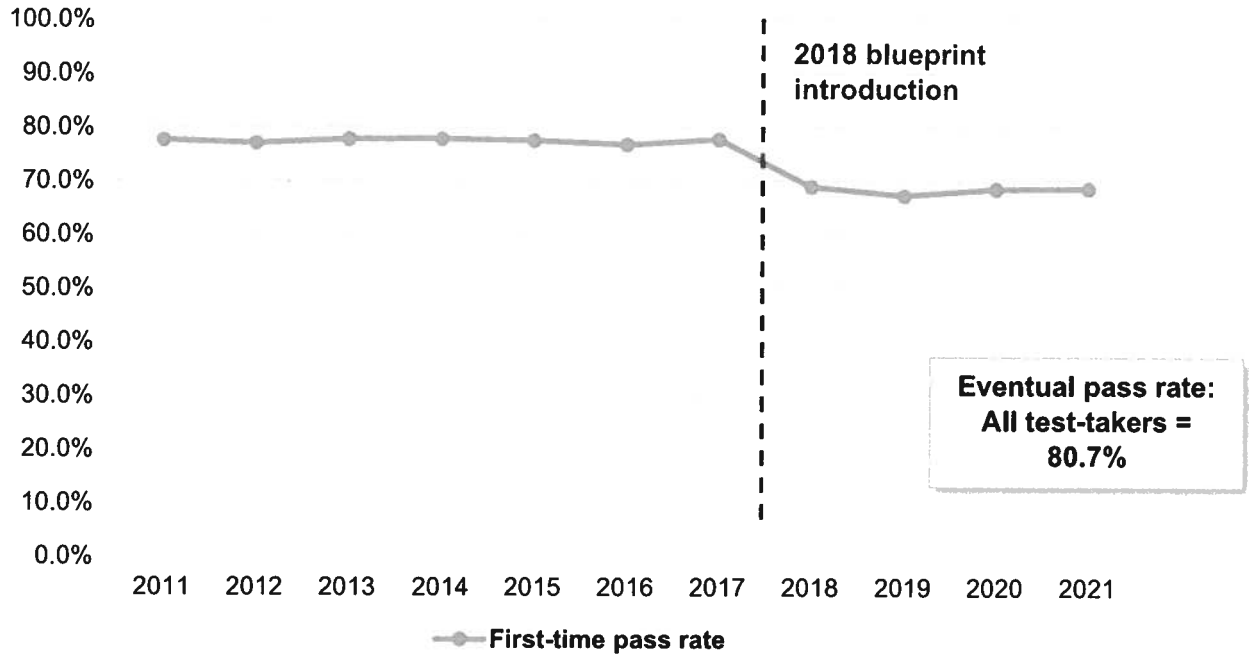
First-time pass rate numbers by year are not reported in the figures below but can be found in Appendix D.

First-time and eventual pass rates

From 2011 to 2021, most test-takers (74.4 percent) passed the Bachelors exam on their first attempt. Refer to Table D1 in Appendix D for first-time pass rate numbers by year. When taking into account the number of test-takers who passed the exam regardless of whether it was their first or a subsequent attempt (i.e., eventual pass rate), even more test-takers (80.7 percent) passed the Bachelors exam during this time period.

First-time pass rates decreased slightly (~9 percent) between 2017 and 2018. This is most likely because of the introduction of a new exam blueprint. Refer to Methodology for more information on exam blueprints.

Figure 15. 2011–2021 Bachelors exam first-time pass rates by year and eventual pass rate

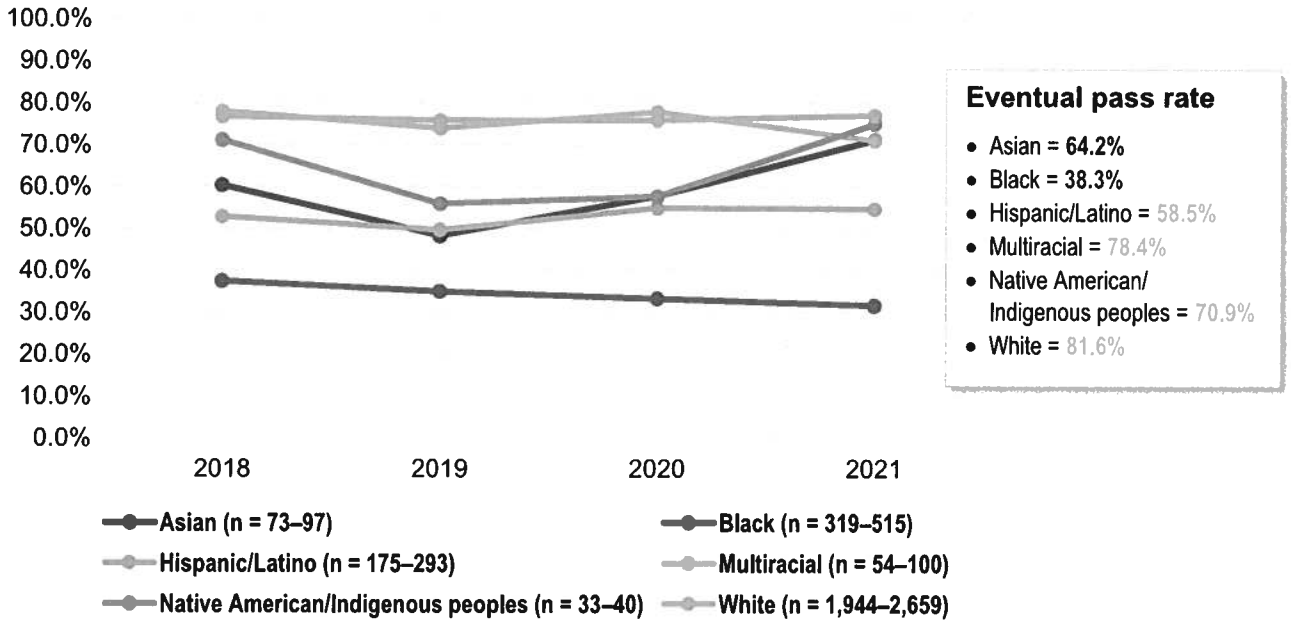


Pass rates by race/ethnicity

When considering the Bachelors exam performance of test-takers by race/ethnicity, first-time pass rates were highest for white test-takers, averaging 76.2 percent during the 2018–2021 time period, followed by multiracial (73.5 percent), Native American/Indigenous peoples (63.6 percent), Asian (59.6 percent), Hispanic/Latino (52.8 percent), and Black (33.3 percent) test-takers. Refer to Table D2 in Appendix D for first-time pass rate numbers by year. Eventual pass rates were higher overall across all race/ethnicity groups, but demonstrated the same pattern as described for first-time pass rates.

First-time pass rates have remained somewhat stable from 2018 to 2021 for several race/ethnicity groups, decreasing less than 1 percent for white test-takers, and increasing 1.9 percent and 3.9 percent for Hispanic/Latino and Native American/Indigenous peoples test-takers, respectively. The largest decreases in first-time pass rates were observed for test-takers identifying as multiracial or Black, with pass rates decreasing 6.9 percent for multiracial test-takers and 5.9 percent for Black test-takers from 2018 to 2021. Asian test-takers showed 10.9 percent increase in first-time pass rates of 10.9 percent from 2018 to 2021. This increase should be interpreted with caution, however, because of the relatively small sample size of this population each year which could cause more volatility in pass rates compared to groups with larger sample sizes.

Figure 16. 2018–2021 Bachelors exam first-time pass rates by year and eventual pass rates by race/ethnicity

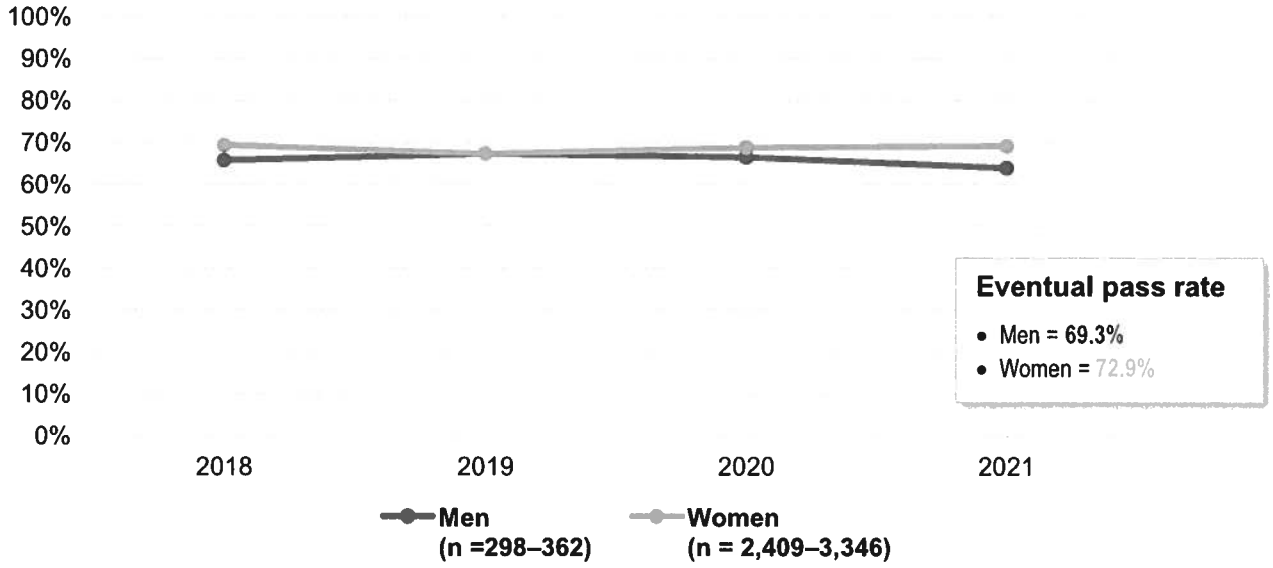


Note. Data shown may not reflect all test-takers because those who selected options such as *Prefer not to say* or filled in their own identifiers were excluded from this analysis. These options were not available to test-takers at all points during the target time period. ASWB has altered the response options available on the exam registration forms and will continue to evaluate these options to ensure test-takers may accurately respond.

Pass rates by gender

Reviewing Bachelors exam performance by gender, pass rates were slightly higher for women than for men. This applied when reviewing pass rates by individual year from 2018 to 2021, as well as the four-year average, for which the first-time pass rate was 68.4 percent for women and 65.9 percent for men. Refer to Table D3 in Appendix D for first-time pass rate numbers by year. Eventual pass rates were higher overall for both women and men but demonstrated the same pattern as described for first-time pass rates.

Figure 17. 2018–2021 Bachelors exam first-time pass rates by year and eventual pass rates by gender

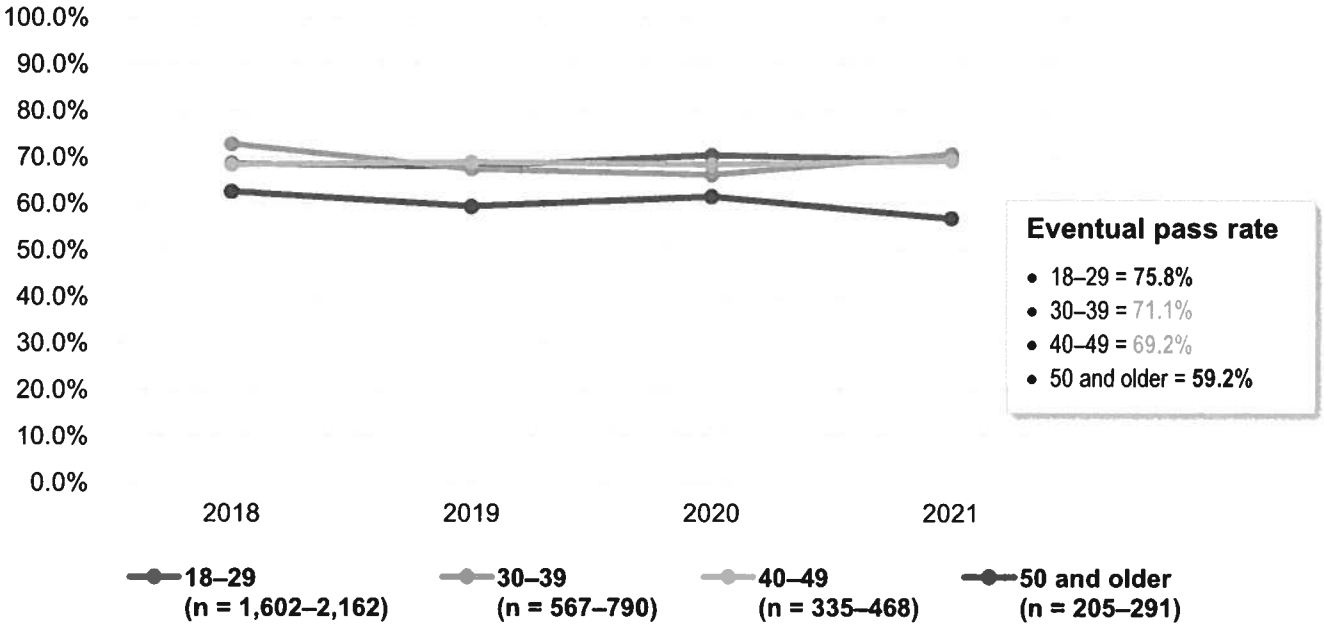


Note. Data shown may not reflect all test-takers because those who selected options such as *Prefer not to say* or filled in their own identifiers were excluded from this analysis. These options were not available to test-takers at all points during the target time period. ASWB has altered the response options available on the exam registration forms and will continue to evaluate these options to ensure test-takers may accurately respond.

Pass rates by age

Reviewing Bachelors exam performance by age, pass rates tended to be higher for test-takers in lower age categories than for those in higher age categories with some exceptions. Averaging across 2018 to 2021, the first-time pass rate was 69.1 percent for test-takers between 18 and 29, 68.2 percent for those between 30 and 39, 68.9 percent for those between 40 and 49, and 59 percent for those 50 and older. Refer to Table D4 in Appendix D for first-time pass rate numbers by year. Eventual pass rates were higher across all age categories but demonstrated similar patterns as described for first-time pass rates, with the exception being that the eventual pass rate for test-takers between the ages of 30 and 39 was higher (71.1 percent) than for those between 40 and 49 (69.2 percent).

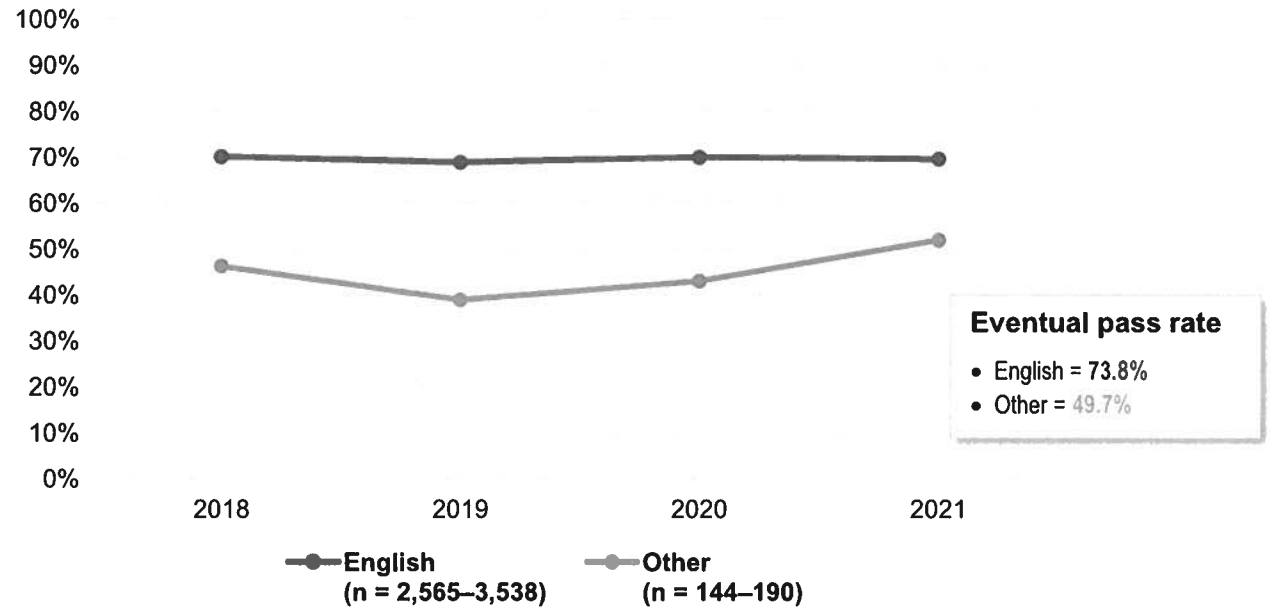
Figure 18. 2018–2021 Bachelors exam first-time pass rates by year and eventual pass rates by age



Pass rates by primary language

Reviewing Bachelors exam performance by primary language, pass rates were higher for those who indicated that their primary language was English than for those who indicated that their primary language was not English. This trend was observed for first-time pass rates by individual year from 2018 to 2021, as well as the four-year average, for which the first-time pass rate was 69.4 percent for test-takers whose primary language was English and 44.6 percent for those whose primary language was not English. Refer to Table D5 in Appendix D for first-time pass rate numbers by year. Eventual pass rates were higher overall for both groups of test-takers but demonstrated the same pattern as described for first-time pass rates.

Figure 19. 2018–2021 Bachelors exam first-time pass rates by year and eventual pass rates by primary language



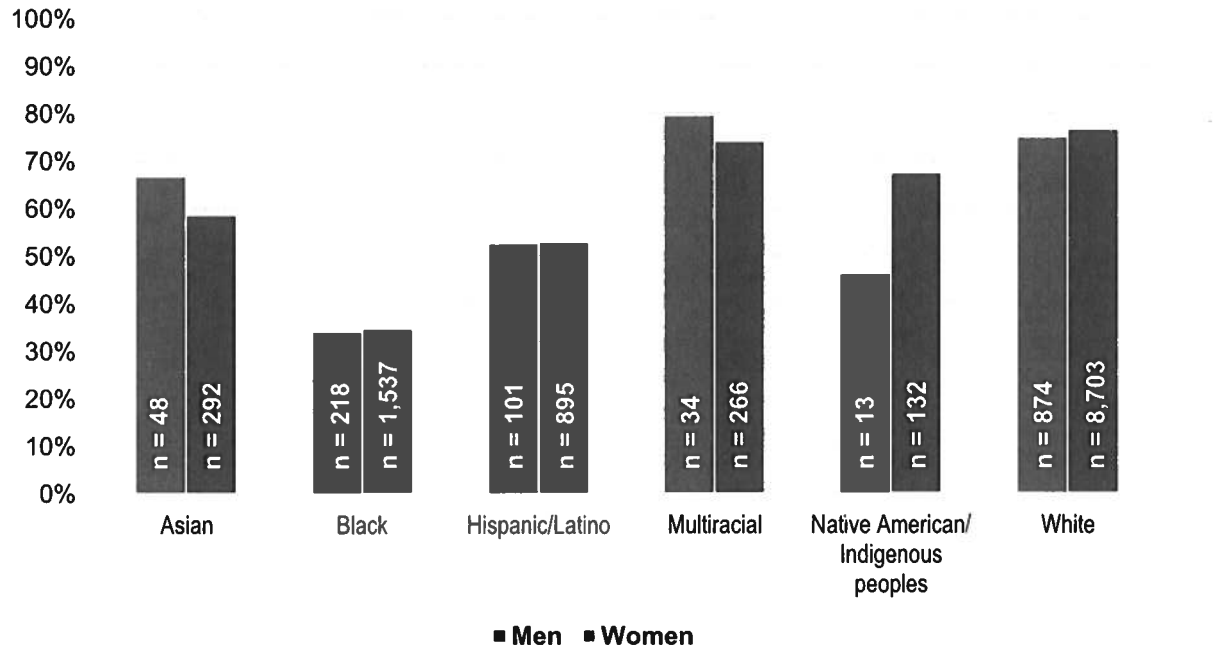
Pass rates by race/ethnicity and gender

Note: First-time pass rates by race/ethnicity and gender should be interpreted with caution for male Asian, multiracial, and Native American/Indigenous peoples test-takers because these samples are too small (i.e., less than 50) to confirm consistent patterns.

From 2018 to 2021, women who reported their race/ethnicity as Black, Hispanic/Latino, Native American/Indigenous peoples, and white had higher first-time pass rates on the Bachelors exam than men. For Asian and multiracial groups, men had higher pass rates than women. Averaging across 2018 to 2021, the smallest differences in first-time pass rates between genders were observed for Black and Hispanic/Latino test-takers (both less than 1 percent). The difference between genders for white test-takers was also relatively small, with the first-time pass rate for women being 1.7 percent higher than that for men. The largest gender difference was observed for Native American/Indigenous peoples test-takers, with the first-time pass rate for women being 21.3 percent higher than for men; however, the sample size for Native American/Indigenous peoples test-takers, particularly men, was very small (13 test-takers between 2018 and 2021), so findings should be interpreted with caution. For both Asian and multiracial test-takers, first-time pass rates for men were 8.1 percent and 5.4 percent higher, respectively, than for women.

Overall, the patterns observed across gender and race/ethnicity were consistent with the general race/ethnicity findings for first-time pass rates on the Bachelors exam, with the highest pass rates occurring for white test-takers and the lowest being observed for Black test-takers regardless of gender. Refer to Table D6 in Appendix D for first-time pass rate numbers by year.

Figure 20. 2018–2021 Bachelors exam first-time pass rates by race/ethnicity and gender



Note. Data shown may not reflect all test-takers because those who selected options such as *Prefer not to say* or filled in their own identifiers were excluded from this analysis. These options were not available to test-takers at all points during the target time period. ASWB has altered the response options available on the exam registration forms and will continue to evaluate these options to ensure test-takers may accurately respond.

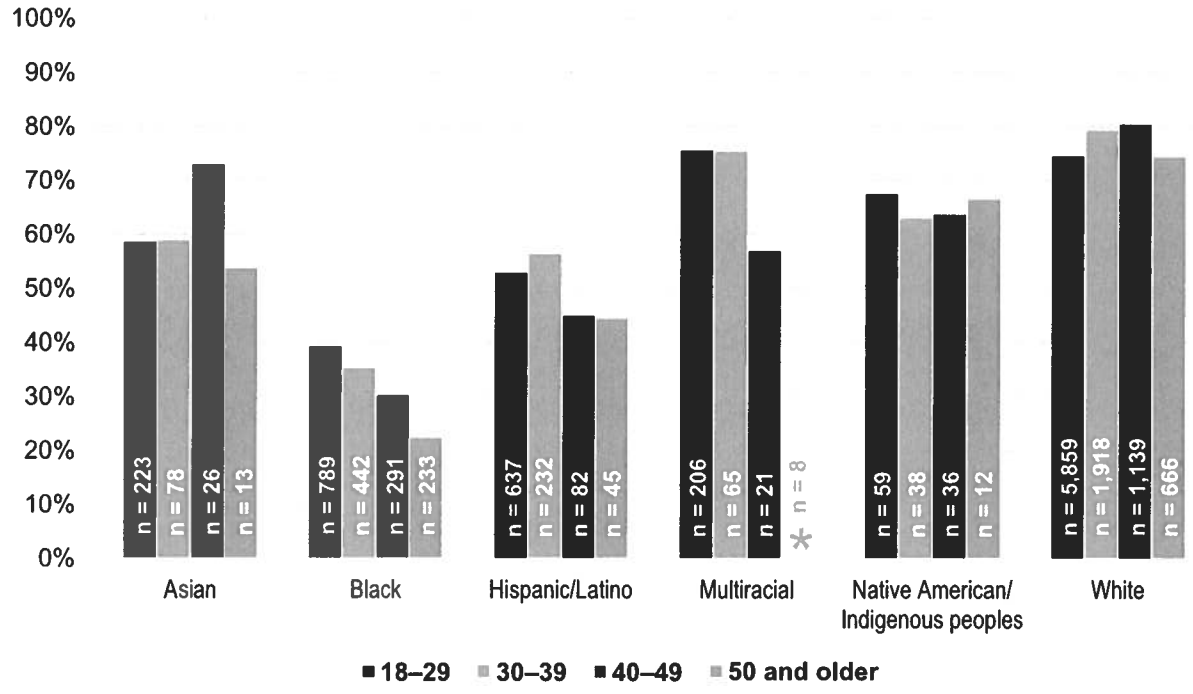
Pass rates by race/ethnicity and age

Note: First-time pass rates by race/ethnicity and age should be interpreted with caution for test-takers across age categories where the subgroup sample size is less than 50, because these samples are too small to confirm consistent patterns.

Unlike findings for the Clinical and Masters exams, first-time pass rate trends for the Bachelors exam varied when taking into account both age and race/ethnicity of test-takers, though this is likely attributable to very low sample sizes for some subgroups. There were some instances, for example, where the highest pass rates were observed for test-takers representing higher age categories. This was the case for 30- to 39-year-old Hispanic/Latino test-takers, whose average first-time pass rate was 56.5 percent, and for 40- to 49-year-old Asian and white test-takers, whose average first-time pass rates were 73.1 percent and 80.6 percent, respectively. Again, the sample size for Asian test-takers in this age category was very small, so findings should be interpreted with caution.

Overall, within race/ethnicity subgroups, first-time pass rates mostly decreased as age increased, with the largest differences occurring between test-takers who were 18 to 29 years old and those 50 years and older. Refer to Table D7 in Appendix D for first-time pass rate numbers by year. The smallest difference in first-time pass rates between these two age categories was observed for white test-takers (less than 1 percent), while the largest differences between these categories were observed for Black (17 percent) and Hispanic/Latino (8.6 percent) test-takers.

Figure 21. 2018–2021 Bachelors exam first-time pass rates by race/ethnicity and age



Note. (*) To protect the privacy of test-takers, pass rate data are not reported for samples less than 10. Data shown may not reflect all test-takers because those who selected options such as Prefer not to say or filled in their own identifiers were excluded from this analysis. These options were not available to test-takers at all points during the target time period. ASWB has altered the response options available on the exam registration forms and will continue to evaluate these options to ensure test-takers may accurately respond.

ASSOCIATE EXAM FINDINGS

ASSOCIATE EXAM FINDINGS

In contrast to the findings reported for the Clinical, Masters, and Bachelors exams, first-time and eventual pass rates for the Associate exam are reported for the 2011–2021 time period rather than 2018–2021 because of the small sample sizes.

Test-taker population

Test-taker population overall

From 2011 to 2021, the number of Associate exam first-time test-takers has increased 237 percent, from 91 in 2011 to 307 in 2021. The largest number of first-time test-takers was 793 in 2015. This increase was attributable to Massachusetts lifting the exemption for Department of Children and Families workers, requiring all staff to become licensed. A slight drop in test-takers occurred in 2020. This was likely caused by the start of the COVID-19 pandemic and associated restrictions that reduced capacity in testing centers to accommodate social distancing.

Table 10. 2011–2021 number of Associate exam first-time test-takers by year

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Total test-takers	91	72	119	162	793	678	520	407	307	254	307

Test-taker population by race/ethnicity

From 2011 to 2021, white test-takers made up the largest proportion of Associate exam first-time test-takers, comprising approximately 74 percent in 2011 but decreasing to 57 percent by 2021.

This decrease in the proportion of white first-time test-takers corresponded with an increase in the overall proportion of first-time test-takers from historically marginalized communities, which grew from 19.8 percent in 2011 to 34.5 percent in 2021. (Note: For the purposes of this report, "historically marginalized communities" includes test-takers who reported their race/ethnicity as Asian, Black, Hispanic/Latino, multiracial, and Native American/Indigenous peoples.) The most marked increase in the proportion of first-time test-takers was observed for Black test-takers, which grew 7 percent from 2011 to 2021.

Table 11. 2011–2021 number of Associate exam first-time test-takers by race/ethnicity

Race/Ethnicity	In 2011	Proportion of test-takers	In 2021	Proportion of test-takers	Total 2011–2021	Proportion increase/ decrease 2011–2021
Asian	0	0%	8	3%	60	+3%
Black	8	9%	48	16%	624	+7%
Hispanic/Latino	8	9%	40	13%	632	+4%
Multiracial	2	2%	8	3%	90	+1%
Native American/ Indigenous peoples	0	0%	2	1%	29	+1%
White	67	74%	176	57%	2,037	-17%
Total	91	--	307	--	3,710	--

Note. Percentages may not total 100 percent because test-takers who selected options such as *Prefer not to say* or filled in their own identifiers were excluded from this analysis. These options were not available to test-takers at all points during the target time period. ASWB has altered the response options available on the exam registration forms and will continue to evaluate these options to ensure test-takers may accurately respond.

Test-taker population by gender

The number of individuals taking the Associate exam more than doubled from 2011 to 2021, but the proportion of men and women remained approximately the same, with women accounting for 86.5 percent and men 13.2 percent.

Table 12. Number of Associate exam first-time test-takers by gender

Gender	In 2011	Proportion of test-takers	In 2021	Proportion of test-takers	Total 2011–2021	Proportion increase/ decrease 2011–2021
Men	12	13%	41	13%	703	0%
Women	79	87%	265	86%	3,005	0%
Total	91	--	307	--	3,710	--

Note. Data shown may not reflect all test-takers because those who selected options such as *Prefer not to say* or filled in their own identifiers were excluded from this analysis. These options were not available to test-takers at all points during the target time period. ASWB has altered the response options available on the exam registration forms and will continue to evaluate these options to ensure test-takers may accurately respond.

Pass rates

The sections that follow provide findings related to first-time and eventual pass rates for individuals taking the Associate exam. Figures provide information related to first-time pass rate trends, as well as eventual pass rates aggregated over the target time period. Refer to Methodology for more information on the distinction between first-time and eventual pass rates.

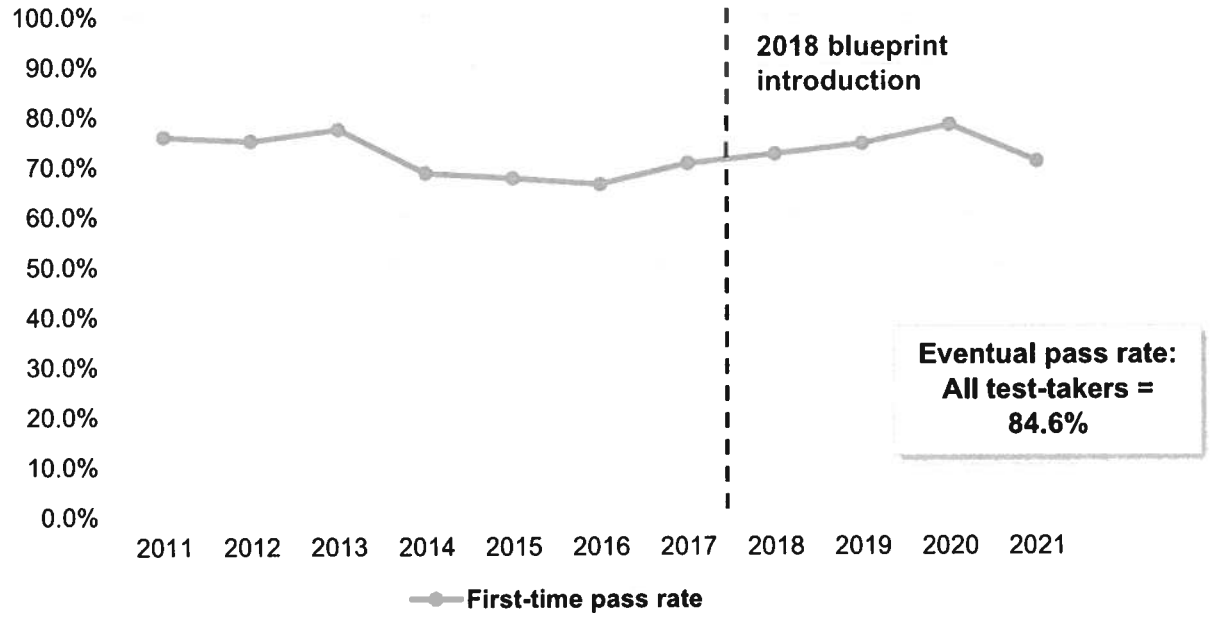
Because of the small sample sizes for many subgroups taking the Associate exam, most figures below reflect eventual pass rates rather than first-time pass rates. Eventual pass rates include more test-takers and therefore allow for more opportunities to present relevant data, while still protecting the privacy of individual test-takers. All pass rates for the Associate exam should be interpreted with caution because of the relatively small sample size each year and across the 10-year target time period.

First-time pass rates by year, where applicable, and eventual pass rates are not reported in the figures below but can be found in Appendix E.

First-time and eventual pass rates

From 2011 to 2021, most test-takers (70.4 percent) passed the Associate exam on their first attempt. Refer to Table E1 in Appendix E for first-time pass rate numbers by year. When considering the number of test-takers who passed the exam regardless of whether it was their first or a subsequent attempt (i.e., eventual pass rate), even more test-takers (84.6 percent) passed the Associate exam during this time period.

Figure 22. 2011–2021 Associate exam first-time pass rates by year and eventual pass rate

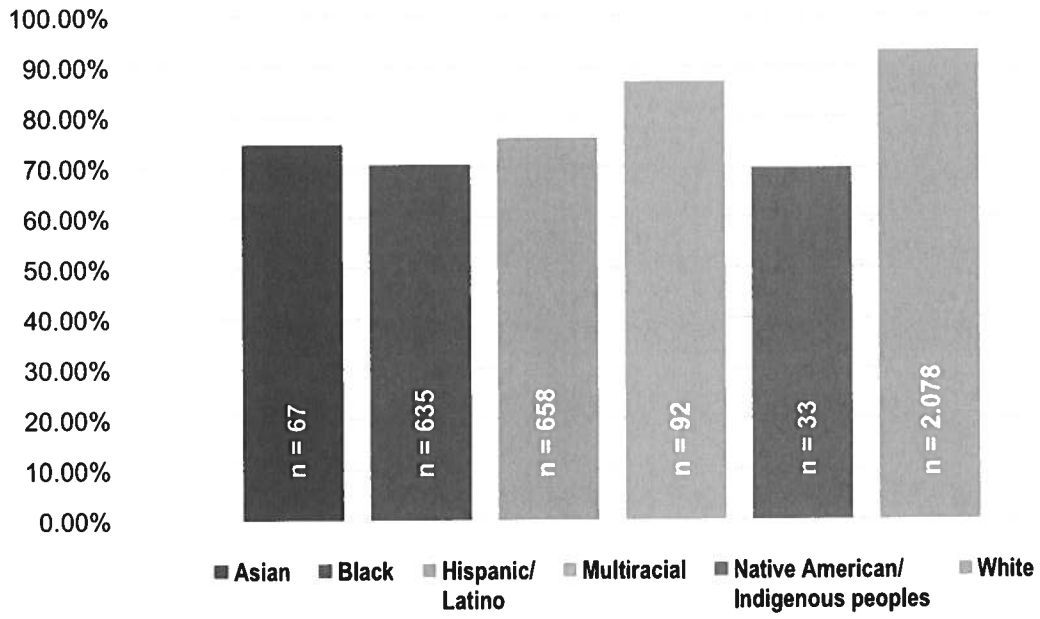


Pass rates by race/ethnicity

Note: The eventual pass rate for multiracial test-takers should be interpreted with caution as this sample is too small (i.e., less than 50) to confirm consistent patterns.

When considering the Associate exam performance of test-takers by race/ethnicity, eventual pass rates were highest for white test-takers, averaging 93 percent during the 2011–2021 time period, followed by multiracial (87 percent), Hispanic/Latino (75.8 percent), Asian (74.6 percent), Black (70.6 percent), and Native American/Indigenous peoples (69.7 percent).

Figure 23. 2011–2021 Associate exam eventual pass rates by race/ethnicity

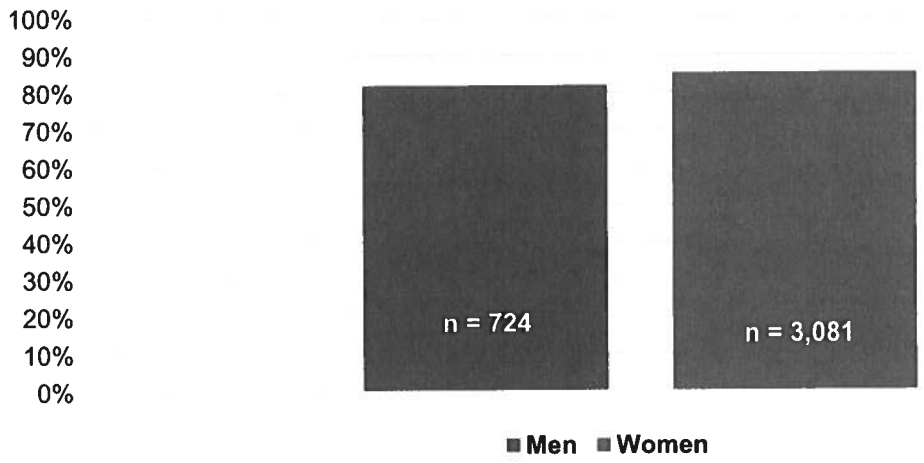


Note. Data shown may not reflect all test-takers because those who selected options such as *Prefer not to say* or filled in their own identifiers were excluded from this analysis. These options were not available to test-takers at all points during the target time period. ASWB has altered the response options available on the exam registration forms and will continue to evaluate these options to ensure test-takers may accurately respond.

Pass rates by gender

Reviewing Associate exam performance by gender from 2011 to 2021, eventual pass rates were slightly higher for women (85.2 percent) than for men (81.8 percent).

Figure 24. 2011–2021 Associate exam eventual pass rates by gender

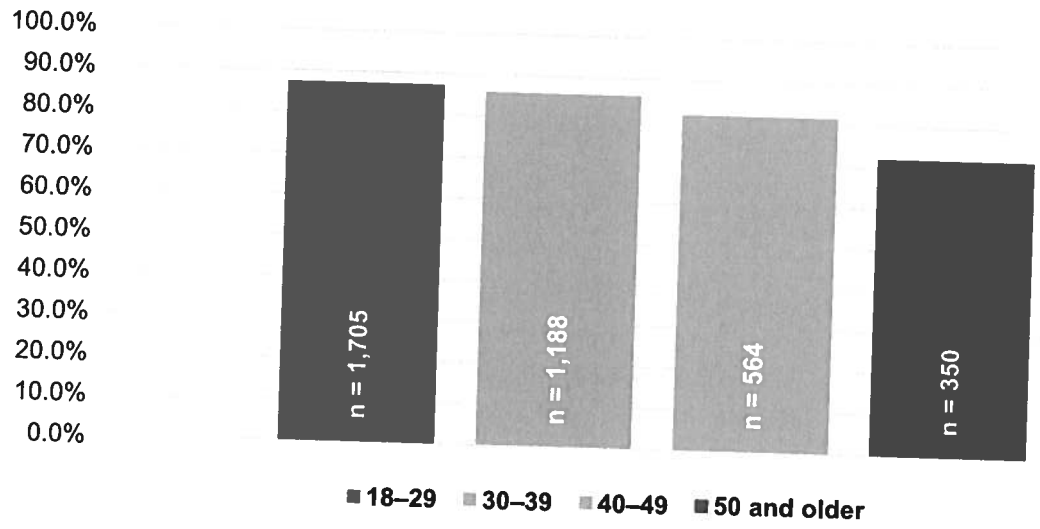


Note. Data shown may not reflect all test-takers because those who selected options such as *Prefer not to say* or filled in their own identifiers were excluded from this analysis. These options were not available to test-takers at all points during the target time period. ASWB has altered the response options available on the exam registration forms and will continue to evaluate these options to ensure test-takers may accurately respond.

Pass rates by age

Reviewing Associate exam performance by age from 2011 to 2021, pass rates were higher for test-takers in lower age categories than for those in higher age categories. Specifically, the eventual pass rate was 87.2 percent for test-takers between the ages of 18 and 29, 85.8 percent for those between 30 and 39, 81.6 percent for those between 40 and 49, and 72.3 percent for those 50 and older.

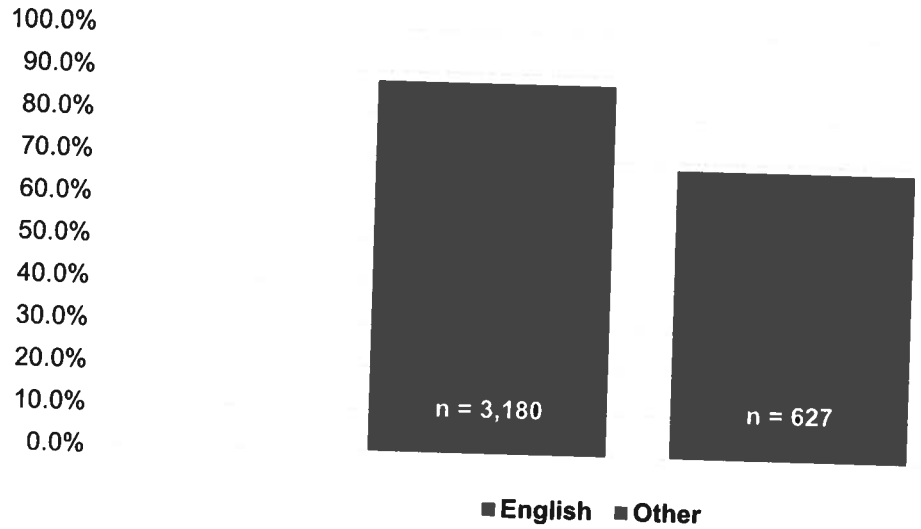
Figure 25. 2011–2021 Associate exam eventual pass rates by age



Pass rates by primary language

Reviewing Associate exam performance by primary language from 2011 to 2021, eventual pass rates were higher for test-takers who indicated their primary language was English (87.8 percent) than for those who indicated their primary language was not English (68.3 percent).

Figure 26. 2011–2021 Associate exam eventual pass rates by primary language

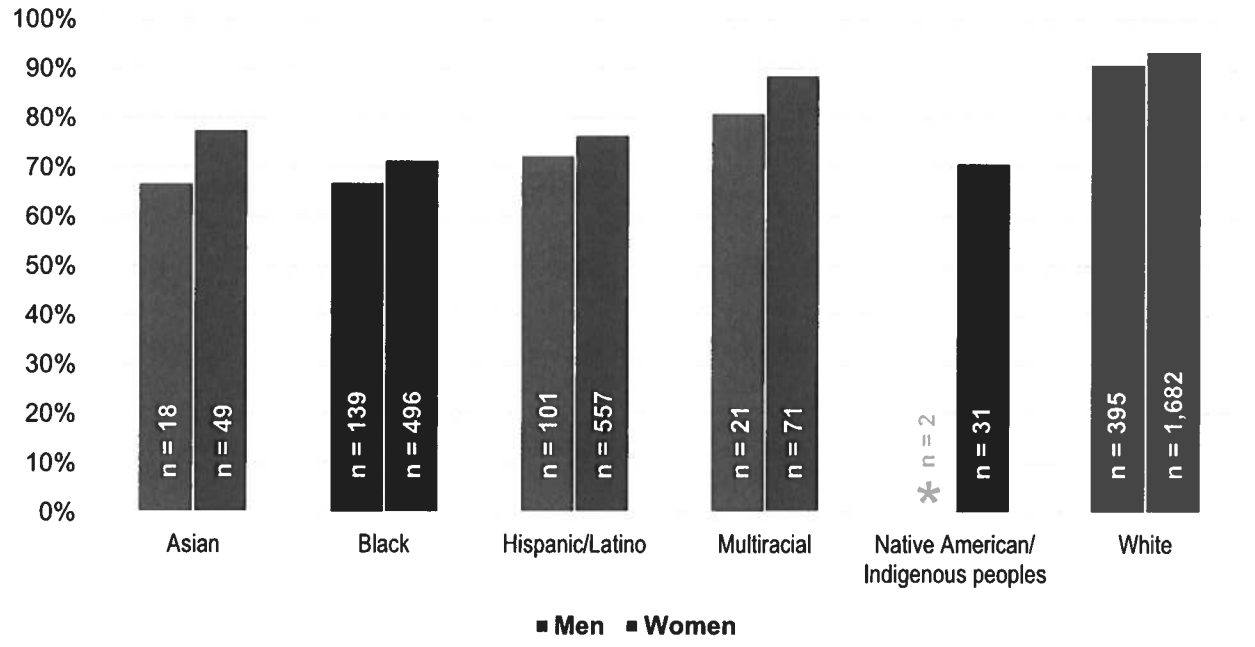


Pass rates by race/ethnicity and gender

Note: Eventual pass rates by race/ethnicity and gender should be interpreted with caution for male and female Asian, multiracial, and Native American/Indigenous peoples test-takers as these samples are too small (i.e., less than 50) to confirm consistent patterns. Data for male Native American/Indigenous test-takers are not shown because the sample size of this subgroup is less than 10.

Across all race/ethnicity categories, women had higher eventual pass rates on the Associate exam compared to men. Among groups with sample sizes greater than 10, the difference in eventual pass rates between men and women was the smallest for white test-takers (3.5 percent). Differences between men and women were slightly larger for multiracial (7.7 percent), Black (4.7 percent), and Hispanic/Latino (4.2 percent) test-takers, with the largest difference in pass rates between men and women occurring for Asian test-takers (10.1 percent). Note that the number of women across all race/ethnicity categories who took the Associate exam from 2011 to 2021 was, on average, three to four times larger than the number of men from those race/ethnicity categories who took the Associate exam during the same time; therefore, many of these differences may not be reliable. Refer to Table E2 in Appendix E for eventual pass rate numbers by gender and race/ethnicity.

Figure 27. 2011–2021 Associate exam eventual pass rates by race/ethnicity and gender



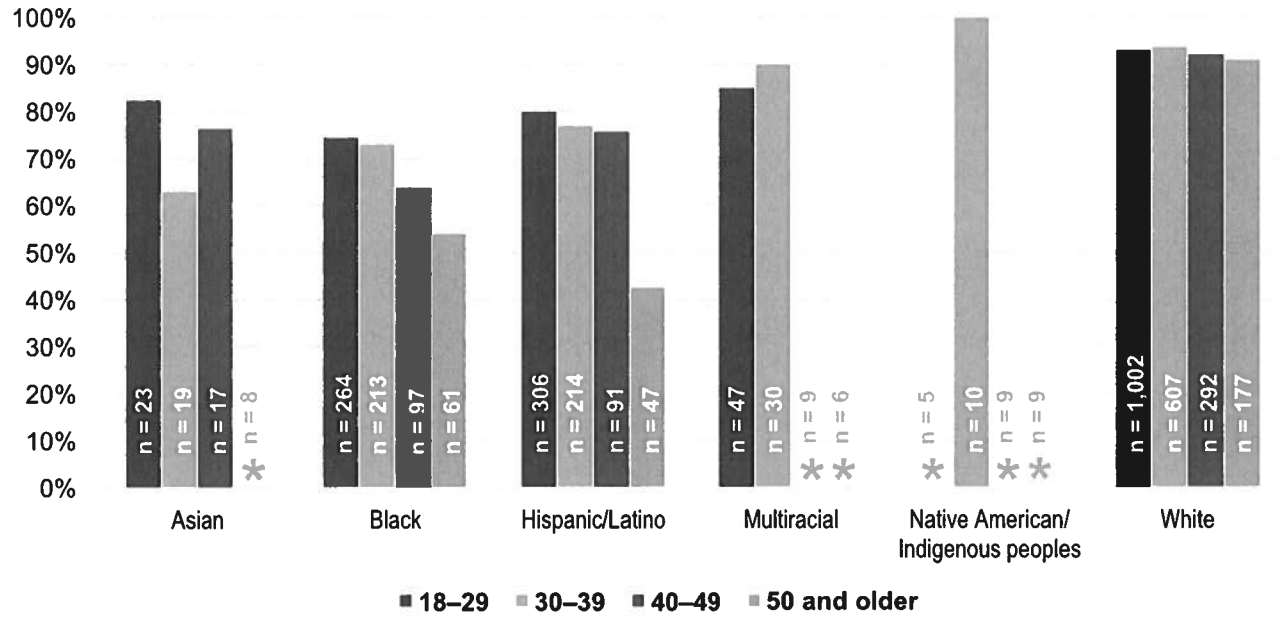
Note. (*) To protect the privacy of test-takers, pass rate data are not reported for numbers less than 10. Data shown may not reflect all test-takers because those who selected options such as *Prefer not to say* or filled in their own identifiers were excluded from this analysis. These options were not available to test-takers at all points during the target time period. ASWB has altered the response options available on the exam registration forms and will continue to evaluate these options to ensure test-takers may accurately respond.

Pass rates by race/ethnicity and age

Note: Eventual pass rates by age and race/ethnicity should be interpreted with caution for Asian, multiracial, and Native American/Indigenous peoples test-takers across all age categories because these samples are too small (i.e., less than 50) to confirm consistent patterns.

Within race/ethnicity subgroups, eventual pass rates tended to decrease as age categories increased, with the largest differences occurring between test-takers who were 18 to 29 years old and those 50 and older. Where comparisons between groups could be drawn, the smallest difference in eventual pass rates between these two age categories was observed for white test-takers (2.2 percent). Larger differences between these categories were observed for Hispanic/Latino (37.5 percent) and Black (20.5 percent) test-takers. Note that, for these race/ethnicity categories, the sample sizes of test-takers who were 18 to 29 years old were approximately four to seven times larger than the sample sizes of test-takers who were 50 years and older. Thus, conclusions based on pass rate differences between these groups may be unreliable. Refer to Table E3 in Appendix E for eventual pass rate numbers by age and race/ethnicity.

Figure 28. 2011–2021 Associate exam eventual pass rates by race/ethnicity and age



Note. (*) To protect the privacy of test-takers, pass rate data are not reported for numbers less than 10. Data shown may not reflect all test-takers because those who selected options such as *Prefer not to say* or filled in their own identifiers were excluded from this analysis. These options were not available to test-takers at all points during the target time period. ASWB has altered the response options available on the exam registration forms and will continue to evaluate these options to ensure test-takers may accurately respond.

ADVANCED GENERALIST EXAM FINDINGS

ADVANCED GENERALIST EXAM FINDINGS

Similar to the Associate exam findings, first-time and eventual pass rates for the Advanced Generalist exam are reported for the 2011–2021 time period rather than 2018–2021 because of the small sample sizes.

Test-taker population

Test-taker population overall

From 2011 to 2021, the number of Advanced Generalist exam first-time test-takers decreased 73 percent, from 630 test-takers in 2011 to 173 in 2021. The largest number of test-takers occurred in 2011 when 630 individuals took the exam for the first time. This number dropped to 150 in 2012 and remained relatively consistent until 2020, when another slight drop in test-takers occurred. This was likely caused by the start of the COVID-19 pandemic and associated restrictions that reduced capacity in testing centers to accommodate social distancing.

Table 13. 2011–2021 number of Advanced Generalist exam first-time test-takers by year

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Total test-takers	630	150	162	159	197	177	164	146	127	134	173

Test-taker population by race/ethnicity

From 2011 to 2021, white test-takers made up the largest proportion of Advanced Generalist exam first-time test-takers, comprising approximately 59 percent in 2011 and increasing to 72 percent by 2021.

This increase in the proportion of white first-time test-takers corresponded with a decrease in that of first-time test-takers from historically marginalized communities, which dropped from 38 percent in 2011 to 26.9 percent of the test-taker population in 2021. (Note: For the purposes of this report, "historically marginalized communities" includes test-takers who reported their race/ethnicity as Asian, Black, Hispanic/Latino, multiracial, and Native American/Indigenous peoples.) The most marked change in the proportion of first-time test-takers was observed for Black test-takers, which decreased 18 percent between 2011 and 2021.

Table 14. 2011–2021 number of Advanced Generalist exam first-time test-takers by race/ethnicity

Race/Ethnicity	In 2011	Proportion of test-takers	In 2021	Proportion of test-takers	Total 2011–2021	Proportion increase/ decrease 2011–2021
Asian	6	1%	7	4%	48	+3%
Black	212	34%	28	16%	438	-18%
Hispanic/Latino	11	2%	6	4%	56	+2%
Multiracial	10	2%	6	4%	43	+2%
Native American/ Indigenous peoples	1	<1%	0	0%	12	<1%
White	373	59%	125	72%	1,562	+13%
Total	630	--	173	--	2,219	--

Note. Percentages may not total 100 percent because test-takers who selected options such as *Prefer not to say* or filled in their own identifiers were excluded from this analysis. These options were not available to test-takers at all points during the target time period. ASWB has altered the response options available on the exam registration forms and will continue to evaluate these options to ensure test-takers may accurately respond.

Test-taker population by gender

The number of individuals taking the Advanced Generalist exam more than doubled from 2011 to 2021, but the proportion of men and women taking the exam remained approximately the same, with 87.7 percent women and 12.2 percent men.

Table 15. 2011–2021 number of Advanced Generalist exam first-time test-takers by gender

Gender	In 2011	Proportion of test-takers	In 2021	Proportion of test-takers	Total 2011–2021	Proportion increase/ decrease 2011–2021
Men	77	12%	21	12%	271	0%
Women	553	88%	152	88%	1,947	0%
Total	630	--	173	--	2,219	--

Note. Data shown may not reflect all test-takers because those who selected options such as *Prefer not to say* or filled in their own identifiers were excluded from this analysis. These options were not available to test-takers at all points during the target time period. ASWB has altered the response options available on the exam registration forms and will continue to evaluate these options to ensure test-takers may accurately respond.

Pass rates

The sections that follow provide findings related to first-time and eventual pass rates for individuals taking the Advanced Generalist exam. Figures provide information related to first-time pass rate trends, as well as eventual pass rates aggregated over the target time period. Refer to Methodology for more information on the distinction between first-time and eventual pass rates.

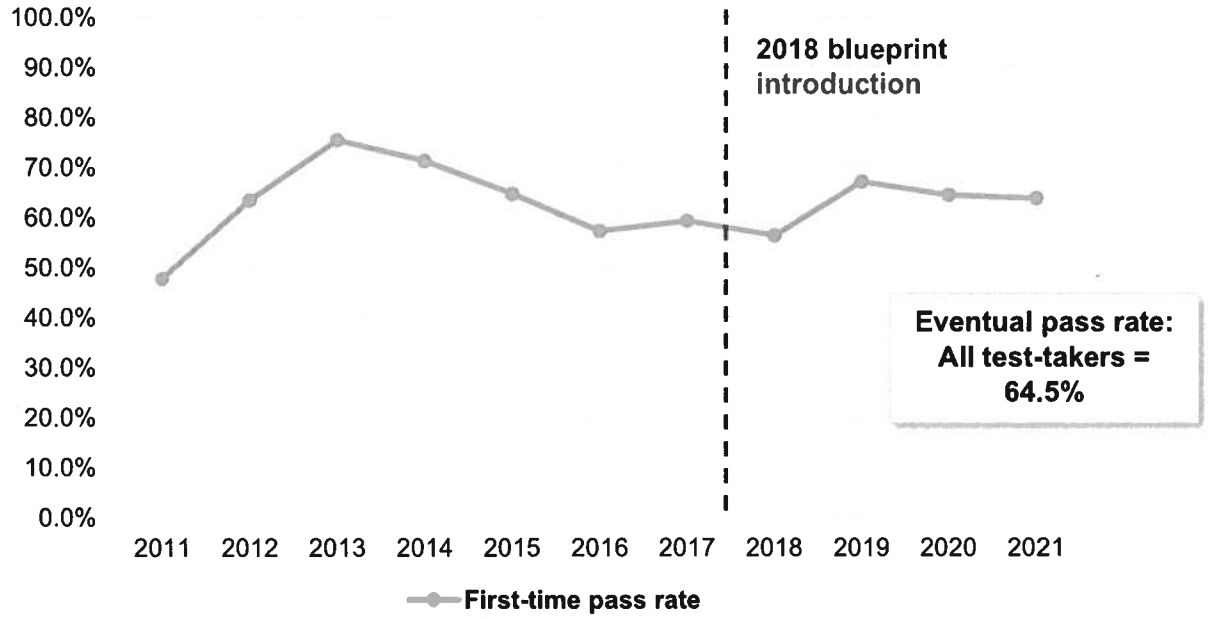
Because of the small sample sizes for many subgroups who took the Advanced Generalist exam, most figures below reflect eventual pass rates rather than first-time pass rates. Eventual pass rates include more test-takers and therefore allow for more opportunities to present relevant data while still protecting the privacy of individual test-takers. All pass rates for the Advanced Generalist exam should be interpreted with caution because of the relatively small sample size of this test-taking population each year and across the 10-year target time period.

First-time pass rates by year, where applicable, and eventual pass rates are not reported in the figures below but can be found in Appendix F.

First-time and eventual pass rates

From 2011 to 2021, more than half of test-takers (59.4 percent) passed the Advanced Generalist exam on their first attempt. Refer to Table F1 in Appendix F for first-time pass rate numbers by year. Considering the total number of test-takers who passed the exam regardless of whether it was their first or a subsequent attempt (i.e., eventual pass rate), even more test-takers (64.5 percent) passed the Advanced Generalist exam during this time period.

Figure 29. 2011–2021 Advanced Generalist exam first-time pass rates by year and eventual pass rate

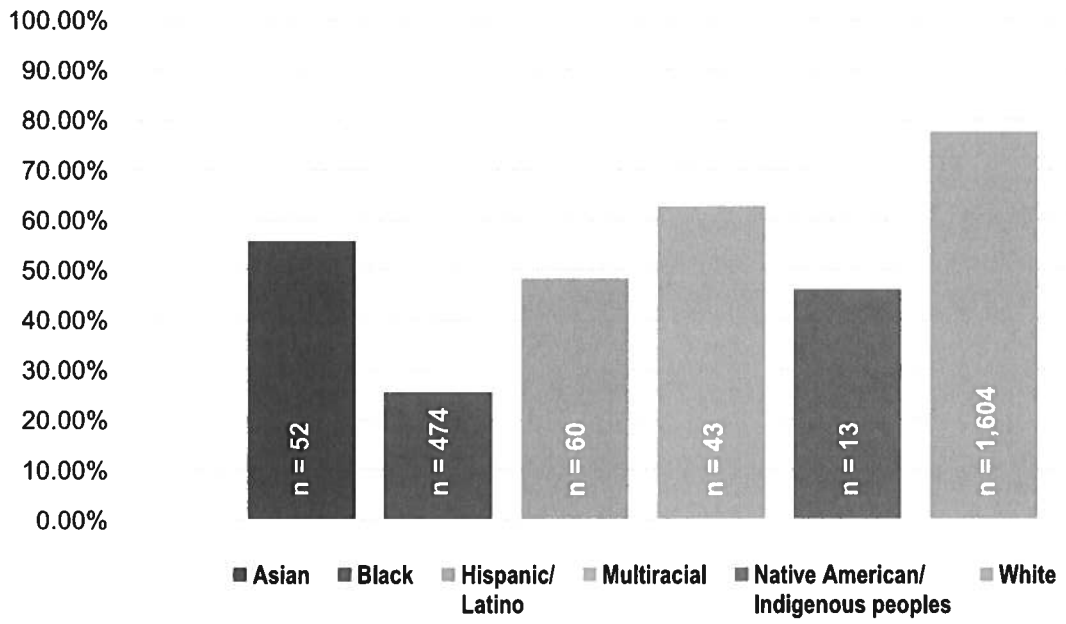


Pass rates by race/ethnicity

Note: The eventual pass rate for multiracial and Native American/Indigenous peoples test-takers should be interpreted with caution because these sample sizes are too small (i.e., less than 50) to confirm consistent patterns.

When considering the Advanced Generalist exam performance of test-takers by race/ethnicity, eventual pass rates were highest for white test-takers, averaging 77.7 percent during the 2011–2021 time period, followed by multiracial (62.8 percent), Asian (55.8 percent), Hispanic/Latino (48.3 percent), Native American/Indigenous peoples (46.2 percent), and Black (25.5 percent) test-takers.

Figure 30. 2011–2021 Advanced Generalist exam eventual pass rates by race/ethnicity

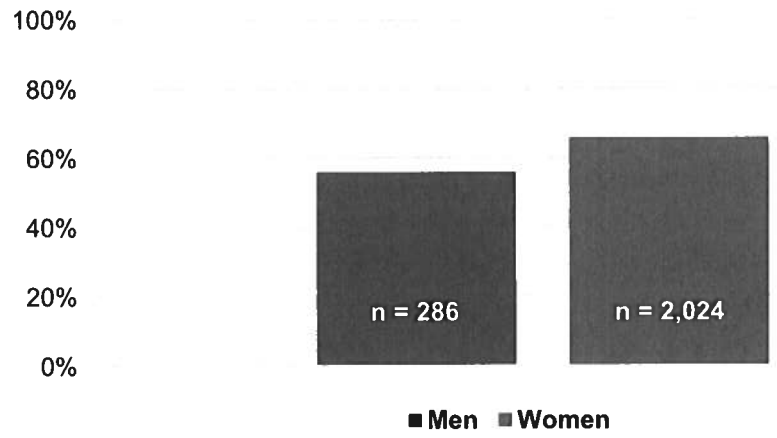


Note. Data shown may not reflect all test-takers because those who selected options such as *Prefer not to say* or filled in their own identifiers were excluded from this analysis. These options were not available to test-takers at all points during the target time period. ASWB has altered the response options available on the exam registration forms and will continue to evaluate these options to ensure test-takers may accurately respond.

Pass rates by gender

Reviewing Advanced Generalist exam performance by gender from 2011 to 2021, eventual pass rates were higher for women (65.7 percent) than for men (55.9 percent).

Figure 31. 2011–2021 Advanced Generalist exam eventual pass rates by gender

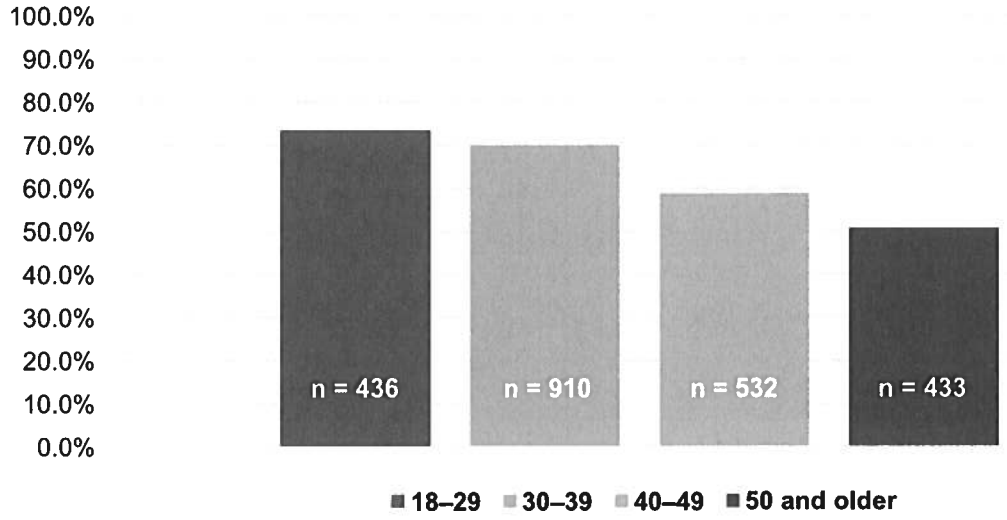


Note. Data shown may not reflect all test-takers because those who selected options such as *Prefer not to say* or filled in their own identifiers were excluded from this analysis. These options were not available to test-takers at all points during the target time period. ASWB has altered the response options available on the exam registration forms and will continue to evaluate these options to ensure test-takers may accurately respond.

Pass rates by age

Reviewing Advanced Generalist exam performance by age from 2011 to 2021, pass rates were higher for test-takers in lower age categories than for those in higher age categories. Specifically, the eventual pass rate was 73.6 percent for test-takers between the ages of 18 and 29, 70 percent for those between 30 and 39, 58.8 percent for those between 40 and 49, and 50.8 percent for those 50 and older.

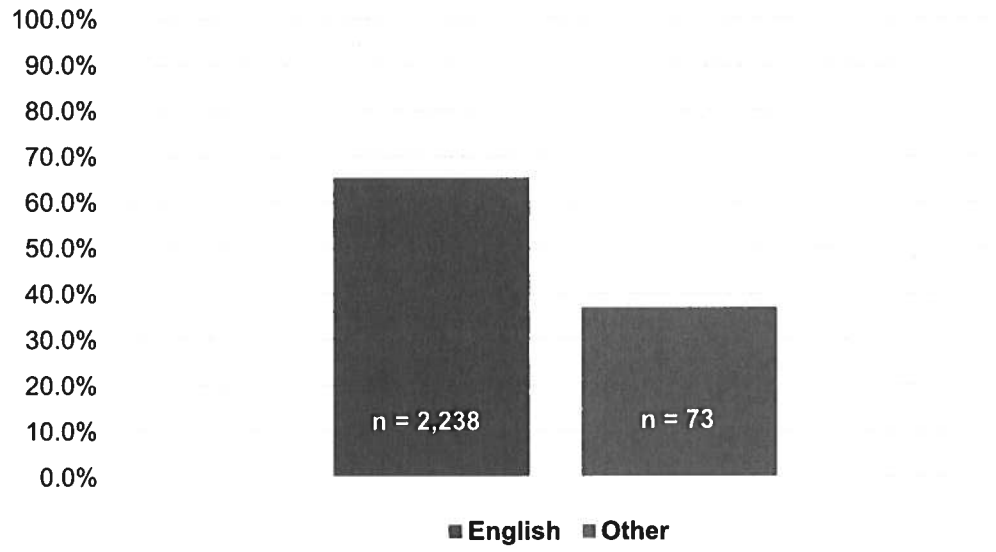
Figure 32. 2011–2021 Advanced Generalist exam eventual pass rates by age



Pass rates by primary language

Reviewing Advanced Generalist exam performance by primary language from 2011 to 2021, eventual pass rates were higher for test-takers who reported that their primary language was English (65.4 percent) than for those who reported that their primary language was not English (37 percent).

Figure 33. 2011–2021 Advanced Generalist exam eventual pass rates by primary language

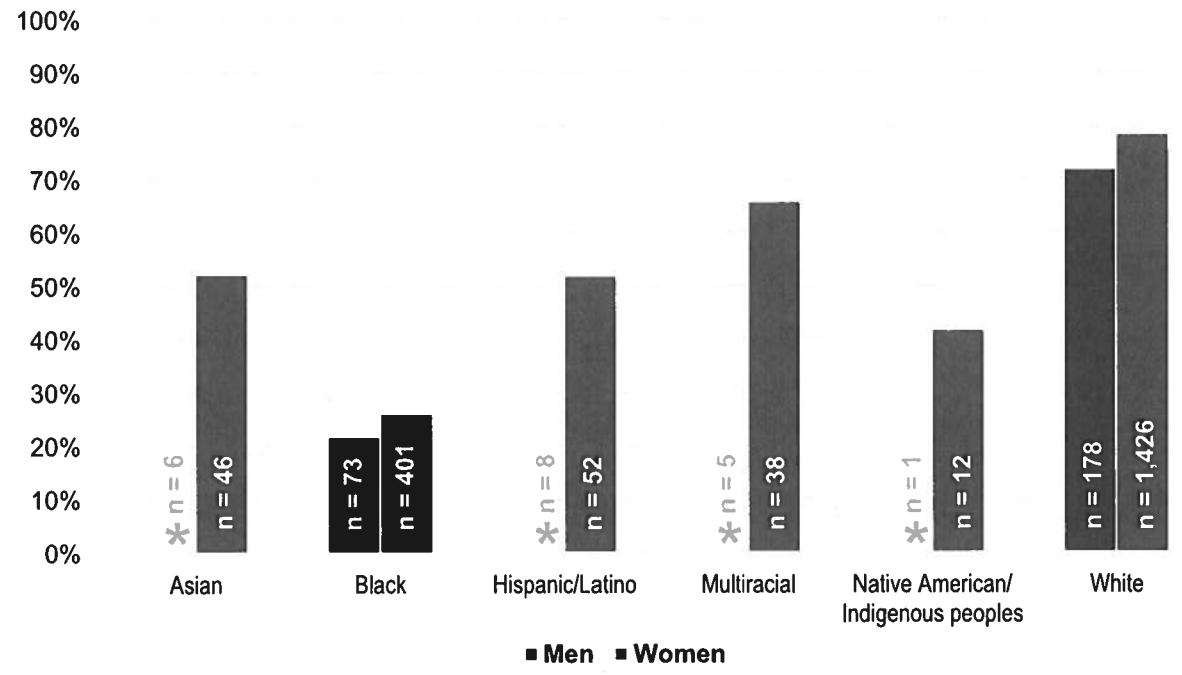


Pass rates by race/ethnicity and gender

Note: Eventual pass rates by race/ethnicity and gender should be interpreted with caution for female Asian, multiracial, and Native American/Indigenous peoples test-takers because these sample sizes are too small (i.e., less than 50) to confirm consistent patterns.

Across all race/ethnicity categories where data are reported, women had higher eventual pass rates than men on the Advanced Generalist exam. Among groups with sample sizes greater than 10, the difference in eventual pass rates between men and women was 6.5 percent for white test-takers and 4.3 percent for Black test-takers. It should be noted that the number of women from these two race/ethnicity categories who took the Advanced Generalist exam from 2011 to 2021 was, on average, four to eight times larger than the number of men from these race/ethnicity categories who took the Advanced General exam during the same period. Therefore, conclusions based on these differences may not be reliable. Refer to Table F2 in Appendix F for eventual pass rate numbers by gender and race/ethnicity.

Figure 34. 2011–2021 Advanced Generalist exam eventual pass rates by race/ethnicity and gender



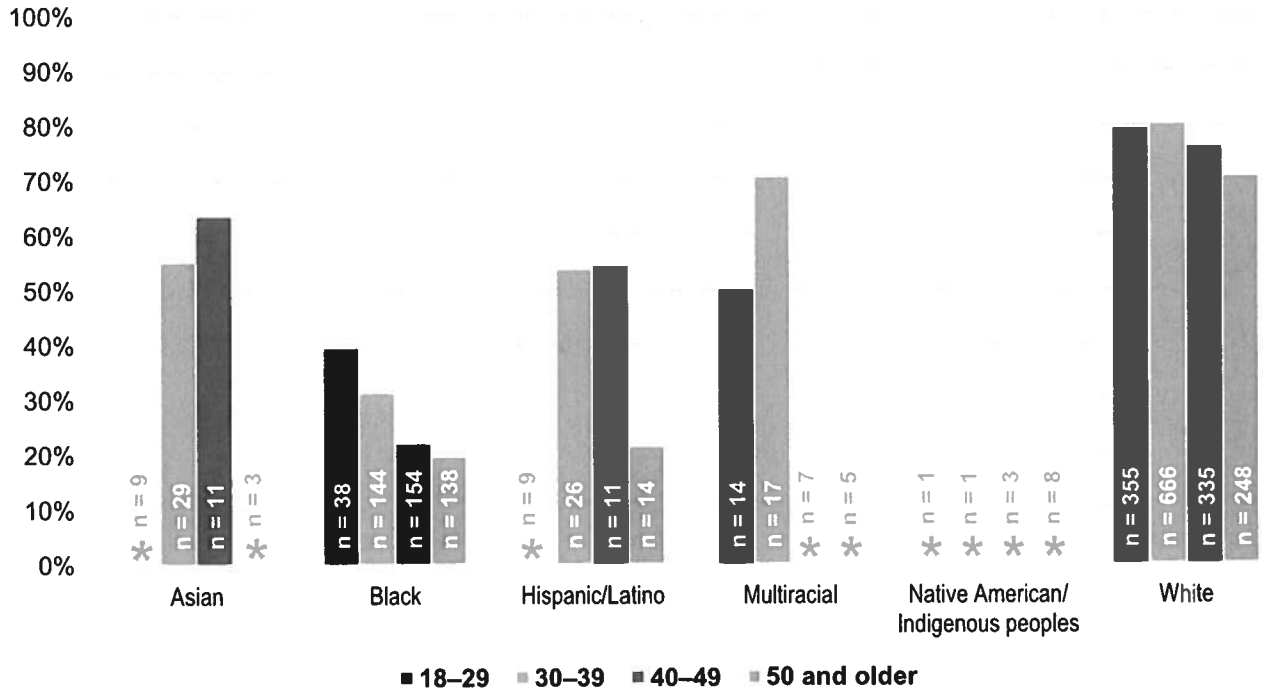
Note. (*) To protect the privacy of test-takers, pass rate data are not reported for numbers less than 10. Data shown may not reflect all test-takers because those who selected options such as *Prefer not to say* or filled in their own identifiers were excluded from this analysis. These options were not available to test-takers at all points during the target time period. ASWB has altered the response options available on the exam registration forms and will continue to evaluate these options to ensure test-takers may accurately respond.

Pass rates by race/ethnicity and age

Note: Eventual pass rates by race/ethnicity and age should be interpreted with caution for Asian, Hispanic/Latino, multiracial, and Native American/Indigenous peoples test-takers across all age categories and for Black test-takers in the 18- to 29-year-old age category because these sample sizes are too small (i.e., less than 50) to confirm consistent patterns.

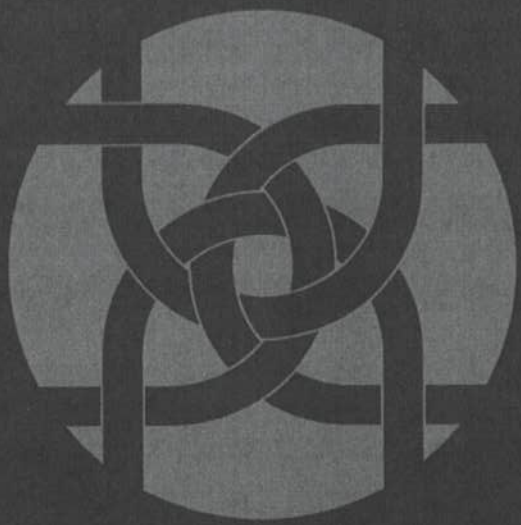
Within race/ethnicity subgroups, eventual pass rates tended to decrease as age categories increased, with the largest differences among age categories predominantly occurring between test-takers who were 18 to 29 years old and test-takers who were 50 and older. Where comparisons between groups could be drawn, the difference in eventual pass rates between these two age categories was 8.8 percent for white test-takers and 18.1 percent for Black test-takers. Note that for Black test-takers, the number of individuals who were 50 years and older was approximately three and a half times larger than the number of test-takers who were 18 to 29 years old. Thus, conclusions based on the difference between these groups may be unreliable. Refer to Table F3 in Appendix F for eventual pass rate numbers by age and race/ethnicity.

Figure 35. 2011–2021 Advanced Generalist exam eventual pass rates by race/ethnicity and age



Note. (*) To protect the privacy of test-takers, pass rate data are not reported for numbers less than 10. Data shown may not reflect all test-takers because those who selected options such as *Prefer not to say* or filled in their own identifiers were excluded from this analysis. These options were not available to test-takers at all points during the target time period. ASWB has altered the response options available on the exam registration forms and will continue to evaluate these options to ensure test-takers may accurately respond.

DISCUSSION



DISCUSSION

This report provides data on test-taker participation and performance on the ASWB social work licensing exams between 2011 and 2021. Although the findings for each exam are independent of each other, trends across all five exams can be observed. These trends merit additional evaluation and ongoing discussion to better understand their implications.

Demographic changes in the test-taker population

Several findings show that the proportion of test-takers from historically marginalized communities (defined for this report as those reporting their race/ethnicity as Asian, Black, Hispanic/Latino, multiracial, or Native American/Indigenous peoples) increased from 2011 to 2021. This finding suggests that more test-takers from these communities are actively seeking social work licensure. The proportion of white test-takers, however, remains the largest across the exams. Similar trends can be observed when examining the proportion of test-takers by gender. Most test-takers—like most social workers— are women.

Further research should be done to expand understanding of the demographic makeup of the profession and the communities that social workers serve. This research may include exploring differences in how social workers are recruited to the profession and evaluating the amount and type of support social work students receive as they enter the profession. It may also be valuable to identify and, where possible, address the challenges that social workers face in seeking licensure and to learn why some may be more likely to engage with or avoid the licensure process.

Pass rates by race/ethnicity

Across all five exams, differences were observed in pass rates among racial/ethnic subgroups, the largest being between white test-takers and Black test-takers, who tend to have the lowest pass rates of all racial/ethnic groups.

Variations in exam performance across different racial/ethnic groups are not unique to the ASWB examinations. Other professional licensure tests, such as the Praxis® exam for teacher licensure (Nettles et al., 2011), Nursing Council Licensure Exam (NCLEX-RN®; Lockie, 2013), the North American Pharmacist Licensure Examination (NAPLEX®; Chisholm-Burns et al., 2017), and the bar exam (American Bar Association, 2022) have also reported different pass rates for historically marginalized groups, suggesting systemic issues affecting all licensure candidates. Census data have consistently shown that individuals from historically marginalized groups disproportionately experience socioeconomic hardship related to lower household income, higher poverty rates, inequities in educational resources and attainment, and lower rates of health coverage, wealth, and home ownership (Shrider et al., 2021). Accordingly, historically marginalized groups may be more likely to experience challenges in the period leading up to exam administration, including but not limited to access to comprehensive, accurate, and effective exam preparation resources; sufficient time or availability to prepare for taking an exam; and adequate financial resources to pay for the exam.

Other issues may affect test-takers during the administration of the exam itself, such as the experience of stereotype threat. Stereotype threat is a phenomenon stemming from an individual's fears that performance on a task may confirm or reinforce preexisting negative stereotypes about the racial, ethnic, gender, and/or cultural group of which the individual is a member (Steele & Aronson, 1995). For example, knowing that an exam is intended to measure one's intellectual ability or priming

one's identification with a racial or ethnic group (for whom negative stereotypes regarding test performance may exist) has been shown to affect exam performance negatively for individuals from those groups (Walton & Spencer, 2009). These factors act independently of test-takers' actual competence or ability and, in some cases, altogether disappear when reframing the objective of the test (e.g., gathering feedback vs. assessing performance; Spencer et al., 2016) or helping test-takers reappraise their anxiety (Johns et al., 2008).

Future research should be focused on investigating the challenges, restrictions, and constraints that some members of historically marginalized groups may experience. It is important to explore ways to best support test-takers through all stages of the exam process and ensure that those who seek licensure have a fair and equitable path to success.

Pass rates by age

Another trend observed in the data concerns differences in pass rates based on the age of test-takers. Specifically, test-takers in the lowest age category—those between the ages of 18 and 29 years old—tended to have higher pass rates than test-takers in higher age categories, particularly those over 50 years old. Test-takers of any age may have unique challenges based on multiple factors and responsibilities, including family, finances, and other commitments outside their profession that may make it difficult to prioritize exam preparation. However, the findings suggest that social workers in higher age categories may be experiencing these challenges at a higher rate than their counterparts in lower age categories. Test-takers who recently graduated from a social work program may be more likely to pass the exams compared to test-takers who, despite being experienced professionals, may have graduated from social work school years earlier and are less likely to have benefited from recent instruction specifically targeted at preparing for the exam.

Future research should focus on gaining more context and insight about the lived experiences of test-takers in higher age categories to identify challenges they may face. An early step might be to examine higher age categories at a more granular level. The challenges to licensure faced by social workers in their 50s may be different from those faced by social workers in their 60s or 70s. Future research should explore differences within and across these groups and identify tailored responses to help address these specific challenges.

Pass rates by demographic intersections

Test-takers represent combinations of specific demographic characteristics (e.g., race/ethnicity, gender, gender identity, age, disability, primary language), the intersections of which often result in additional, multiplicative hardships for individuals and groups (Crenshaw, 1989). For example, while Black test-takers tended to have lower pass rates when compared to test-takers from other races/ethnicities, pass rates for Black male test-takers were lower than pass rates for Black female test-takers. A similar trend was observed when comparing Black test-takers in higher age categories to Black test-takers in lower age categories. On the other hand, for certain exams (e.g., Clinical, Masters), the gender differences in pass rates are smaller for Hispanic/Latino test-takers compared to test-takers from other historically marginalized groups. Therefore, it is vital to consider these intersections, particularly within-group variations, when seeking to further understand the varied lived experiences of test-takers, whether related to recruitment, schooling, exam preparation, or administration, and how those experiences can potentially affect exam performance and eventual licensure.

Future research should actively consider the role of intersectionality in all aspects of the social work professional pipeline and should expand data collection and inquiry to gain clearer insight into how various groups experience the exam and what resources would be most effective in improving outcomes for test-takers with intersecting identities.

Conclusion

The primary purpose of social work licensure, and therefore the licensing exams, is to advance safe, competent, and ethical practices to strengthen public protection. Nevertheless, obtaining a social work license has implications for an individual. For example, becoming licensed may help individuals in securing employment, a promotion, or a salary increase. Because supervisory, managerial, and director positions often require licensure, individuals who pass an exam and obtain a social work license have greater career advancement opportunities.

The licensure process is subject to the many systemic factors affecting individuals, particularly those from historically marginalized communities. These systemic factors, combined with implicit factors such as stereotype threat, can affect test-takers at any point along their personal and professional trajectory and culminate in passing or failing a licensing exam.

Ensuring equal opportunity for all to demonstrate their competence on the licensing exams cannot be accomplished solely through the examination program itself. The systemic nature of the challenges will require acknowledging multiple variables and investigating the internal and external factors that may contribute to variation in participation and pass rates. At the same time, the social work examinations must continue to reflect the highest standards of validity and reliability, and further research should be conducted to continue to inform the conversation around diversity, equity, and inclusion.

REFERENCES

REFERENCES

American Bar Association. (2022). *Summary bar pass data: Race, ethnicity, and gender.* https://www.americanbar.org/content/dam/aba/administrative/legal_education_and_admissions_to_the_bar/statistics/2022/2022-bpq-national-summary-data-race-ethnicity-gender-fin.pdf

Chisholm-Burns, M., Spivey, C., Byrd, D., McDonough, S., & Phelps, S. (2017). Examining the association between the NAPLEX, Pre-NAPLEX, and pre- and post-admission factors. *American Journal of Pharmaceutical Education*, *81*(5), Article 86. https://doi.org/10.5688/ajpe81586

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A Black feminist critique of antidiscrimination doctrine, feminist theory, and antiracist politics. *University of Chicago Legal Forum*, *1989*(1), 139–167. https://chicagounbound.uchicago.edu/uclf/vol1989/iss1/8

Lockie, N., Van Lanen, R., & McGannon, T. (2013). Educational implications of nursing students' learning styles, success in chemistry, and supplemental instruction participation on NCLEX-RN performance. *Journal of Professional Nursing*, *29*(1), 49-58. https://doi.org/10.1016/j.profnurs.2012.04.003

Nettles, M. T., Scatton, L. H., Steinberg, J. H., & Tyler, L. L. (2011). Performance and passing rate differences of African American and white prospective teachers on Praxis examinations: A joint project of the National Education Association (NEA) and Educational Testing Service (ETS). *ETS Research Report Series*, *2011*(1), i-82. https://doi.org/10.1002/j.2333-8504.2011.tb02244.x

Shrider, E. A., Kollar, M., Chen, F., & Semega, J. (2021). *Income and poverty in the United States: 2020.* U.S. Census Bureau, Current Population Reports (P60-273). U.S. Government Publishing Office, Washington, DC. https://www.census.gov/content/dam/Census/library/publications/2021/demo/p60-273.pdf

Spencer, S.J., Logel, C., & Davies, P.G. (2016). Stereotype threat. *Annual Review of Psychology*, *67*, 415–437. https://doi.org/10.1146/annurev-psych-073115-103235

Steele, C.M., & Aronson, J. (1995). Stereotype threat and the intellectual test performance of African Americans. *Journal of Personality & Social Psychology*, *69*(5), 797–811. https://doi.org/10.1037/0022-3514.69.5.797

Walton, G. M., & Spencer, S. J. (2009). Latent ability: Grades and test scores systematically underestimate the intellectual ability of negatively stereotyped students. *Psychological Science*, *20*(9),1132–1139. https://doi.org/10.1111/j.1467-9280.2009.02417.x

APPENDIX A
EXAMINATION CATEGORIES

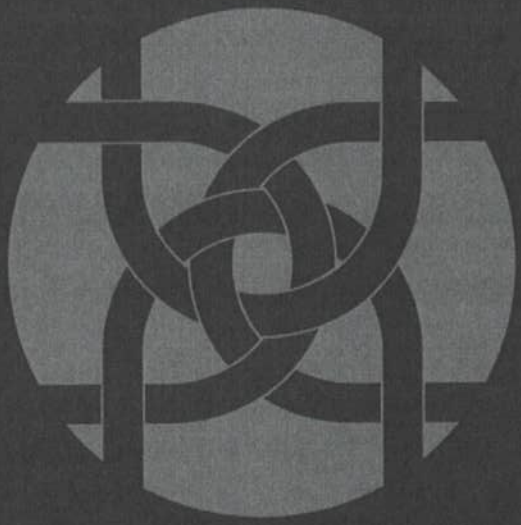
APPENDIX A

EXAMINATION CATEGORIES

Exam	Requirements	Purpose
Associate	Social work degree not required	For use in jurisdictions that issue licenses to applicants who do not possess a social work degree
Bachelors	Bachelor's degree in social work	Basic generalist practice of baccalaureate social work
Masters	Master's degree in social work	Practice of master's social work including the application of specialized knowledge and advanced practice skills
Advanced Generalist	Master's degree in social work; two years (or commensurate experience as defined by the jurisdiction) of experience in nonclinical settings	Practice of advanced generalist social work that occurs in nonclinical settings and may include macro-level practice
Clinical	Master's degree in social work; two years (or commensurate experience as defined by the jurisdiction) of experience in clinical settings	Practice of clinical social work requiring the application of specialized clinical knowledge and advanced clinical skills

APPENDIX B

CLINICAL EXAM: ADDITIONAL STATISTICS



APPENDIX B

CLINICAL EXAM: ADDITIONAL STATISTICS

Table B1. 2011–2021 Clinical exam first-time pass rates by year

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Pass rate	77.5%	76.4%	77.6%	77.6%	75.8%	78.1%	78.3%	73.2%	74.2%	74.8%	75.8%

Table B2. 2018–2021 Clinical exam first-time pass rates by year by race/ethnicity

Race/Ethnicity	2018		2019		2020		2021	
	n	Pass rate	n	Pass rate	n	Pass rate	n	Pass rate
Asian	574	67.2%	561	68.1%	567	72.1%	768	74.9%
Black	2,187	39.2%	2,293	44.0%	2,634	44.6%	2,932	46.2%
Hispanic/Latino	1,838	62.0%	2,071	62.5%	1,873	67.0%	2,726	65.8%
Multiracial	409	77.8%	436	78.4%	430	80.2%	576	80.7%
Native American/ Indigenous peoples	89	65.2%	98	66.3%	97	63.9%	115	59.1%
White	10,437	82.7%	11,205	82.8%	10,684	83.7%	12,977	85.0%

Table B3. 2018–2021 Clinical exam first-time pass rates by year by gender

Gender	2018		2019		2020		2021	
	n	Pass rate	n	Pass rate	n	Pass rate	n	Pass rate
Men	2,084	70.4%	2,250	72.2%	2,227	71.4%	2,618	74.4%
Women	13,927	73.6%	14,947	74.5%	14,571	75.3%	18,007	76.0%

Table B4. 2018–2021 Clinical exam first-time pass rates by year by age

Age	2018		2019		2020		2021	
	n	Pass rate	n	Pass rate	n	Pass rate	n	Pass rate
18–29	4,233	76.8%	4,477	78.4%	4,724	80.3%	5,125	81.4%
30–39	7,002	76.7%	7,663	77.2%	7,269	77.5%	9,420	78.2%
40–49	2,908	66.0%	3,073	68.2%	2,926	68.0%	3,740	69.1%
50 and older	1,879	63.1%	1,994	62.2%	1,882	61.3%	2,372	64.4%

Table B5. 2018–2021 Clinical exam first-time pass rates by year by primary language

Primary language	2018		2019		2020		2021	
	n	Pass rate	n	Pass rate	n	Pass rate	n	Pass rate
English	14,793	75.0%	15,927	75.6%	15,679	75.7%	19,237	77.0%
Other	1,229	52.2%	1,280	55.7%	1,122	62.8%	1,420	59.1%

Table B6. 2018–2021 Clinical exam first-time pass rates by race/ethnicity and gender

Race/Ethnicity	Men		Women	
	n	Pass rate	n	Pass rate
Asian	368	65.8%	2,101	71.9%
Black	1,192	37.2%	8,848	44.7%
Hispanic/Latino	1,164	61.3%	7,341	65.0%
Multiracial	231	77.1%	1,620	79.8%
Native American/ Indigenous peoples	56	57.1%	343	64.4%
White	5,796	82.0%	39,482	83.8%

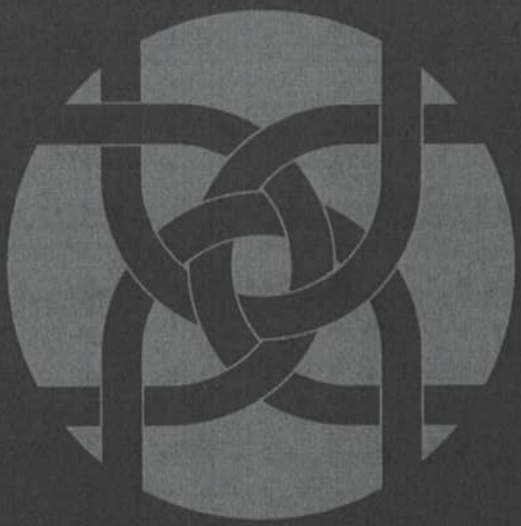
Table B7. 2018–2021 Clinical exam first-time pass rates by race/ethnicity and age

Race/Ethnicity	18 – 29		30 – 39		40 – 49		50 and older	
	n	Pass rate	n	Pass rate	n	Pass rate	n	Pass rate
Asian	596	80.4%	1,317	72.7%	407	59.7%	150	48.0%
Black	1,959	54.2%	4,361	49.8%	2,289	37.2%	1,437	22.0%
Hispanic/Latino	1,923	71.7%	4,470	68.3%	1,511	53.5%	604	40.7%
Multiracial	546	83.7%	889	81.7%	297	70.4%	119	65.5%
Native American/ Indigenous peoples	79	73.4%	146	71.9%	102	55.9%	72	45.8%
White	13,115	84.3%	19,196	86.2%	7,563	80.7%	5,429	76.8%

Note. Data shown may not reflect all test-takers because those who selected options such as *Prefer not to say* or filled in their own identifiers were excluded from this analysis. These options were not available to test-takers at all points during the target time period. ASWB has altered the response options available on the exam registration forms and will continue to evaluate these options to ensure test-takers may accurately respond.

APPENDIX C

MASTERS EXAM: ADDITIONAL STATISTICS



APPENDIX C

MASTERS EXAM: ADDITIONAL STATISTICS

Table C1. 2011–2021 Masters exam first-time pass rates by year

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Pass rate	82.5%	83.3%	82.1%	81.9%	80.4%	81.0%	81.2%	75.5%	74.0%	75.3%	73.0%

Table C2. 2018–2021 Masters exam first-time pass rates by year by race/ethnicity

Race/Ethnicity	2018		2019		2020		2021	
	n	Pass rate	n	Pass rate	n	Pass rate	n	Pass rate
Asian	558	68.8%	575	69.6%	535	72.3%	754	71.2%
Black	3,010	45.0%	3,355	44.5%	3,254	45.2%	4,225	43.9%
Hispanic/Latino	1,755	66.4%	2,031	62.1%	1,878	65.3%	2,752	62.0%
Multiracial	400	82.3%	427	79.2%	430	83.7%	585	77.9%
Native American/ Indigenous peoples	96	66.7%	107	59.8%	114	67.5%	136	65.4%
White	10,474	86.2%	11,160	85.1%	9,984	87.1%	12,423	85.3%

Table C3. 2018–2021 Masters exam first-time pass rates by year by gender

Gender	2018		2019		2020		2021	
	n	Pass rate	n	Pass rate	n	Pass rate	n	Pass rate
Men	2,234	75.3%	2,293	73.8%	2,052	74.2%	2,593	72.7%
Women	14,570	75.5%	15,925	74.0%	14,662	75.5%	19,040	73.1%

Table C4. 2018–2021 Masters exam first-time pass rates by year by age

Age	2018		2019		2020		2021	
	n	Pass rate	n	Pass rate	n	Pass rate	n	Pass rate
18–29	8,858	78.2%	9,433	76.5%	8,587	79.0%	10,584	76.3%
30–39	4,798	74.9%	5,228	73.9%	4,821	74.3%	6,625	72.4%
40–49	2,014	70.8%	2,232	67.8%	2,113	67.7%	2,794	66.8%
50 and older	1,142	65.0%	1,338	66.1%	1,195	66.8%	1,647	64.8%

Table C5. 2018–2021 Masters exam first-time pass rates by year by primary language

Primary language	2018		2019		2020		2021	
	n	Pass rate	n	Pass rate	n	Pass rate	n	Pass rate
English	15,751	76.8%	17,033	75.3%	15,744	76.5%	20,282	74.0%
Other	1,061	55.8%	1,198	55.1%	972	57.4%	1,368	58.8%

Table C6. 2018–2021 Masters exam first-time pass rates by race/ethnicity and gender

Race/Ethnicity	Men		Women	
	n	Pass rate	n	Pass rate
Asian	390	61.0%	2,031	72.4%
Black	1,649	40.6%	12,192	45.1%
Hispanic/Latino	1,052	62.0%	7,361	63.9%
Multiracial	204	80.9%	1,634	80.5%
Native American/ Indigenous peoples	60	68.3%	393	64.4%
White	5,409	87.6%	38,618	85.6%

Table C7. 2018–2021 Masters exam first-time pass rates by race/ethnicity and age

Race/Ethnicity	18 – 29		30 – 39		40 – 49		50 and older	
	n	Pass rate	n	Pass rate	n	Pass rate	n	Pass rate
Asian	1,387	75.3%	700	64.0%	251	64.9%	84	61.9%
Black	5,590	51.3%	4,576	44.3%	2,282	38.0%	1,396	29.5%
Hispanic/Latino	4,264	67.9%	2,763	63.2%	983	54.5%	406	44.8%
Multiracial	977	82.7%	623	80.4%	172	72.7%	70	70.0%
Native American/ Indigenous peoples	133	72.9%	152	67.8%	102	56.9%	66	54.5%
White	24,202	85.1%	11,819	88.0%	4,977	84.9%	3,043	85.2%

Note. Data shown may not reflect all test-takers because those who selected options such as *Prefer not to say* or filled in their own identifiers were excluded from this analysis. These options were not available to test-takers at all points during the target time period. ASWB has altered the response options available on the exam registration forms and will continue to evaluate these options to ensure test-takers may accurately respond.

APPENDIX D

BACHELORS EXAM: ADDITIONAL STATISTICS

APPENDIX D

BACHELORS EXAM: ADDITIONAL STATISTICS

Table D1. 2011–2021 Bachelors Exam first-time pass rates by year

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Pass rate	77.5%	77.0%	77.7%	77.8%	77.5%	76.7%	77.7%	69.0%	67.3%	68.5%	68.7%

Table D2. 2018–2021 Bachelors exam first-time pass rates by year by race/ethnicity

Race/Ethnicity	2018		2019		2020		2021	
	n	Pass rate	n	Pass rate	n	Pass rate	n	Pass rate
Asian	73	60.3%	85	48.2%	85	57.6%	97	71.1%
Black	515	37.5%	475	34.9%	319	33.2%	446	31.6%
Hispanic/Latino	254	52.8%	274	49.6%	175	54.9%	293	54.6%
Multiracial	77	77.9%	69	73.9%	54	77.8%	100	71.0%
Native American/ Indigenous peoples	38	71.1%	34	55.9%	33	57.6%	40	75.0%
White	2,659	76.7%	2,573	75.7%	1,944	75.8%	2.406	77.0%

Table D3. 2018–2021 Bachelors exam first-time pass rates by year by gender

Gender	2018		2019		2020		2021	
	n	Pass rate	n	Pass rate	n	Pass rate	n	Pass rate
Men	362	65.7%	349	67.3%	298	66.4%	327	63.9%
Women	3,346	69.3%	3,233	67.3%	2,409	68.8%	3,166	69.1%

Table D4. 2018–2021 Bachelors exam first-time pass rates by year by age

Age	2018		2019		2020		2021	
	n	Pass rate	n	Pass rate	n	Pass rate	n	Pass rate
18–29	2,162	68.6%	2,145	67.9%	1,602	70.3%	2,010	69.4%
30–39	790	72.8%	763	67.4%	567	66.1%	766	70.6%
40–49	468	68.4%	412	68.9%	335	68.4%	454	69.2%
50 and older	291	62.5%	263	59.3%	205	61.5%	264	56.8%

Table D5. 2018–2021 Bachelors exam first-time pass rates by year by primary language

Primary language	2018		2019		2020		2021	
	n	Pass rate	n	Pass rate	n	Pass rate	n	Pass rate
English	3,538	70.1%	3,393	68.9%	2,565	70.0%	3,315	69.6%
Other	173	46.2%	190	38.9%	144	43.1%	179	52.0%

Table D6. 2018–2021 Bachelors exam first-time pass rates by race/ethnicity and gender

Race/Ethnicity	Men		Women	
	n	Pass rate	n	Pass rate
Asian	48	66.7%	292	58.6%
Black	218	33.9%	1,537	34.6%
Hispanic/Latino	101	52.5%	895	52.8%
Multiracial	34	79.4%	266	74.1%
Native American/ Indigenous peoples	13	46.2%	132	67.4%
White	874	74.8%	8,703	76.5%

Table D7. 2018–2021 Bachelors exam first-time pass rates by race/ethnicity and age

Race/Ethnicity	18 – 29		30 – 39		40 – 49		50 and older	
	n	Pass rate	n	Pass rate	n	Pass rate	n	Pass rate
Asian	223	58.7%	78	59.0%	26	73.1%	13	53.8%
Black	789	39.3%	442	35.3%	291	30.2%	233	22.3%
Hispanic/Latino	637	53.1%	232	56.5%	82	45.1%	45	44.4%
Multiracial	206	75.7%	65	75.4%	21	57.1%	8	--
Native American/ Indigenous peoples	59	67.8%	38	63.2%	36	63.9%	12	66.7%
White	5,859	74.7%	1,918	79.4%	1,139	80.6%	666	74.5%

Note. To protect the privacy of test-takers, pass rate data are not reported for samples n <10. Data shown may not reflect all test-takers because those who selected options such as *Prefer not to say* or filled in their own identifiers were excluded from this analysis. These options were not available to test-takers at all points during the target time period. ASWB has altered the response options available on the exam registration forms and will continue to evaluate these options to ensure test-takers may accurately respond.

APPENDIX E

ASSOCIATE EXAM: ADDITIONAL STATISTICS

APPENDIX E

ASSOCIATE EXAM: ADDITIONAL STATISTICS

Table E1. 2011–2021 Associate exam first-time pass rates by year

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Pass rate	75.8%	75.0%	77.3%	68.5%	67.5%	66.2%	70.4%	72.2%	74.3%	78.0%	70.7%

Table E2. 2011–2021 Associate exam eventual pass rates by race/ethnicity and gender

Race/Ethnicity	Men		Women	
	n	Pass rate	n	Pass rate
Asian	18	66.7%	49	77.6%
Black	139	66.9%	496	71.6%
Hispanic/Latino	101	72.3%	557	76.5%
Multiracial	21	81.0%	71	88.7%
Native American/ Indigenous peoples	2	--	31	71.0%
White	395	90.9%	1,682	93.5%

Note. To protect the privacy of test-takers, pass rate data are not reported for samples n <10.

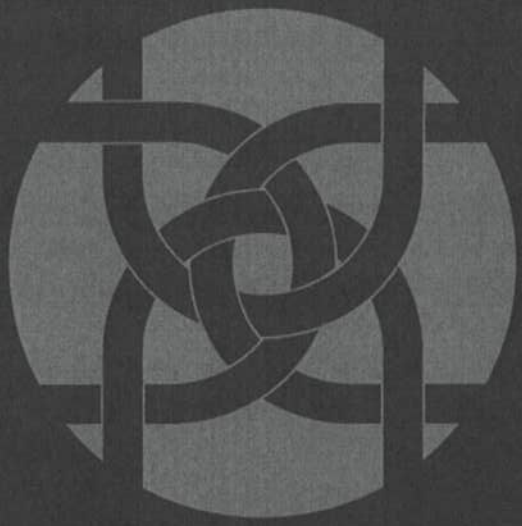
Table E3. 2011–2021 Associate exam eventual pass rates by race/ethnicity and age

Race/Ethnicity	18–29		30–39		40–49		50 and older	
	n	Pass rate	n	Pass rate	n	Pass rate	n	Pass rate
Asian	23	82.6%	19	63.2%	17	76.5%	8	--
Black	264	74.6%	213	73.2%	97	63.9%	61	54.1%
Hispanic/Latino	306	80.1%	214	77.1%	91	75.8%	47	42.6%
Multiracial	47	85.1%	30	90.0%	9	--	6	--
Native American/ Indigenous peoples	5	--	10	100.0%	9	--	9	--
White	1,002	93.2%	607	93.7%	292	92.1%	177	91.0%

Note. To protect the privacy of test-takers, pass rate data are not reported for samples n <10. Data shown may not reflect all test-takers because those who selected options such as *Prefer not to say* or filled in their own identifiers were excluded from this analysis. These options were not available to test-takers at all points during the target time period. ASWB has altered the response options available on the exam registration forms and will continue to evaluate these options to ensure test-takers may accurately respond.

APPENDIX F

ADVANCED GENERALIST EXAM: ADDITIONAL STATISTICS



APPENDIX F

ADVANCED GENERALIST EXAM: ADDITIONAL STATISTICS

Table F1. 2011–2021 Advanced Generalist exam first-time pass rates by year

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Pass rate	47.6%	63.3%	75.3%	71.1%	64.5%	57.1%	59.1%	56.2%	66.9%	64.2%	63.6%

Table F2. 2011–2021 Advanced Generalist exam eventual pass rates by race/ethnicity and gender

Race/Ethnicity	Men		Women	
	n	Pass rate	n	Pass rate
Asian	6	--	46	52.2%
Black	73	21.9%	401	26.2%
Hispanic/Latino	8	--	52	51.9%
Multiracial	5	--	38	65.8%
Native American/ Indigenous peoples	1	--	12	41.7%
White	178	71.9%	1,426	78.4%

Note. To protect the privacy of test-takers, pass rate data are not reported for samples n <10.

Table F3. 2011–2021 Advanced Generalist exam eventual pass rates by race/ethnicity and age

Race/Ethnicity	18–29		30–39		40–49		50 and older	
	n	Pass rate	n	Pass rate	n	Pass rate	n	Pass rate
Asian	9	--	29	55.2%	11	63.6%	3	--
Black	38	39.5%	144	31.3%	154	22.1%	138	19.6%
Hispanic/Latino	9	--	26	53.8%	11	54.5%	14	21.4%
Multiracial	14	50.0%	17	70.6%	7	--	5	--
Native American/ Indigenous peoples	1	--	1	--	3	--	8	--
White	355	79.4%	666	80.2%	335	76.1%	248	70.6%

Note. To protect the privacy of test-takers, pass rate data are not reported for samples n <10. Data shown may not reflect all test-takers because those who selected options such as Prefer not to say or filled in their own identifiers were excluded from this analysis. These options were not available to test-takers at all points during the target time period. ASWB has altered the response options available on the exam registration forms and will continue to evaluate these options to ensure test-takers may accurately respond.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North American Pass Rates
For the ASWB Examinations 2019

Exam Category and Group Type	Total Number of Examinations	Pass Rate	
		Number	Percentage
Associate			
First-Time	304	225	74.0
Repeat Group	116	48	41.4
Total Group	420	273	65.0
Bachelors			
First-Time	3,565	2,402	67.4
Repeat Group	1,097	374	34.1
Total Group	4,662	2,776	59.5
Masters			
First-Time	18,211	13,472	74.0
Repeat Group	7,240	1,976	27.3
Total Group	25,451	15,448	60.7
Advanced Generalist			
First-Time	127	85	66.9
Repeat Group	59	13	22.0
Total Group	186	98	52.7
Clinical			
First-Time	17,187	12,746	74.2
Repeat Group	8,511	2,967	34.9
Total Group	25,698	15,713	61.1
Total	56,417	34,308	60.8

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2020 Pass Rates for the ASWB Examinations
United States and Canada

Exam Category and Group Type	Total Number of Examinations	Pass Rate	
		Number	Percentage
Associate			
First-Time	250	194	77.6
Repeat Group	87	39	44.8
Total Group	337	233	69.1
Bachelors			
First-Time	2,696	1,848	68.5
Repeat Group	856	325	38.0
Total Group	3,552	2,173	61.2
Masters			
First-Time	16,698	12,585	75.4
Repeat Group	6,774	2,174	32.1
Total Group	23,472	14,759	62.9
Advanced Generalist			
First-Time	134	86	64.2
Repeat Group	53	17	32.1
Total Group	187	103	55.1
Clinical			
First-Time	16,776	12,550	74.8
Repeat Group	7,902	2,900	36.7
Total Group	24,679	15,451	62.6
Total	52,227	32,719	62.6

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Pass Rates of NV in 2019

Exam Category and Group Type	Total Number of Examinations	Pass Rate	
		Number	Percentage
Associate			
First-Time			
Repeat Group			
Total Group			
Bachelors			
First-Time	72	50	69.4
Repeat Group	20	10	50.0
Total Group	92	60	65.2
Masters			
First-Time	230	180	78.3
Repeat Group	65	17	26.2
Total Group	295	197	66.8
Advanced Generalist			
First-Time			
Repeat Group			
Total Group			
Clinical			
First-Time	90	72	80.0
Repeat Group	30	14	46.7
Total Group	120	86	71.7
Total	507	343	67.7

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Pass Rates of NV in 2020

Exam Category and Group Type	Total Number of Examinations	Pass Rate	
		Number	Percentage
Associate			
First-Time			
Repeat Group			
Total Group			
Bachelors			
First-Time	34	21	61.8
Repeat Group	8	4	50.0
Total Group	42	25	59.5
Masters			
First-Time	188	145	77.1
Repeat Group	49	17	34.7
Total Group	237	162	68.4
Advanced Generalist			
First-Time			
Repeat Group			
Total Group			
Clinical			
First-Time	124	96	77.4
Repeat Group	31	16	51.6
Total Group	155	112	72.3
Total	434	299	68.9

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School Pass/Fail Summary Report

School: University of Nevada - Las Vegas **Examination: BACHELORS**

The following table presents the numbers of examinations administered to candidates who indicated that they attended the college or university listed above. Figures indicate the percentage of first-time, repeat, and total examinees who passed the Bachelors examination during the year(s) 2019. Note that failing examinees may repeat the examination more than once.

Year	First-Time				Repeat				Total			
	Pass	Fail	Total	Rate	Pass	Fail	Total	Rate	Pass	Fail	Total	Rate
2019	20	12	32	62%	5	4	9	56%	25	16	41	61%

The following table provides the North American percentages of passing candidates for first-time, repeat, and total examinees for the year(s) 2019. These data are provided for comparative purposes only.

Year	North American Pass Rates		
	First-Time	Repeat	Total
2019	67%	34%	60%

Inferences and suppositions cannot be reliably made from pass rate data for groups of fewer than 200 candidates.

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School Pass/Fail Summary Report

School: University of Nevada - Las Vegas **Examination: BACHELORS**

The following table presents the numbers of examinations administered to candidates who indicated that they attended the college or university listed above. Figures indicate the percentage of first-time, repeat, and total examinees who passed the Bachelors examination during the year(s) 2020. Note that failing examinees may repeat the examination more than once.

Year	First-Time				Repeat				Total			
	Pass	Fail	Total	Rate	Pass	Fail	Total	Rate	Pass	Fail	Total	Rate
2020	4	6	10	*40%*	0	1	1	*0%*	4	7	11	*36%*

The following table provides the percentages of passing candidates for first-time, repeat, and total examinees in the United States and Canada for the year(s) 2020. These data are provided for comparative purposes only.

Year	Pass Rates – U.S. & Canada		
	First-Time	Repeat	Total
2020	*68.5%*	*38.0%*	*61.2%*

Inferences and suppositions cannot be reliably made from pass rate data for groups of fewer than 200 candidates.

ASWB
Association of Social Work Boards

School Pass/Fail Summary Report

School: University of Nevada - Las Vegas **Examination: MASTERS**

The following table presents the numbers of examinations administered to candidates who indicated that they attended the college or university listed above. Figures indicate the percentage of first-time, repeat, and total examinees who passed the Masters examination during the year(s) 2019. Note that failing examinees may repeat the examination more than once.

Year	First-Time				Repeat				Total			
	Pass	Fail	Total	Rate	Pass	Fail	Total	Rate	Pass	Fail	Total	Rate
2019	63	22	85	74%	9	21	30	30%	72	43	115	63%

The following table provides the North American percentages of passing candidates for first-time, repeat, and total examinees for the year(s) 2019. These data are provided for comparative purposes only.

Year	North American Pass Rates		
	First-Time	Repeat	Total
2019	74%	27%	61%

Inferences and suppositions cannot be reliably made from pass rate data for groups of fewer than 200 candidates.

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School Pass/Fail Summary Report

School: University of Nevada - Las Vegas **Examination: MASTERS**

The following table presents the numbers of examinations administered to candidates who indicated that they attended the college or university listed above. Figures indicate the percentage of first-time, repeat, and total examinees who passed the Masters examination during the year(s) 2020. Note that failing examinees may repeat the examination more than once.

Year	First-Time				Repeat				Total			
	Pass	Fail	Total	Rate	Pass	Fail	Total	Rate	Pass	Fail	Total	Rate
2020	46	14	60	*77%*	9	17	26	*35%*	55	31	86	*64%*

The following table provides the percentages of passing candidates for first-time, repeat, and total examinees in the United States and Canada for the year(s) 2020. These data are provided for comparative purposes only.

Year	Pass Rates - U.S. & Canada		
	First-Time	Repeat	Total
2020	*75.4%*	*32.1%*	*62.9%*

Inferences and suppositions cannot be reliably made from pass rate data for groups of fewer than 200 candidates.

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School Pass/Fail Summary Report

School: University of Nevada - Las Vegas **Examination: CLINICAL**

The following table presents the numbers of examinations administered to candidates who indicated that they attended the college or university listed above. Figures indicate the percentage of first-time, repeat, and total examinees who passed the Clinical examination during the year(s) 2019. Note that failing examinees may repeat the examination more than once.

Year	First-Time				Repeat				Total			
	Pass	Fail	Total	Rate	Pass	Fail	Total	Rate	Pass	Fail	Total	Rate
2019	37	13	50	74%	11	13	24	46%	48	26	74	65%

The following table provides the North American percentages of passing candidates for first-time, repeat, and total examinees for the year(s) 2019. These data are provided for comparative purposes only.

Year	North American Pass Rates		
	First-Time	Repeat	Total
2019	74%	35%	61%

Inferences and suppositions cannot be reliably made from pass rate data for groups of fewer than 200 candidates.

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School Pass/Fail Summary Report

School: University of Nevada - Las Vegas **Examination: CLINICAL**

The following table presents the numbers of examinations administered to candidates who indicated that they attended the college or university listed above. Figures indicate the percentage of first-time, repeat, and total examinees who passed the Clinical examination during the year(s) 2020. Note that failing examinees may repeat the examination more than once.

Year	First-Time				Repeat				Total			
	Pass	Fail	Total	Rate	Pass	Fail	Total	Rate	Pass	Fail	Total	Rate
2020	62	10	72	*86%*	8	7	15	*53%*	70	17	87	*80%*

The following table provides the percentages of passing candidates for first-time, repeat, and total examinees in the United States and Canada for the year(s) 2020. These data are provided for comparative purposes only.

Year	Pass Rates - U.S. & Canada		
	First-Time	Repeat	Total
2020	*74.8%*	*36.7%*	*62.6%*

Inferences and suppositions cannot be reliably made from pass rate data for groups of fewer than 200 candidates.

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School Pass/Fail Summary Report

School: University of Nevada - Reno

Examination: BACHELORS

The following table presents the numbers of examinations administered to candidates who indicated that they attended the college or university listed above. Figures indicate the percentage of first-time, repeat, and total examinees who passed the Bachelors examination during the year(s) 2019. Note that failing examinees may repeat the examination more than once.

Year	First-Time				Repeat				Total			
	Pass	Fail	Total	Rate	Pass	Fail	Total	Rate	Pass	Fail	Total	Rate
2019	20	5	25	80%	5	4	9	56%	25	9	34	74%

The following table provides the North American percentages of passing candidates for first-time, repeat, and total examinees for the year(s) 2019. These data are provided for comparative purposes only.

Year	North American Pass Rates		
	First-Time	Repeat	Total
2019	67%	39%	60%

Inferences and suppositions cannot be reliably made from pass rate data for groups of fewer than 200 candidates.

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School Pass/Fail Summary Report

School: University of Nevada - Reno **Examination: BACHELORS**

The following table presents the numbers of examinations administered to candidates who indicated that they attended the college or university listed above. Figures indicate the percentage of first-time, repeat, and total examinees who passed the Bachelors examination during the year(s) 2020. Note that failing examinees may repeat the examination more than once.

Year	First-Time				Repeat				Total			
	Pass	Fail	Total	Rate	Pass	Fail	Total	Rate	Pass	Fail	Total	Rate
2020	12	3	15	*80%*	4	3	7	*57%*	16	6	22	*73%*

The following table provides the percentages of passing candidates for first-time, repeat, and total examinees in the United States and Canada for the year(s) 2020. These data are provided for comparative purposes only.

Year	Pass Rates – U.S. & Canada		
	First-Time	Repeat	Total
2020	*68.5%*	*38.0%*	*61.2%*

Inferences and suppositions cannot be reliably made from pass rate data for groups of fewer than 200 candidates.

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School Pass/Fail Summary Report

School: University of Nevada - Reno **Examination: MASTERS**

The following table presents the numbers of examinations administered to candidates who indicated that they attended the college or university listed above. Figures indicate the percentage of first-time, repeat, and total examinees who passed the Masters examination during the year(s) 2019. Note that failing examinees may repeat the examination more than once.

Year	First-Time				Repeat				Total			
	Pass	Fail	Total	Rate	Pass	Fail	Total	Rate	Pass	Fail	Total	Rate
2019	74	13	87	85%	6	9	15	40%	80	22	102	78%

The following table provides the North American percentages of passing candidates for first-time, repeat, and total examinees for the year(s) 2019. These data are provided for comparative purposes only.

Year	North American Pass Rates		
	First-Time	Repeat	Total
2019	74%	27%	61%

Inferences and suppositions cannot be reliably made from pass rate data for groups of fewer than 200 candidates.

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School Pass/Fail Summary Report

School: University of Nevada - Reno

Examination: MASTERS

The following table presents the numbers of examinations administered to candidates who indicated that they attended the college or university listed above. Figures indicate the percentage of first-time, repeat, and total examinees who passed the Masters examination during the year(s) 2020. Note that failing examinees may repeat the examination more than once.

Year	First-Time				Repeat				Total			
	Pass	Fail	Total	Rate	Pass	Fail	Total	Rate	Pass	Fail	Total	Rate
2020	63	15	78	*81%*	4	8	12	*33%*	67	23	90	*74%*

The following table provides the percentages of passing candidates for first-time, repeat, and total examinees in the United States and Canada for the year(s) 2020. These data are provided for comparative purposes only.

Year	Pass Rates – U.S. & Canada		
	First-Time	Repeat	Total
2020	*75.4%*	*32.1%*	*62.9%*

Inferences and suppositions cannot be reliably made from pass rate data for groups of fewer than 200 candidates.

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School Pass/Fail Summary Report

School: University of Nevada - Reno

Examination: CLINICAL

The following table presents the numbers of examinations administered to candidates who indicated that they attended the college or university listed above. Figures indicate the percentage of first-time, repeat, and total examinees who passed the Clinical examination during the year(s) 2019. Note that failing examinees may repeat the examination more than once.

Year	First-Time				Repeat				Total			
	Pass	Fail	Total	Rate	Pass	Fail	Total	Rate	Pass	Fail	Total	Rate
2019	31	3	34	91%	1	3	4	25%	32	6	38	84%

The following table provides the North American percentages of passing candidates for first-time, repeat, and total examinees for the year(s) 2019. These data are provided for comparative purposes only.

North American Pass Rates			
Year	First-Time	Repeat	Total
2019	74%	35%	61%

Inferences and suppositions cannot be reliably made from pass rate data for groups of fewer than 200 candidates.

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Association of Social Work Boards

School Pass/Fail Summary Report

School: University of Nevada - Reno

Examination: CLINICAL

The following table presents the numbers of examinations administered to candidates who indicated that they attended the college or university listed above. Figures indicate the percentage of first-time, repeat, and total examinees who passed the Clinical examination during the year(s) 2020. Note that failing examinees may repeat the examination more than once.

Year	First-Time				Repeat				Total			
	Pass	Fail	Total	Rate	Pass	Fail	Total	Rate	Pass	Fail	Total	Rate
2020	26	8	34	*76%*	7	2	9	*78%*	33	10	43	*77%*

The following table provides the percentages of passing candidates for first-time, repeat, and total examinees in the United States and Canada for the year(s) 2020. These data are provided for comparative purposes only.

Year	Pass Rates - U.S. & Canada		
	First-Time	Repeat	Total
2020	*74.8%*	*36.7%*	*62.6%*

Inferences and suppositions cannot be reliably made from pass rate data for groups of fewer than 200 candidates.

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Serving as a delegate - handout

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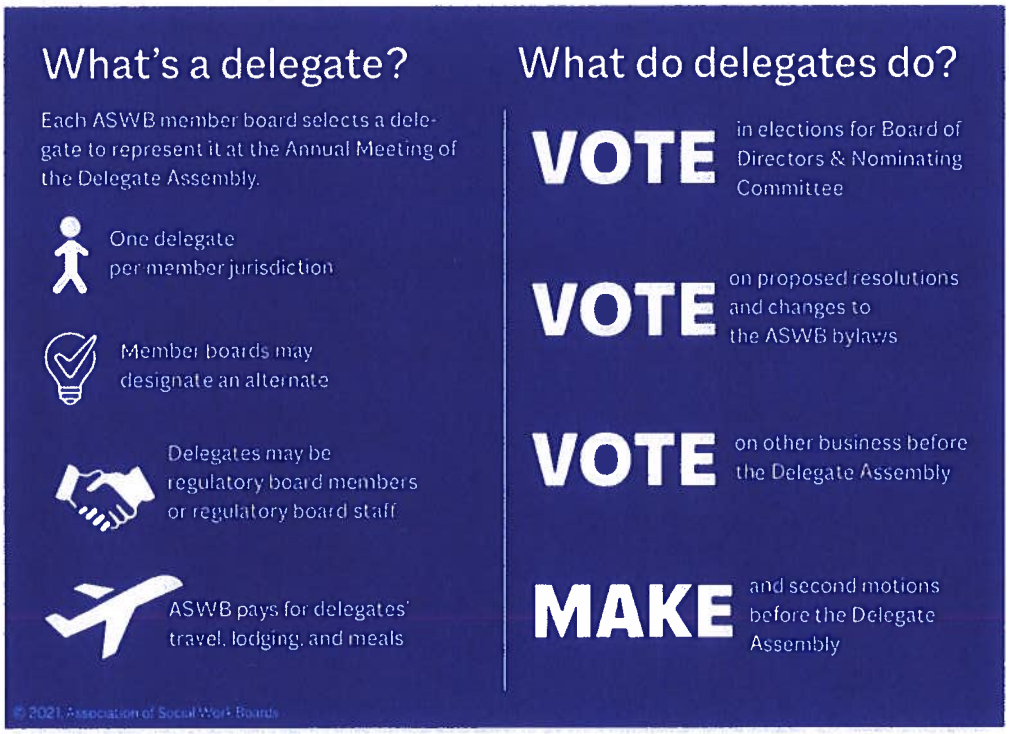
Serving as a delegate

Delegates are individual representatives of ASWB member organizations. Each ASWB member jurisdiction is allowed one delegate at the Annual Meeting of the Delegate Assembly.



Contact us
If you have questions about becoming a delegate, contact our volunteer engagement and outreach staff.

These delegates are funded to attend the meeting, which means all travel, meals, and lodging are paid for by ASWB.

Member jurisdictions are encouraged to send additional representatives to the meeting who may serve as alternates, but those representatives are generally not funded.

From Article VI, Section 7 of the ASWB's bylaws:

> *A Member Board is entitled to be represented by a single vote on each issue put to a vote before the Delegate Assembly. Member Boards shall vest the right to vote in their Delegates and Alternate Delegates. Voting by proxy is prohibited. Delegates, Alternate Delegates, all members and employees of Member Boards, and all members of Association committees shall have the privilege of the floor at all Delegate Assembly meetings. Only Delegates are eligible to make and second motions.*

Delegates are expected to vote in elections for leadership positions within ASWB, as well as amendments to the ASWB bylaws and any other business. Delegates will receive information about official actions at the annual meeting prior to attending and are encouraged to discuss these matters with their fellow board members.

3 E

Review and Discuss Board Compensation Payment Process. (For Possible Action).

Board Member Salary - Time Log

Per NRS 641B.140 and BESW Policy and Procedure

Jul-22

For the purposes of NRS 641B.140, the Board considers the following activities to be "business of the Board': attending Board meetings; preparation before a meeting; travel; cooperating with an investigation; testifying on behalf of the Board; attending training approved by the Board, or provided by the Attorney General's Office; attend meetings of professional organizations as a representative of the Board; attend public meetings at the request of the Board; respond to requests from the Executive Director; perform the duties and functions as an officer of the Board.

Date	Task(s)	Hours	$18.75 per hour	Days	$150 per day
7/1/2022			$0.00		$0.00
7/2/2022			$0.00		$0.00
7/3/2022			$0.00		$0.00
7/4/2022			$0.00		$0.00
7/5/2022			$0.00		$0.00
7/6/2022			$0.00		$0.00
7/7/2022			$0.00		$0.00
7/8/2022			$0.00		$0.00
7/9/2022			$0.00		$0.00
7/10/2022			$0.00		$0.00
7/11/2022			$0.00		$0.00
7/12/2022			$0.00		$0.00
7/13/2022			$0.00		$0.00
7/14/2022			$0.00		$0.00
7/15/2022			$0.00		$0.00
7/16/2022			$0.00		$0.00
7/17/2022			$0.00		$0.00
7/18/2022			$0.00		$0.00
7/19/2022			$0.00		$0.00
7/20/2022			$0.00		$0.00
7/21/2022			$0.00		$0.00
7/22/2022			$0.00		$0.00
7/23/2022			$0.00		$0.00
7/24/2022			$0.00		$0.00
7/25/2022			$0.00		$0.00
7/26/2022			$0.00		$0.00
7/27/2022			$0.00		$0.00
7/28/2022			$0.00		$0.00
7/29/2022			$0.00		$0.00
7/30/2022			$0.00		$0.00
7/31/2022			$0.00		$0.00
	Totals		$0.00		$0.00

By signing below I confirm that I, "Board Member Name", have performed "business of the Board" and am therefore entitled to compensation pursuant to NRS 641B.140 and the Nevada State Board of Examiners for Social Workers.

Date Signature

EXECUTIVE DIRECTOR'S REPORT 3 F

NASW Conference and More – Handout 3 F - i

Check out Conference Announcement, ASWB Bias Report, and more

NASW-Nevada Chapter <khillman.naswnv@socialworkers.org>
Reply-To: khillman.naswnv@socialworkers.org

NASW · NEVADA CHAPTER
National Association of Social Workers

2022 Social Work Virtual Mental Health Conference

Reconnecting Through Social Work

Oct. 13th and 14th, 2022
Hosted by NASW-Nevada and NASW-North Dakota

Session Highlights:

The Ethics of Documentation (3 CEUS)
Presenter: Gary Bailey

This year's annual conference is only months away! We are excited to see so many of you attending and networking with Nevada social workers and even social workers from around the USA as you earn up to 9 CEUs.

Registration is now open:
Register here.

CONFERENCE SCHEDULE AND WORKSHOP DESCRIPTIONS

Micro level steps that promote Mezzo and Macro Level Clinical Practice attuned to DEI (1 CEU)
Presenter: Latoyia Griffin

Suicide Awareness and Prevention for LGBTQIA2S+ Youth (2 CEUs)
Presenter: Faye Seidler

To see the full day's schedule, workshops, and full workshop descriptions, click here.

REGISTRATION RATES
Additional processing fees will apply to the below registration rates

Registration

- Nonmember: $200.00
- NASW Member: $150.00

Student Rate (MSW and BSW)

- Nonmember: $109.00 (includes 1 year Student NASW membership)
- NASW Member: $59.00

Get more exposure for your agency or organization with an NASW Sponsorship!

DIGITAL EXHIBITOR SPONSORSHIP
This year's Exhibit Hall utilizes a digital interactive sponsorship! Attendees will be able to interact with exhibitors right inside the virtual conference program. Registered participants can view personalized exhibitor messages and company websites, interact with vendors via real-time chat sessions, and connect through virtual community discussions.

To find out more about becoming an exhibitor click here!

SPONSORSHIP OPPORTUNITIES
Custom sponsorship packages are available ranging from $2,000 to $15,000. If you would like to elevate your presence at the conference and reach an even larger audience with the chapter, please reach out to NASW-Nevada Chapter Executive Director Kyle Hillman. khillman.naswnv@socialworkers.org

ASWB

First Time Pass Rates

Clinical Exam:

- **White Test Takers: 83.8%**
- **Black Test Takers: 44.7%**

Masters Exam:

- **White Test Takers: 85.3%**
- **Black Test Takers: 43.9%**

Bachelors Exam:

- **White Test Takers: 76.5%**
- **Black Test Takers: 34.6%**

Data from Appendix - Table B6, C2., & D6 of the 2022 ASWB Exam Pas Rate Analysis

ASWB Finally Released Testing Data: It is not good.

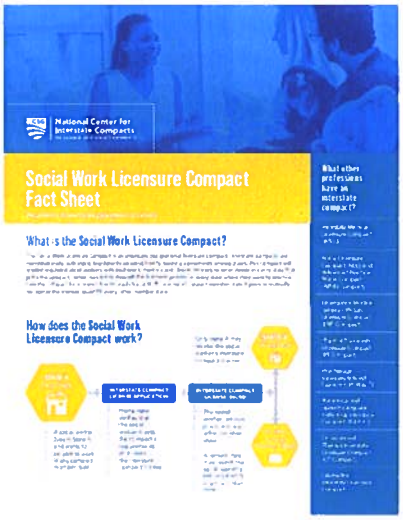
Today the ASWB released a much-anticipated report regarding the pass-fail rate (with demographics) which the organization had long refused to release.

The data confirms long-held beliefs that the ASWB exam is biased against certain populations including black test takers and older adults.

As we are still reviewing the information including the appendixes with first-time pass rates - we will likely have more to say - but we encourage you to review the data yourself at: https://www.aswb.org/wp-content/uploads/2022/07/2022-ASWB-Exam-Pass-Rate-Analysis.pdf

DRAFT SOCIAL WORK COMPACT RELEASED!

The Council of State Governments (CSG) is partnering with the Department of Defense (DoD) and the Association of Social Work Boards (ASWB) with support from the National



Association of Social Workers (NASW) and Clinical Social Work Association (CSWA) to support the mobility of licensed social workers through the development of a new interstate compact. This additional licensing pathway will facilitate multistate practice among member states and reduce the barriers to license portability.

An initial draft of the Social Work Compact has been completed. The draft is now available for review and public comment. To read the Social Work Compact draft model language: Social-Work-Licensure-Compact-Draft-7_11_22.pdf (csg.org)

JOIN US:

Social Work Compact Discussion

August 25th, 6:30-7:30pm

A webinar to take a critical look at what is in the draft compact and what may be missing. We will also discuss what this may mean for Nevada social workers and what the next steps are for the compact and Nevada's participation.

Opportunity to have your questions answered at the end.

Free (open to members and nonmembers): Register at - https://events.zoom.us/e/view/EqWUkYE4TiqmnzMSc90MTA?id=EqWUkYE4TiqmnzMSc90MTA

Job Listings:

Therapist and Clinical Interns - Resource Family Services

We are looking for therapists or clinical interns preferred but not required to add to our private practice. Position can be part time or full time. We are a full service behavioral health practice and we are credentialed with most insurances in the state of Nevada. We also do EAP work and Disruptive Event Management. We provide services to adults, teens and children. With over 25 years of experience in Las Vegas, we offer great compensation, supervision and training in a close knit sharing environment. Clinical Interns can also apply. You can email us at blink@resourcefamilyservices.com or contact us with any questions at 702 334-7322.

Upcoming Events:

NASW Student Series | Managing Social Work Student Debt: What You Need to Know in 2022

- Date: August 18 from 3 p.m.-4:30 p.m. PST
- Location: Online
- Register at https://us02web.zoom.us/meeting/register/tZcqdOuvrjgtGtJ3nH21V7pJL3PRcd-ZwxoA

A Critical Look at the Social Work Licensure Compact: what you need to know.

- Date: August 25th from 6:30pm-7:30pm PST
- Location: Online
- Register: https://events.zoom.us/e/view/EqWUkYE4TiqmnzMSc90MTA?id=EqWUkYE4TiqmnzMSc90MTA

Specialty Practice Section Webinar, "Pain Management: Differentiation Between Physiological Dependency and Substance Use Disorder. Prevention and Intervention

- Date: August 30 from 11 a.m.-12:30 p.m. PST
- Location: Online
- Register for 1.5 Substance Use Disorder Hours at https://naswinstitute.inreachce.com/Details/Information/ffdce945-6e59-4b58-986d-e71d3514b27f

NASW Nevada & NASW North Dakota 2022 Mental Health Conference
Virtual - October 13th and 14th 2022.

On-Demand CEU Education:

NASW is committed to helping social workers meet their professional development needs. Social Work Online CE Institute houses hundreds of on-demand titles produced by the NASW Chapters and National Office, and, for your ease of mind, uses the same NASW login to access the Institute and all your training history. NASW members can access both free CEs and CEs at

discounted rates! Not a member of NASW yet? No worries, nonmembers can also purchase titles (at the nonmember rate).

Sign-up here: https://naswinstitute.inreachce.com/

THANK YOU TO OUR MEMBERS!

Not a member of NASW yet?
Now is a perfect time to check out your professional organization
Click here to learn more

NASW-Nevada Chapter | 871 Coronado Center Dr, Suite 200, Las Vegas, NV 89052