BEHAVIORAL SCIENCES REGULATORY BOARD
LICENSED PSYCHOLOGY ADVISORY COMMITTEE
Tuesday, April 9, 2024

The meeting will be conducted virtually on the Zoom platform. Advisory Committee members, BSRB staff, and anyone approved for public comment will utilize the Zoom platform while other remote attendees will be directed to the YouTube broadcast (or the conference call phone number), to ensure a secure and accessible meeting.

You may view the meeting here: https://youtube.com/live/GG52M3Nf-yI?feature=share

To join the meeting by conference call: 877-278-8686. The pin: 327072

If there are any technical issues during the meeting, you may call the Board office at, 785-296-3240. The Behavioral Sciences Regulatory Board may take items out of order as necessary to accommodate the time restrictions of Board members and visitors. All times and items are subject to change.

April 9, 2024, 6:00 p.m.

I. Call to order and Roll Call

II. Agenda Approval

III. Review and Approval of Minutes from Advisory Committee Meeting on February 13, 2024

IV. Executive Director's Report

V. Update on PSYPACT Commission

VI. Old Business
- **A. Continued Discussion on Draft Regulation for Documentation of Continuing Education**
- **B. Continued Discussion on Possible Changes to K.A.R. 102-1-12 Educational Requirements**

VII. New Business
- **A. Discussion on Possible Survey for Licensed Psychologists**
- **B. Advisory Committee Membership**
- **C. Discussion on a Jurisprudence Examination**
- **D. Additional Discussion Topics for FY 2024**

VIII. Upcoming Meetings: June 11, 2024, from 6pm until 8pm

IX. Adjournment

BEHAVIORAL SCIENCES REGULATORY BOARD
LICENSED PSYCHOLOGY ADVISORY COMMITTEE MEETING
FEBRUARY 13, 2024

Draft Minutes

I. **Call to Order.** Richard Nobles, Chair of the Advisory Committee, called the meeting to order at 6 p.m.

Committee Members. Richard Nobles, Linda Heitzman-Powell, David Stevens, Abby Callis, Mark Goodman, Matthew Guelker, Jessica Hamilton, Edward Hunter, Tiffany Johnson, Sarah Kirk, Rodney McNeal, Jay Middleton and Doug Wright were present via Zoom.

BSRB Staff. David Fye and Leslie Allen were present via Zoom.

II. **Agenda Approval.** Doug Wright moved to approve the agenda as written. Abby Callis seconded.

III. **Review and Approval of Minutes from Previous Advisory Committee Meetings on December 12, 2023.** Jessica Hamilton moved the approve the minutes. Linda Heitzman-Powell seconded. The motion passed.

IV. **Executive Director Report.** David Fye, Executive Director for the Behavioral Sciences Regulatory (BSRB) provided a report on agency activities, actions from recent Board meetings, and legislative updates.

V. **Update on PSYPACT Commission.** Currently there are 94 individuals practicing under PSYPACT. There are 8 people that are practicing under limited days. The Executive Director highlighted items from the 2023 PSYPACT Commission newsletter for the Advisory Committee.

VI. **Old Business**

A. **Discussion of Possible Changes to Unprofessional Conduct Regulations.** The Executive Director previously asked all the Advisory Committees to review the unprofessional conduct regulations for their profession and to recommend appropriate changes to be forwarded to the Board. In addition to the previous changes recommended by the Advisory Committee, no recommendations included:

a. The Advisory Committee unanimously recommended changing the language of K.A.R 102-1-10a (f)(3) to reference *"engaging in behavior that is abusive, demeaning or discriminatory to a client, student, or supervisee based on factor that may include but are not limited to age, gender, gender identity, culture, national origin, religion, sexual orientation, disability, language, socioeconomic status, ethnicity, health status, relationship status, or status in any other marginalized group"* so this language will be sent to the Board for consideration.

DRAFT

b. Advisory Committee members unanimously agreed to recommend regulatory language on the topic of telehealth, which would state *"If engaged in distance-services, failing to fulfill these requirements:*
(1) Informing the client of risks and benefits of distance counseling,
(2) Disclosing the possibility of technology failure and providing alternative methods of service.
(3) Detailing emergency procedures to follow when the counselor is unavailable; and
(4) Taking appropriate steps to encrypt or ensure the security of confidential client information or any activity which protects confidential client information from risk of privacy breach." These recommended changes will be forwarded to the Board for consideration.

c. Advisory Committee members discussed possible new language on social media. The Advisory Committee unanimously recommended adding language "*When using social media, Psychologists should maintain professional boundaries and behaviors with client including but not limited to confidentiality, security, and dual roles"* to item 4 and for this language to be sent to the Board for consideration.

d. The Advisory Committee discussed the unprofessional conduct regulation prohibiting sexual contact with a former client within 24 months and recommended adjusting this standard to "*never*." This recommended change will be presented to the Board for consideration.

B. Continued Discussion on Continuing Education Regulation and Draft for New Regulation for Documentation for Continuing Education. Advisory Committee members reviewed and discussed K.A.R. 102-1-15. It was noted that the 50-hour requirement for continuing education hours every two-year license period is one of the highest standards and the majority of states have a lower total, around 40 hours every two-year license period. Advisory Committee members recommended moving from 50 hours to 40 total hours. The Advisory Committee will continue discussion on the draft regulation for documentation of continuing education at the next meeting.

VII. New Business

A. Review of K.A.R. 102-1-12 Educational Requirements. Each Advisory Committee has been asked to review the regulation on educational requirements for licensure for their profession and to recommend appropriate changes. Due to time constraints, this topic will be discussed at a future meeting.

B. Possible Survey for Licensed Psychologists. The Executive Director discussed working with the Social Work Advisory Committee to create a survey for social workers, which provided helpful data from licensees on their license examination, interest in a multi-state compact, supervision in general, the transition from mostly in-person supervision to remote supervision, and continuing education. The Executive Director noted the BSRB has the ability to assist each of the Advisory Committees with a similar survey, if there is interest in surveying psychologists in Kansas. The

DRAFT

Advisory Committee members will review the report from the survey of social workers (which is posted on the BSRB website) and will consider questions for a plan to have a discussion on possible survey questions at a future meeting.

C. **Additional Discussion Topics for FY 2024.** This topic will be discussed at a future meeting.

VIII. **Next Advisory Committee Meeting Date.** The next meeting will be on Tuesday, April 9, 2024, at 6 pm.

IX. **Adjournment.** Mark Goodman moved to Adjourn. Jessica Hamilton seconded. The motion passed.

DRAFT

Commission News

VOL. 5, Issue 1
March 2024

Message from The Chair: Patrick Hyde

The PSYPACT Commission extends a warm welcome to South Dakota which has recently enacted legislation to become an active member of PSYPACT in July of 2024. PSYPACT looks forward to the continued growth of the Commission, and recognizes that there is pending, but not enacted, legislation in four additional states. As well as focusing on growing the compact, the PSYPACT Commission is releasing its Annual Report for 2023 which provides useful information regarding the Commission's activities. Lastly, the Commission is planning to hold its upcoming annual meeting in-person, which will take place in Washington D.C. on November 18th – 19th, I hope to see all of you at the upcoming meeting.

Patrick Hyde
Chair, PSYPACT Commission

Upcoming Meetings

Training and PR	4/10/2024
Strategic Planning Workgroup	4/11/2024
Finance Committee	4/16/2024
Requirements Review	5/17/2024
Commission Mid-Year	7/15/2024

Executive Director Update: Janet Orwig

Happy Spring! Spring is the time to get excited for things to come and PSYPACT is off to a great start for 2024. I want to welcome our new PSYPACT Specialist, Ashley Lucas. Gina and I are very excited to have her join us at PSYPACT. You will all get an opportunity to meet her at the July Commission meeting.

Just a few highlights from the first quarter:

- South Dakota enacted legislation to join PSYPACT which becomes effective July 1, 2024.
- We have over 12, 700 Authorization to Practice Interjurisdictional Telepsychology (APIT) holders.
- The Strategic Planning Workgroup continues to review data and work on creating a draft of the first PSYPACT strategic plan and will be presenting this draft to you at the July Commission meeting.

Thank you to all who have graciously volunteered to serve on Committees. We still have a vacancy on the Appeals Committee. If anyone is interested, please email me at jorwig@psypact.org.

Join us in wishing Ronald Ross a happy retirement. We appreciate the work you have done with the PSYPACT Commission and wish you well

As always, I cannot thank you enough for all you do for PSYPACT.

Janet P. Orwig, MBA, CAE
PSYPACT Executive Director

PSYPACT Commissioners

Lori Rall Alabama	Gary Lenkeit Nevada
Heidi Paakkonen Arizona	TBD New Hampshire
Lisa Fitzgibbons Arkansas	Sean Evers New Jersey
Nate Brown Colorado	Susan Hurt North Carolina
Glenda S. George CNMI	Sara Quam North Dakota
Christian Andresen Connecticut	Ronald Ross Ohio
Shauna Slaughter Delaware	Teanne Rose Oklahoma
LaTrice Herndon District of Columbia	Steven Erickson Pennsylvania
Mary Denise O'Brien Florida	Peter Oppenheimer Rhode Island
Don Meck Georgia	Andrea Eaton South Carolina
Dawn Cureton Idaho	TBD South Dakota
TBD Illinois	Mark Fleming Tennessee
Stephen Ross Indiana	Patrick Hyde Texas
David Fye Kansas	Jana Johansen Utah
Leslie Jenkins Kentucky	TBD Vermont
Jayne Boulos Maine	Jaime Hoyle Virginia
Lorraine Smith Maryland	Leslie Cohn Washington
Amy Gumbrecht Michigan	Scott Fields West Virginia
Robin McLeod Minnesota	Daniel Schroeder Wisconsin
Pam Groose Missouri	JoAnn Reid Wyoming
Dina Mekic Nebraska	Mariann Burnetti-Atwell ASPPB

Legislation Updates:

Currently we have 39 effective PSYPACT participating states, soon to be 41. South Dakota and Vermont become effective on 7/1/2024. The following states have active PSYPACT Legislation: California, Massachusetts, Mississippi and New York. Hawaii introduced legislation in the first quarter, however the legislation failed.

Committee Updates:

Finance: *Heidi Paakkonen, Teanne Rose, Jaime Hoyle*
The Finance Committee met on January 22, 2024, via Zoom. The Committee reviewed the 4th quarter 2023 financial information, the 4th quarter 2023 Bank Reconciliations, and the Year End 2023 documents. The Committee also discussed updates on the investment initiatives and reviewed the audit process and documents.

Compliance Committee: *Jaime Hoyle, Lisa FItzgibbons, Scott Fields*
The Compliance Committee met on January 31, 2024 via Zoom. The Committee reviewed the compliance for PSYPACT Member States for the 4th quarter of 2023 and for FY December 31, 2023. The Committee also discussed the next steps regarding non-compliance and made recommendations to the Executive Board for consideration..

Rules: *Patrick Hyde Don Meck, Pam Groose, Lorraine Smith, Susan Hurt*
The Rules Committee met on February 14, 2024, via Zoom. The Committee reviewed the legal opinion regarding Home State, updates and inquiries from the Trust Insurance Presentation, the Code of Ethics and Conflict of Interest Policy. A policy regarding reporting of violation of Authorization Holders was also discussed.

Training and Public Relations:
Lori Rall, Heidi Paakkonen, Mariann Burnetti-Atwell
The Training and Public Relations Committee met on February 16, 2024, via Zoom The Committee reviewed Policy 1.25- Sponsorship, and reviewed the first draft of the annual report. Policy 2.6 was also reviewed and possible revisions were discussed. These topics will be reviewed again at the next meeting. The PSYPACT letterhead was reviewed and revisions were suggested and forwarded to the Executive Board for consideration.

Requirements Review: Gary Lenkeit, Peter Oppenheimer, Teanne Rose, Ron Ross
The Requirements Review Committee met on March 1 , 2024 , via Zoom. The Committee reviewed the conduct questions from the application procedures. The Committee also reviewed the draft letter to ASPPB Mobility Committee and discussed next steps.

Executive Board:
Patrick Hyde, Lori Rall, Heidi Paakkonen, Gary Lenkeit, Pam Grosse, Mariann Burnetti-Atwell
The Executive Board met on March 5, 2024, via Zoom. The Committee reviewed updates from each committee, received updates from the Executive Director, discussed a possible trademark infraction and reviewed a request from the Federation of State Medical Boards regarding Provider Bridge.

Executive Board Members

Chair - Patrick Hyde

Vice Chair - Lori Rall

Treasurer - Heidi Paakkonen

Member at Large - Gary Lenkeit

Member at Large - Pam Groose

Ex Officio Member - Mariann Burnetti - Atwell

Staff Contact Information:

Janet Orwig
PSYPACT Executive Director
jorwig@psypact.org

Ashley Lucas
PSYPACT Specialist
alucas@psypact.org

Gina Polk
PSYPACT Specialist
gpolk@psypact.org

PSYPACT by the Numbers

TELEPSYCHOLOGY

11408

Active PSYPACT APITs

TEMPORARY PRACTICE

675

Active PSYPACT TAPs

STATE LEVEL BREAKDOWN

State	APITs	TAPs	State	APITs	TAPs
ALABAMA	65	14	NEBRASKA	66	4
ARIZONA	281	31	NEVADA	104	11
ARKANSAS	39	8	NEW HAMPSHIRE	108	4
COLORADO	563	29	NEW JERSEY	750	23
CNMI	1	0	NORTH CAROLINA	486	33
CONNECTICUT	243	17	NORTH DAKOTA	17	0
DELAWARE	123	4	OHIO	417	24
DC	302	21	OKLAHOMA	61	6
FLORIDA	688	37	PENNSYLVANIA	1017	43
GEORGIA	466	33	RHODE ISLAND	85	1
IDAHO	33	4	SOUTH CAROLINA	56	5
ILLINOIS	997	46	TENNESSEE	201	13
INDIANA	122	7	TEXAS	876	53
KANSAS	94	8	UTAH	186	29
KENTUCKY	101	8	VIRGINIA	671	42
MAINE	73	5	WASHINGTON	349	24
MARYLAND	861	28	WEST VIRGINIA	47	5
MICHIGAN	180	10	WISCONSIN	112	7
MINNESOTA	283	15	WYOMING	12	1
MISSOURI	268	22			

Active Authorizations as of 3/31/2024

ASPPB
Association of State and Provincial Psychology Boards

NEWSLETTER APR 2024

The CEO **Corner**

Greetings,

As I take time to write you today, I am reminded of how fast time flies as it seems just like yesterday, we were working on developing the 2023 Fourth Quarter Newsletter.

In preparing for the 2024 First Quarter Newsletter, as in prior times, the first thing that comes to mind is the overwhelming appreciation I and ASPPB has for our members, volunteers, liaisons, and staff. It is only because each of you are we able to stay true to the Association's mission to support member jurisdictions in fulfilling your responsibility of public protection.

As we stepped into an immediately busy new year, our efforts have keenly been focused on moving forward numerous items related to the Association's Strategic Plan. Throughout this edition you will have the opportunity to see a snapshot of this work and will be able to see how we have taken what we have learned from you during the Diagnostic Process and are now bringing life into those ideas.

On a personal note, I am happy to share that the tour of jurisdictional visits has begun. Early in this year, I was able to visit with the California Board of Psychology during their first meeting of 2024. It was impressive to see the Board in action and to see the responsible and innovative work they are doing to ensure public safety for the citizens of California. In addition, I am happy to share that at this time, additional visits have been scheduled with New York, Florida, and Prince Edward Island. Over the next few years I look forward to meeting with you all.

In closing, thank you in advance for taking the time to read through this quarter's newsletter. I would love to hear what you think of this edition and who might have a story or a piece of news that you would like to see spotlighted in our next edition.

Until next time, please take care and I hope to see you in Boston at the 2024 Midyear Meeting.

Mariann Burnetti-Atwell, PsyD
Chief Executive Officer

Meetings & **Events**

The Meeting and Events department is getting ready for ASPPB's Midyear Meeting taking place in Boston, Massachusetts this April. The theme for this year's Midyear Meeting is Securing the Framework: Maintaining Support While Building Success. During our meeting we will be taking a look at topics such as the EPPP Item Development, there will be a panel discussion on Recruiting, Onboarding, and Mentoring for Board and College Members, and so much more! It is going to be a fantastic meeting, and we look forward to seeing you there!

For any questions or comments regarding the meeting please feel free to reach out to John Mickley at jmickley@asppb.org.

The Meetings and Events department is excited for what 2024 has to offer, and we look forward to seeing you in the New Year!

PSYPACT

April 2024 Update

PSYPACT began 2024 with 39 effective PSYPACT States. California, Hawaii, Mississippi, and South Dakota introduced PSYPACT legislation this quarter. Legislation passed in South Dakota but failed in Hawaii. Massachusetts and New York still have active legislation. Currently we have 39 effective states, 2 enacted, not yet effective and 4 states with active legislation.

Enacted and Effective

Alabama	Indiana	Ohio
Arizona	Kansas	Oklahoma
Arkansas	Kentucky	Pennsylvania
Colorado	Maine	Rhode Island
Commonwealth of the Northern Mariana Islands	Maryland	South Carolina
	Michigan	Tennessee
	Minnesota	Texas
Connecticut	Missouri	Utah
Delaware	Nebraska	Virginia
District of Columbia	Nevada	Washington
Florida	New Hampshire	West Virginia
Georgia	New Jersey	Wisconsin
Idaho	North Carolina	Wyoming
Illinois	North Dakota	

Enacted not yet Effective

South Dakota

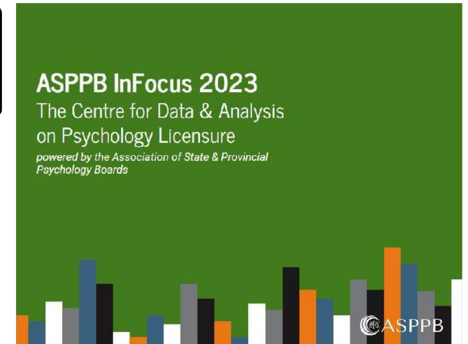
Vermont

The PSYPACT Commission continues to issue authorizations to practice under PSYPACT. As of March 27, 2024, 12,747 Authority to Practice Interjurisdictional Telepsychology (APITs) have been issued and 742 Temporary Authorizations to Practice (TAPs) have also been issued by the PSYPACT Commission.

We look forward to sharing additional updates with you as new states introduce and enact PSYPACT legislation. For more information about PSYPACT, please visit www.psypact.org or email us at **info@psypact.org** with any questions.

Fourth Edition of ASPPB InFocus 2023 and the Centre for Data Analysis on Psychology Licensure (Centre)

ASPPB CENTRE NEWS: The ASPPB Centre for Data & Analysis has joined LinkedIn & Twitter! Be sure to follow us by clicking on the icons below to get the most up-to-date information from the Centre.



Coming Soon:
ASPPB's Fourth Edition of the ASPPB InFocus 2023 and the updated Centre for Data Analysis on Psychology Licensure Website

As part of the Centre's primary initiatives, ASPPB will be presenting the Fourth Edition of the ASPPB InFocus for the 2023 year. This annual report provides information on trending data regarding the number of licensees, jurisdictional licensure requirements, licensure portability and the interjurisdictional utilization of telepsychology. This can be expected to be available in late May or Early June (we'll keep you updated). You may view the previous editions of the ASPPB InFocus anytime by visiting the Centre for Data and Analysis at **www.asppbcentre.org**. Each participating jurisdiction's information is featured in aggregate data as well as individual jurisdictional snapshot pages and data summary pages. We hope you find this information useful and we look forward to continued collaboration with our member boards in the collection and analysis of data for the regulation of the profession of psychology.

Have questions? Email Stacey Camp, Director for the Centre at scamp@asppb.org

The Centre for Data and Analysis on Psychology Licensure is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under Grant Number H1MRH24096 for Licensure Portability Program. Any information, content, or conclusions on this website are those of the authors and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

ASPPB NEWSLETTER APR 2024

Association of State and Provincial Psychology Boards

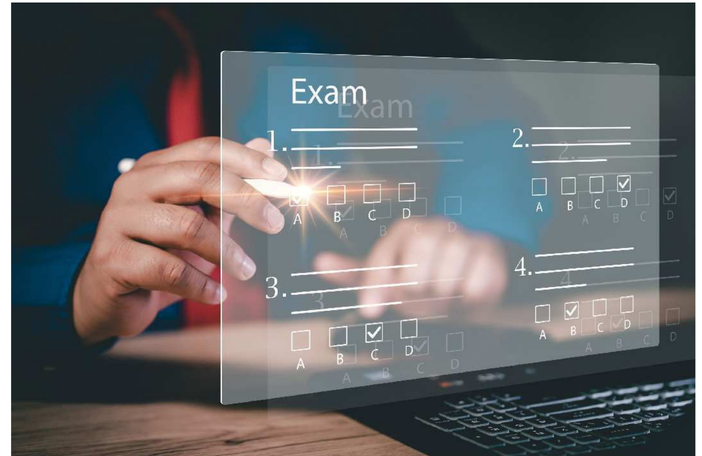
Exam **Updates**

The Exam team held a standard setting meeting on the EPPP (Part 2-Skills) on January 12-13, 2024 in the ASPPB Office. Eleven Subject Matter Experts (SMEs) participated in the meeting. The SMEs were chosen from over 130 volunteers to participate based on their expertise in the field, years of experience, representatives from various organization types, geographical locations, and of diverse demographic backgrounds. The recommended cut scores on the EPPP (Part 2-Skills) for Independent and Supervised Practices were reviewed and approved at the ASPPB Board of Directors meeting in February, and will be applied to the examination form to be published in April.

The Exam team also hosted a four-day item writing workshop for the EPPP (Part 2-Skills). Altogether, X number of item writers came to meet in the ASPPB since they last met in person in March 2020, some are veteran, and some are new item writers. The participants were provided implicit bias training, item writing training, and updates on the EPPP (Part 2- Skills) administration progress and results before they devoted to writing, discussing and revising items. They enjoyed the collegial interactions and appreciated the opportunity to contribute to the EPPP2 through crafting high quality items.

The item writer workshop, the Bank maintenance and Exam Form Review Meetings for the EPPP (Part 1-Knowledge) will be hosted in the Central Office on April 19-20 and on May 3-7.

Last but not the least, we would like to congratulate Hao Song, PhD, Associate Executive Officer of Examination Services being elected as Chair (3-year term begins in 2024) of the Test Validity Research and Evaluation SIG of the American Educational Research Association. This role is a recognition of Dr. Song's commitment and expertise in the development and validation of professional credentialing assessments, which will be continued in her leading of the examination programs at ASPPB.



Dr. Hao Song Appointed as Chair

ASPPB is happy to announce that **Dr. Hao Song, PhD, will be serving as Chair of the Test Validity and Evaluation SIG for the American Educational Research Association (AERA).** Dr. Song joined ASPPB in January 2023 as our Associate Executive Officer of Exam Services.

In the announcement AERA explains that, "Special Interest Groups (SIGs) play a very important role in supporting the mission of AERA and enhancing the vitality of the education research community. (Dr. Song's) role as a SIG officer will help further AERA's commitment to improving and advancing education research." Congratulation's Dr. Song!

For more information, visit: aera.net

ASPPB
Association of State and Provincial Psychology Boards

NEWSLETTER APR 2024

A Closer Look:
Governance Task Force Town Hall

To ensure ASPPB continues to meet its goals and be the best resource possible for its members, the Association took a reflective look at how it governs. The first step was to hire an outside consultant, the Association Management Center (AMC).

AMC began its work by conducting a thorough review of all aspects of the Association's governance processes, while utilizing member feedback and initiatives from the Strategic Plan. AMC then worked with the ASPPB Governance Task Force, comprised of current and former ASPPB Board Members, along with staff to develop recommended modifications while ensuring the suggested changes followed national association best practices. Throughout this project, AMC engaged in interviews with key ASPPB stakeholders, and from that developed a qualitative survey, in collaboration with the Task Force, that was sent out to a larger audience. This groundwork led us to where we are today. As a result of the many months of work by AMC and the Task Force, a Town Hall was held on March 25th to review the recommendations for modifications to the Association's governance processes, and solicit feedback from our members. The Association would like to thank all those who were able to attend, and if you missed the Town Hall, **please watch the recording here.**

While we encourage you to watch the Town Hall recording and review the complete recommendations linked here, a few proposed changes are highlighted on the next page. Please send any feedback or comments to **evolland@connect2amc.com** by April 8th.

Some of these recommendations, if selected would require Bylaws revisions. However, and most importantly, any proposed revisions requiring a Bylaws revision must be voted on by the ASPPB Member Boards. The ASPPB BOD is asking for feedback from you, its members, to help inform their decisions.

-

"Associations are driven by their missions and largely measured by their success in achieving mission-related goals. Good governance provides the vision and direction to ensure an association is on the right path." (ASAE, 2024)

Task Force Members:

- Michelle G. Paul, PhD (President)
- Herbert L. Stewart, PhD (Immediate Past President)
- Alan Slusky, PhD, C. Psych. (Past President)
- Sheila Young, PhD (Past President)
- Gerald O'Brien, PhD (Past President)
- Mariann Burnetti-Atwell, PsyD (CEO)
- Leslie Browning Carroll, CAE (Director of Governance Operations)

Reference: ASAE. Governance. (2024). Retrieved from https://www.asaecenter.org/resources/topics/governance

Town Hall Proposed Changes...

- The Nominations Committee would shift to a Leadership Development Committee (LDC) and work towards establishing competencies and focusing on the skills and experience of candidates for the Board of Directors (BOD). This would also assist in opening opportunities to the members while being more purposeful in determining the best skill sets to advance the organization.

- The Secretary/Treasurer and the Chief Executive Officer (non-voting) would be added to the Executive Committee (EC). The members of the EC currently include the President, President-Elect, and Past-President.

- The track system for the Member-at-Large (MAL) positions would be retired. The MAL would be exposed to all areas of the Association over their term, rather than focus on one for all three years.

- Electronic voting would be allowed to better assist all jurisdictions in having a voice.

- Removal of nominations from the floor for the BOD to ensure all candidates have been part of the same fair, transparent election process.

- The President-Elect would be elected by the BOD from a slate of candidates provided by the LDC. The reasoning behind this is that the BOD has the closest understanding of the competencies necessary for the position, as well as being able to observe those competencies in the boardroom.

- Candidates for President-Elect must be a current member of the ASPPB BOD, or have been a member within the last five years. This ensures that candidates understand the strategy and culture of the Board.

- Removal of BOD members would be by the ASPPB BOD with 2/3 vote to allow for the BOD to exercise its responsibilities while maintaining the confidentiality of potentially sensitive issues.

ASPPB Bylaws can be found here.

ASPPB Governance Task Force Recommendations

ASPPB's STRATEGIC PLAN - April 2024 Update

If you missed the slides we circulated in February regarding how ASPPB plans to apply the membership feedback we received from our 2023 summer survey, you can review those **here**. The high-level next steps on the activities on which we polled—everything from planned innovations in thought leadership and legislative affairs, to how we're incorporating the DEI topics you surfaced into meetings, as well as how to make those meetings better attended through greater financial support—also inform the second year of implementation in the life of our **strategic plan**. A summary is presented here. As always, feel free to reach out to us at **strategicplan@asppb.org** should you have any comments, questions, or concerns.

ANTICIPATE

- After several data-driven exercises with membership to hone our understanding of optimal website structure and usability, a third and final draft of the ASPPB sitemap was approved. Wire-framing, or building out the templates for the new website, has now begun. The goals of ASPPB's new website are twofold:

1. **to enable greater ease of use when it comes to wayfinding and transactional activities, and**
2. **to establish a new space for insightful, original content—or thought leadership—that members can use in their work.**

- Through their feedback last summer, members helped to crucially define where they'd like ASPPB to make investments in providing useful thought leadership. Those content areas include trends in psychology/regulation, legislative affairs, PSYPACT, toolkits, ASPPB Board updates, insights from ASPPB's own meetings and other conferences ASPPB attends, the EPPP exam program, anti-regulation and anti-licensure activities, and best practices for—and spotlights on—member boards.

COLLABORATE

- In the fall of 2023, ASPPB convened the first meeting of the Long Range Planning Committee (LRPC). Since October, it has held five meetings to begin to address the LRPC's three charges, choosing to tackle the Committee's first charge, first. To that end, the LRPC is in the final stages of a draft proposal for a promising new meeting opportunity with executive leaders from the American Psychological Association and the Canadian Psychological Association that would take place regularly. As a reminder, the three charges of the LRPC are as follows:
  - To reset and redefine ASPPB's role with APA/CPA in particular on the three pillars of regulation: education, exam, and experience
  - To design a sound structure of stewardship for major initiatives that steers them in a collaborative way, generates wider awareness/buy-in across constituencies, and helps repair the splintered nature of psychology across the guild, training, and regulator communities
  - To refocus on mobility, uniformity, and competency by taking the lead on a "Uniform Psychology Act" similar to the exemplar Uniform Accountancy Act

- CEO Mariann Burnetti-Atwell launched her "jurisdictional visit" program in February with an extended immersion with the California Board. Designed to create a tighter "weave" and exchange with members, Burnetti-Atwell aims to visit all 66 jurisdictions over the life of the current strategic plan. Upcoming visits include Prince Edward Island, Florida, and New York.

PROTECT

- Establishing a robust legislative affairs apparatus at ASPPB was among the most prominent membership goals for the Association. Taking into account the activities the membership cited in the summer survey as most beneficial in a legislative affairs operation, ASPPB is drafting the framework for a dedicated resource in this area and within the Association.

PERPETUATE

- On the 25th of March, the Association convened a Town Hall on the findings by the governance firm it hired in 2023 to assess and improve its leadership structures and board culture. The Town Hall feedback was greatly appreciated (see page 4), and it will be incorporated into the work of the Governance Task Force as it refines its ultimate recommendations.

ASPPB
Association of State and Provincial Psychology Boards

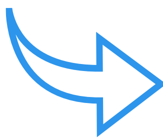
NEWSLETTER APR 2024

Check Out ASPPB on Social Media

In an effort to connect with the wider psychology community, ASPPB manages several social media campaigns. For example FAQ Friday highlights frequently asked questions from one of our departments; PSYPACT or Examination Services.

In January 2024, ASPPB launched a new social media campaign - Member Spotlight Series. Over the next year we will be profiling each of our 66 member boards.

If you're not following ASPPB, you're missing out. Check out the links below to follow us on LinkedIn and Twitter



Main ASPPB Phone Number
678-216-1175

Main ASPPB Fax Number
678-216-1176

Main ASPPB Email
asppb@asppb.org

Mailing Address
ASPPB P.O. Box 849
Tyrone, GA 30276

Are you a board member and your term is about to expire?

Continue your association with ASPPB as an individual member!

MEMBER SPOTLIGHT

COLLEGE OF ALBERTA PSYCHOLOGISTS (CAP)

Created in 1996, when the professional association split into regulatory and fraternal bodies, the **College of Alberta Psychologists** is located in the provincial capital city of Edmonton. The college is one of ten Canadian provinces, and one Canadian territory, that are members of ASPPB. The board oversees **4,962 regulated members** and saw a 4.5% growth in registrations last year. The college is managed by a ten-member council, a registrar, a deputy registrar, and several assistant registrars. For more information, visit asppbcentre.org

2024 ASPPB Board of Directors

President:
Michelle G. Paul, PhD (NV)

President-Elect:
Hugh D. Moore, PhD, MBA (TN)

Past-President:
Herbert L. Stewart, PhD (VA)

Secretary-Treasurer:
Cindy Olvey, PsyD (AZ)

3rd Year Member-at-Large:
Jennifer C. Laforce, PhD, CPsych (MB)

2nd Year Member-at-Large:
Ramona N. Mellott, PhD (AZ)

3rd Year Member-at-Large:
Stacy Waldron, PhD (NE)

102-1-15. Continuing education. (a) Each applicant for renewal of licensure shall have earned 50 continuing education hours in the two years preceding an application for renewal. The required number of continuing education hours shall be prorated for periods of renewal that are less than the full two years, using the ratio of one-third of the continuing education hours for each six months since the date of licensure or most recent renewal. Continuing education hours for each type of continuing education activity as specified below in subsection (d) shall be prorated accordingly for those persons whose periods of renewal are less than the full two years. Each person who is licensed within six months of the current expiration period shall be exempt from the continuing education requirement for that person's first renewal period.

(b) The content of each continuing education activity shall be clearly related to the enhancement of psychology practice, values, skills, or knowledge.

(c) During each two-year renewal cycle and as part of the required continuing education hours, each licensed psychologist shall complete at least three continuing education hours of training on professional ethics and at least six continuing education hours related to diagnosis and treatment of mental disorders. These hours shall be obtained from any of the activities specified in paragraphs (d)(1), (d)(2), (d)(4), and (d)(6) of this regulation.

(d) Acceptable continuing education activities, whether taken within the state or outside the state, shall include the following:

(1) Attendance at workshops, seminars, and presentations that are sponsored, accredited, or conducted by educational institutions, professional associations, or private institutions. These activities shall be sponsored, accredited, or conducted by educational institutions, professional associations, or private institutions that are nationally or regionally accredited for training. Activities conducted by agencies, groups, or individuals that do not meet the requirements of national or regional accreditation shall be acceptable, if the content is clearly related to the enhancement of psychology skills, values, and knowledge. Actual contact hours, excluding breaks and lunch, shall be credited. A maximum of 50 continuing education hours shall be allowed;

(2) the first-time preparation and initial presentation of courses, workshops, or other formal training activities, for which a maximum of 15 continuing education hours shall be allowed;

(3) documented completion of a self-study program. A maximum of 12 continuing education hours shall be allowed;

(4) documented completion of a self-study program with a posttest that is conducted by a continuing education provider as described in paragraph (d)(1). A maximum of 40 continuing education hours shall be allowed;

(5) publication and professional presentation. Fifteen continuing education hours may be claimed for the publication or professional presentation of each scientific or professional paper or book chapter authored by the applicant. A maximum of 45 continuing education hours shall be allowed;

(6) completion of an academic course, for which a maximum of 15 continuing education hours shall be allowed for each academic semester credit hour;

(7) providing supervision as defined in K.A.R. 102-1-1, for which a maximum of 15 continuing education hours shall be allowed;

(8) receiving supervision as defined in K.A.R. 102-1-1, except in connection with any disciplinary action, for which a maximum of 15 continuing education hours shall be allowed;

(9) initial preparation for a specialty board examination, for which a maximum of 25 continuing education hours shall be allowed;

(10) participation in quality care, client or patient diagnosis review conferences, treatment utilization reviews, peer review, case consultation with another licensed psychologist, or other quality assurance committees or activities, for which a maximum of 15 continuing education hours shall be allowed;

(11) participation, including holding office, in any professional organization related to the applicant's professional activities, if the organization's activities are clearly related to the enhancement of psychology or mental health practice, values, skills, or knowledge. A maximum of 12 continuing education hours shall be allowed; and

(12) receiving personal psychotherapy that is provided by a licensed or certified mental health provider and is a part of a designated training program. A maximum of 20 continuing education hours shall be allowed.

(e) Each licensed psychologist shall be responsible for maintaining personal continuing education records. Each licensee shall submit to the board the licensee's personal records of participation in continuing education activities if requested by the board.

(f) In determining whether or not a claimed continuing education activity will be allowed, the licensed psychologist may be required by the board to demonstrate that the content was clearly related to psychology or to verify that psychologist's participation in any claimed or reported activity. If a psychologist fails to comply with this requirement, the claimed credit may be disallowed by the board.

(g) Any applicant who submits continuing education documentation that fails to meet the required 50 continuing education hours may request an extension from the board. The request shall include the applicant's reason for requesting an extension and a plan outlining the manner in which the applicant intends to complete the continuing education requirements. For good cause shown, the applicant may be granted an extension, which shall not exceed six months. (Authorized by and implementing K.S.A. 74-7507; effective May 1, 1984; amended, T-85-35, Dec. 19, 1984; amended May 1, 1985; amended May 1, 1986; amended May 1, 1987; amended July 24, 1989; amended Oct. 27, 2000; amended July 11, 2003.)

Printable Format

102-1-15a. Documentation of continuing education. Each of the following forms of documentation shall be accepted as proof that a licensee has completed the continuing education activity:

(a) A signed statement from the provider of a seminar, institute, conference, workshop, or course indicating that the licensee attended the program;

(b) a copy of an academic course syllabus and verification that the licensee presented the course or a copy of a letter from the presentation sponsor or a copy of the brochure announcing the licensee as the presenter, the agenda of the presentation, and verification that the licensee presented the seminar, institute, conference, workshop, or course;

(c) a copy of a self-study program or the full bibliographic information about the book including page numbers and summary on how the information can apply to their practice. Our regs don't say the CEUs have to apply to the LP's practice. For each video recording, audio recording, computerized interactive learning module, or telecast that the licensee utilized for continuing education purposes, a written statement from the licensee specifying the media format, content title, presenter or sponsor, content description, length, and activity date. A certificate of completion is required for all courses;

(d); a copy of an article or book chapter written by the licensee and verification of publication or written presentation at a professional meeting;

(e) An official transcript or other written proof indicating the licensee's passing grade for an academic course or a statement signed by the instructor indicating

the number of actual contact hours that the licensee attended for an audited academic course;

(f) written, signed verification from the university practicum or intern instructor or other official training director for whom the licensee supervised undergraduate or graduate students or a written. A signed verification including the dates of supervision, from the postgraduate supervisee for whom the licensee provided supervision;

(g) if receiving non-disciplinary supervision, a written, signed verification including the dates of supervision from the licensee who provided supervision;

(h) a signed letter from a professional organization or certifying entity outlining the licensee's participation in that professional organization or credentialing board;

(i) a signed statement of attendance from the provider of the institute, symposium, workshop, or seminar and a bill of services. (Authorized by K.S.A. 2023 Supp. 74-7507; implementing K.S.A. 74-5318; effective P-
______________________.)

DRAFT

An official State of Kansas government website. Here's how you know.

Scott Schwab
Kansas Secretary of State

Agency 102

Behavioral Sciences Regulatory Board

Article 1.—Certification of Psychologists

Printable Format

102-1-12. Educational requirements. (a) Definitions.

(1) "Core faculty member" means an individual who is part of the program's teaching staff and who meets the following conditions:

(A) Is an individual whose education, training, and experience are consistent with the individual's role within the program and are consistent with the published description of the goals, philosophy, and educational purpose of the program;

(B) is an individual whose primary professional employment is at the institution in which the program is housed; and

(C) is an individual who is identified with the program and is centrally involved in program development, decision making, and student training as demonstrated by consistent inclusion of the individual's name in public and departmental documents.

(2) "In residence," when used to describe a student, means that the student is present at the physical location of the institution for the purpose of completing coursework during which the student and one or more core faculty members are in physical proximity and face-to-face contact.

(3) "Primary professional employment" means a minimum of 20 hours per week of instruction, research, any other service to the institution in the course of employment, and the related administrative work.

(b) A graduate applicant for psychology licensure shall be deemed to have received a doctoral degree based on a program of studies in content primarily psychological as set forth in K.S.A. 74-5310, and amendments thereto, or the substantial equivalent of this program in both subject matter and extent of training, if at the time the applicant graduated from the program, this doctoral degree program was accredited by the American psychological association. If the applicant began the program after March 10, 2006, the accredited program shall require that at least 24 semester credit hours in the substantive areas identified in paragraph (b)(13)(C), or the equivalent number of quarter or trimester credit hours, be completed while the applicant is in residence. If not so accredited, the doctoral degree program from which the applicant was granted the degree shall meet all of the following criteria:

(1) The doctoral program is offered by an institution of higher education that is regionally accredited by an accrediting agency substantially equivalent to those agencies that accredit the universities in Kansas.

(2) The program offers doctoral education and training in psychology, one goal of which is to prepare students for the practice of psychology.

(3) The program stands as a recognized, coherent organizational entity within a university or college.

(4) There is a clear administrative authority with primary responsibility within the program for the substantive content areas as set forth in paragraph (b)(13) and for the emphasis areas of psychology.

(5) The program is an established, organized, and comprehensive sequence of study designed by administrators who are responsible for the program to provide an integrated educational experience in psychology.

(6) There is an identifiable, full-time, professional faculty whose members hold earned graduate degrees in psychology, and the person responsible for directing the program is licensed or academically eligible at the doctoral level to engage in the practice of psychology.

(7) The ratio of students to core faculty members does not exceed 15 students to one core faculty member.

(8) The student's major advisor is a member of the psychology faculty.

(9) The program has an identifiable body of students who are matriculated in the program for a degree.

(10) The program publicly states an explicit philosophy of training by which it intends to prepare students for the practice of psychology. The program's philosophy,

educational model, and curriculum plan shall be substantially consistent with the mission and goals of the program's sponsor institution and shall be consistent with the following principles of the discipline:

(A) Psychological practice is based on the science of psychology, which, in turn, is influenced by the professional practice of psychology.

(B) Training for practice is sequential, cumulative, graded in complexity, and designed to prepare students for further organized training.

(11) The program, except for industrial and organizational psychology programs, requires an internship that meets the following requirements:

(A) Consists of at least 1,800 hours over one year of full-time training or two consecutive years of half-time training;

(B) accepts as interns only applicants enrolled in a doctoral program as defined in this subsection or in a program that meets the requirements of paragraph (b)(2) of K.A.R. 102-1-5a;

(C) has a clearly designated doctoral-level staff psychologist who is responsible for the integrity and quality of the training program. This person shall be licensed, certified, or registered in the jurisdiction in which the program exists to engage in the practice of psychology and shall be present at the training facility for a minimum of 20 hours per week;

(D) provides training and supervision in a wide range of professional activities, including diagnosis, remediation techniques, interdisciplinary relationships, and consultation, and provides experience with a population of clients or patients presenting a diverse set of problems and backgrounds;

(E) is taken after the completion of all graduate courses other than those designated for writing the dissertation, including both the required graduate coursework emphasizing the practice of psychology and the preinternship training requirements;

(F) provides the intern or resident with a minimum of four hours of general training supervision for every 40 hours of training experience. At least one hour of individual clinical supervision shall be provided for every 10 hours during which the supervisee has direct patient or client contact;

(G) provides the majority of supervision by licensed, doctoral-level psychologists;

(H) exists as a distinct and organized program that is clearly recognizable within an institution or agency, as well as in pertinent public, official documents issued by the institution or agency, and that is clearly recognizable as a training program for

psychologists;

(I) identifies interns as being in training and not as staff members;

(J) has a training staff that consists of at least two doctoral-level psychologists who serve on a full-time basis as individual clinical supervisors and who are licensed, certified, or registered as psychologists in the jurisdiction in which the program exists;

(K) is an integrated and formally organized training experience, not an after-the-fact tabulation of experience; and

(L) provides at least two hours per week in didactic activities, including case conferences, seminars, in-service training, and grand rounds.

(12) Before awarding the doctoral degree, the program requires each student to complete a minimum of three full-time academic years of graduate study, or the equivalent, and to complete an internship that meets the requirements of paragraph (b)(11). At least two of the three academic training years, or the equivalent, shall be completed at the institution from which the doctoral degree is granted, and at least two consecutive semesters, or the equivalent number of quarters or trimesters, shall be completed while the student is in residence at the same institution. The program's coursework shall also include the skill courses appropriate for the applicant's major or area of emphasis.

(13) The program has and implements a clear and coherent curriculum plan that provides the means whereby all students can acquire and demonstrate substantial understanding of and competency in the current body of knowledge in the following three substantive areas:

(A) The breadth of scientific psychology, its history of thought and development, its research methods, and its applications. Each student shall have completed a one-semester course consisting of three semester credit hours, or the equivalent number of quarter or trimester credit hours, in each of the following six areas:

(i) Biological aspects of behavior, including clinical neuropsychology and the biological foundations of psychopathology;

(ii) cognitive and affective aspects of behavior, including theories of perception, human learning and memory, cognitive development, and theories and research in human learning;

(iii) social aspects of behavior, including social psychology, advanced social psychology, and social psychology theories, research, and clinical applications;

(iv) the history and systems of psychology, including the history of psychology and

theories of personality;

(v) psychological measurement, including an introduction to mathematical methods in psychology, educational measurement methods in psychological research, and research methods in clinical psychology; and

(vi) research methodology and techniques of data analysis, including statistical methods in psychology, research design in education, multivariate analysis, and multivariate statistical methods;

(B) the scientific, methodological, and theoretical foundations of practice. Each student shall have completed a one-semester course consisting of three semester credit hours, or the equivalent number of quarter or trimester credit hours, in each of the following four areas:

(i) Individual differences in behavior, including the basis and nature of individuality, intelligence and cognition, and cross-cultural counseling;

(ii) human development, including advanced child behavior and development, behavioral analysis of child development, the psychology of the adult personality, gerontology, and counseling with adults;

(iii) dysfunctional behavior or psychopathology, including advanced psychopathology; and

(iv) professional, ethical, legal, and quality assurance principles and standards, including professional, legal, and ethical problems in clinical psychology and legal, ethical, and professional issues in counseling; and

(C) the methods of diagnosing or defining problems through psychological assessment and measurement and the strategies and techniques of therapeutic intervention or remediation. A minimum of 24 semester credit hours in this substantive area, or the equivalent number of quarter or trimester credit hours, shall be completed by the student while the student is in residence and shall be distributed between the following two areas:

(i) Nine semester credit hours in assessment, or the equivalent number of quarter or trimester credit hours. Assessment courses shall include theories and methods of assessment and diagnosis, including intelligence testing, behavioral and personality assessment in children, theory and construction of personality tests, and techniques of psychodiagnostic assessment; and

(ii) 15 semester credit hours, or the equivalent number of quarter or trimester credit hours, in techniques of therapeutic interventions and effective therapeutic intervention, consultation, and supervision, including counseling and interviewing

skills, theories of group counseling, psychological clinical services, psychotherapy, group therapeutic techniques, and psychotherapy with families.

(14) The program requires at least 90 semester credit hours, or the equivalent number of quarter or trimester credit hours, of formal graduate study in the psychology program. At least 60 of these semester credit hours, or the equivalent number of quarter or trimester credit hours, shall be distributed among the content areas specified in paragraph (b)(13).

(15) At least 60 semester credit hours of the coursework for the doctoral program, or the equivalent number of quarter or trimester hours, are clearly designated on the transcript as graduate-level courses in the program, exclusive of practicum, internship, and dissertation credits. The number of credits received through extension programs shall not exceed 10 semester credit hours or the equivalent number of quarter or trimester credit hours. The number of postdoctoral credit hours from a regionally accredited university or college taken to meet licensure requirements shall not exceed 10 semester credit hours or the equivalent number of quarter or trimester credit hours.

(16) When the program has an applied emphasis, which may include clinical psychology, counseling psychology, or school psychology, the training shall also include a minimum of at least two semesters of a coordinated practicum. The practicum in the application of skills related to the areas of emphasis shall be performed in a setting that is preapproved by the appropriate administrative authorities of the program.

(17) The program advertises in official documents, including course catalogues and announcements, the program standards and descriptions and the admission requirements of the program.

(18) The program has admission requirements that are, in part or in full, based on objective, standardized achievement tests and measures.

(19) The program includes an ongoing, objective review and evaluation of student learning and progress, and the program reports this evaluation in the official transcript.

(20) The program includes a comprehensive examination or an equivalent assessment approved by the board of the applicant's knowledge and progress within the training program, and the program requires that the applicant pass this requirement before awarding the doctoral degree.

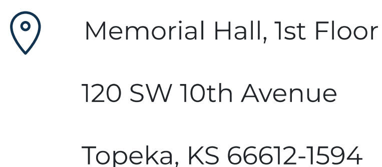
(21) As a part of the graduation requirements, each student is required to initiate, prepare, conduct, and report original research or an equivalent project as determined by the program. This original research or equivalent project shall not be substituted for

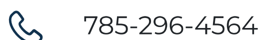
successful completion of the comprehensive examination required under paragraph (b)(20).

(22) The institution offering the graduate program has a library and equipment and resources available that are adequate for the size of the student body and the scope of the program offered, including suitable scientific and practicum facilities. (Authorized by K.S.A. 2007 Supp. 74-7507; implementing K.S.A. 74-5310; effective May 1, 1982; amended May 1, 1984; amended, T-85-35, Dec. 19, 1984; amended May 1, 1985; amended May 1, 1986; amended May 1, 1987; amended Dec. 18, 1998; amended Oct. 27, 2000; amended March 10, 2006; amended, T-102-4-24-07, April 24, 2007; amended April 11, 2008.)

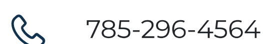
Printable Format

Kansas Secretary of State

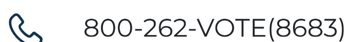




Business Services Division



Elections Division



Publications Division

© 2024 Kansas Secretary of State

Behavioral Sciences Regulatory Board

Survey of Social Workers

February 2024

Introduction 3
Question 1. *In what county/counties do you practice social work?* 4
Question 2. *Do you practice in a predominantly urban area, rural area, or frontier area?* 20
Question 3. *What is the highest level of social work license you have attained in Kansas?* 21
Question 4. *Would bachelor's-level social workers be interested in moving from a single-state license to a multi-state license if Kansas joins a multi-state compact?.* 22
Question 5. *Would master's-level social workers be interested in moving from a single-state license to a multi-state license if Kansas joins a multi-state compact?* 23
Question 6. *Would clinical-level social workers be interested in moving from a single-state license to a multi-state license if Kansas joins a multi-state compact?* 24
Question 7. *Should Kansas discontinue requiring passage of a national examination as a license requirement for a bachelor's-level permanent social work license?* 25
Question 8. *Should Kansas discontinue requiring passage of a national examination as a license requirement for a master's-level permanent social work license?* 26
Question 9. *Should Kansas discontinue requiring passage of a national examination as a license requirement for a clinical-level permanent social work license?* 27
Question 10. *If you provided clinical-level supervision to practitioners over the past two years, have you provided any supervision by televideo, rather than in-person?* 28
Question 11. *If you provided clinical-level supervision by televideo over the past two years, based on your experiences, do you believe this flexibility has resulted in mostly positive changes, mostly negative changes, or something else? Based on what you have observed, has the ability to provide supervision remotely helped individuals better access supervision?* 29
Question 12. *If you received clinical-level supervision over the past two years, have you received any supervision by televideo, rather than in person?* 42
Question 13. *If you received clinical-level supervision by televideo over the past two years, do you believe the quality of supervision provided remotely has been mostly positive, mostly negative, or something else? Has the ability to receive supervision remotely helped with accessing supervisors?* ...43
Question 14. *Do you believe lowering the required number of continuing education hours from 40 hours to 30 hours would negatively affect professionalism and safe practice?* 61
Additional Comments 62

Introduction

In the fall of 2023, members of the Social Work Advisory Committee for the Kansas Behavioral Sciences Regulatory (BSRB) requested the creation of a survey for social work licensees under the BSRB. The purpose of the survey was to collect input on matters affecting the social work profession and topics relevant to the work of the Advisory Committee. (The BSRB previously collected input from social work licensees using surveys in 2015 and 2021.) The Advisory Committee requested the Executive Director draft potential questions for a survey concerning the topics of clinical supervision, supervision by televideo, a proposed multi-state compact for the social work profession, the license examinations for each level of permanent license, and continuing education.

At the December 5, 2023, meeting of the Social Work Advisory Committee, the Executive Director presented draft questions to the members of the Advisory Committee for review and consideration. The members of the Advisory Committee expressed support for the questions and requested a short survey to obtain both qualitative and quantitative data. Additionally, questions were included on the survey to determine whether responses were submitted by a broad range of practitioners, including social workers practicing in urban, rural, and frontier areas.

As of January 12, 2024, the number of social workers with a permanent license under the BSRB totaled 8,288, including practitioners with associate level licenses, bachelor's level licenses, master's level licenses, and clinical level licenses. On Friday, February 2, 2024, all permanently licensed social workers under the BSRB received an e-mail from the BSRB stating that a message would be sent directly to them from SurveyMonkey.com with a link to complete a fourteen-question survey from the Social Work Advisory Committee for the BSRB, on topics relevant to the social work profession, and those individuals were encouraged to complete the survey. Licensees were asked to complete the survey no later than the end-of-the day on Friday, February 9, 2024. Reminder messages were sent to licensees who had not yet completed the survey on Wednesday, February 7, 2024, and Friday, February 9, 2024. The survey was officially closed at noon on Saturday, February 10, 2024.

Over the period of time that the survey was open for responses, 2,716 social workers completed the survey (compared to 1,087 social workers who completed a similar survey offered by the BSRB in December 2021). The results of the 2024 survey are included on the following pages.

Note: the following pages include survey responses from the social workers who completed the survey. Identical responses were groups and small edits were made for spelling and grammar, but otherwise language in this report reflects responses as they were provided in the survey.

Question 1. In what county/counties do you practice social work?
0
27
16 north west Kansas counties
17 Northwest Kansas
23 County's in SW KS.
Across the state in multiple and varying counties
Across the state, primarily Douglas
All (46 Responses)
All 105 counties (Statewide position)
All counties in the states of Kansas and Missouri
All counties in the states of Kansas and Oregon
all Kansas and Nebraska counties
All Kansas counties via Telehealth
All of Kansas telehealth
All of Kansas via telehealth
All of rural KS
All over NW and SW KS
All State of Kansas Counties
All via telehealth, Shawnee in person
All, practice located in Johnson
Allen (2 Responses)
Allen and Neosho
Allen, Anderson, and Neosho
Allen, Anderson, Clark, Finney, Ford, Gray, Haskell, Hodgeman, Johnson, Meade, and Seward
Allen, Crawford, Labette, Neosho, and Woodson
Allen, Labette, Montgomery, Neosho, Wilson, and Woodson
Allen, Neosho, and Woodson
Allen, Neosho, Wilson, and Woodson (2 Responses)
Allen, Neosho, Woodson, Wilson
America, Kansas, NE counties
Anderson
Anderson, Douglas, and Johnson
Anderson, Douglas, Johnson, Leavenworth, and Wyandotte
Anderson, Kansas, United States
Anderson, Linn, and Miami
Anderson/Allen
Arizona - returning to Kansas this year
Atchison (8 Responses)
Atchison and Leavenworth
Atchison and Leavenworth (2 Responses)
Atchison, Brown, and Leavenworth
Atchison, Brown, Clay, Jackson, Jefferson, and Nemaha

Atchison, Brown, Jackson, and Shawnee
Atchison, Douglas, Franklin, Johnson, and Shawnee
Atchison, Douglas, Johnson, Leavenworth, and Wyandotte (2 Responses)
Atchison, Douglas, Johnson, Leavenworth, Miami, Wyandotte
Atchison, Douglass, Johnson, Leavenworth, and Wyandotte
Atchison, Jefferson, Leavenworth, Miami, and Wyandotte
Atchison, Johnson, Leavenworth, Shawnee, and Wyandotte
Atchison, Leavenworth, and Wyandotte
Atchison, Leavenworth, and Wyandotte (2 Responses)
Atchison/Brown
Available in all due to virtual option but mostly Johnson and where K-State is
BA BU CL EK GW HP KM PR SU
Barber, Butler, Cowley, Elk, Greenwood, Harper, Kingman, Pratt, Sedgwick, and Sumner
Barber, Butler, Cowley, Elk, Greenwood, Harper, Kingman, Pratt, Sedgwick, and Sumner
Barber, Butler, Cowley, Harper, and Sedgwick
Barber, Harper, Kingman, and Pratt
Barber, Harper, Kingman, Pratt, and Sumner
Barber, Harper, Kingman, Pratt, Reno, and Sedgwick
Barber, Kingman, Pratt, Harper, Sumner, Cowley, Butler, Elk, Greenwood
Barton (3 Responses)
Barton and Ellis telehealth throughout the state
Barton and Pawnee
Barton, Butler, Ellsworth, Leavenworth, Norton, Pawnee, Reno, and Shawnee, and Sumner
Barton, Cedar, and Vernon
Barton, Ford, Pawnee, and Russell
Barton, Pawnee, Reno, and Sedgwick
Barton, Pawnee, Rice, and Stafford
Barton, Pawnee, Stafford
Barton, Rice, Stafford, Pawnee, Reno, Saline
Based in Sedgwick, but practice across the state
Bexar, TX
Bourbon (4 Responses)
Bourbon, Cherokee, Crawford, and Linn
Bourbon, Cherokee, Crawford, and Linn and others
Bourbon, Crawford, Cherokee, Labette, Montgomery
Bourbon, Crawford, Linn, and Miami
Brown (3 Responses)
Brown and Jackson
Brown and Nemaha
Brown Jackson Doniphan Nemaha
Brown, Atchison, Doniphan, Nemaha, and Jackson counties
Brown, Doniphan, Jackson, and Nemaha
Brown, Doniphan, Jackson, Johnson, Marshall, Nemaha, and Shawnee

Brown, Doniphan, Leavenworth, and Marshall
Brown, Doniphan, Nemaha, Marshall, Jefferson, Jackson, Pottawatomie, Wabaunsee. Sometimes Shawnee.
Brown, Nemaha
Brown, Nemaha, and Shawnee
Buchanan, MO (2 Responses)
Buchanan, MO, and all surrounding.
Butler (22 Responses)
Butler and Sedgwick
Butler and Sedgwick (5 Responses)
Butler, Barber, Comanche, Cowley, Clark, Chase, Edward's, Greenwood, Kingman, Kiowa, Marion, Pratt, Rice, Reno, Stanford, Harvey, Harper and Sumner
Butler, Chase, Cowley, Elk, Greenwood, Harper, Harvey, Kingman, Marion, McPherson, Reno, Saline, Sedgwick, and Sumner
Butler, Cowley, Elk, Greenwood, Kingman, Pratt, Sedgwick, and Sumner
Butler, Cowley, Harper, Harvey, Kingman, Sedgwick, Sumner
Butler, Cowley, Harvey, Kingman, Reno, Sedgwick, and Sumner
Butler, Cowley, Harvey, Reno, and Sedgwick
Butler, Cowley, McPherson, Reno, Rice, and Sedgwick
Butler, Cowley, Pratt, Sedgwick, and Sumner
Butler, Elk, and Greenwood
Butler, Elk, Greenwood, and Sedgwick
Butler, Ellsworth, Norton, Pawnee, Reno, Sedgwick, and Shawnee
Butler, Harvey, and Sedgwick (2 Responses)
Butler, Harvey, Jackson, Sedgwick, Wilson, and any county in KS for virtual needs
Butler, Harvey, Sedgwick, and Sumner
Butler, Kingman, Sedgwick, and Sumner
Butler, Labette, and Montgomery
Butler, Pratt, and Sedgwick
Butler, Reno, Saline, and Sedgwick
Butler, Sedgwick (5 Responses)
Butler, Sedgwick, Harvey
Butler, Sedgwick, McPherson
Butler, Sedgwick, Sumner
Butler, Sedgwick, Sumner, Cowley, multiple other counties across Kansas.
Cass and Johnson
Cass, Clay, and Jackson
Cass, Clay, Douglas, Jackson, Jefferson, Johnson, Jefferson, and Miami
Cass, Clay, Jackson, Johnson, and Wyandotte
Cass, Clay, Jackson, Johnson, Platte, and Wyandotte
Cass, Clay, Jackson, Johnson, Shawnee, and Wyandotte
Cass, Clay, Jackson, MO, Johnson, and Wyandotte
Cass, MO (2 Responses)

Chase
Chase, Coffey, Greenwood, Lyon, Morris, Osage, and Wabaunsee
Chase, Geary, Harper Lyon, Marion, McPherson, and Reno
Chase, Lyon, and Morris
Chautauqua
Chautauqua, Cowley, Elk, Montgomery, and Wilson
Chautauqua, Cowley, Elk, Montgomery, and Wilson
Chautauqua, Cowley, Elk, Montgomery, and Wilson
Chautauqua, Elk, Greenwood, Montgomery, and Wilson
Chautauqua, Greenwood, Montgomery, and Wilson
Cherokee (5 Responses)
Cherokee and Crawford
Cherokee, Crawford, Labette
Cherokee, Labette, Crawford, Montgomery
Cheyenne, Decatur, Ellis, Gove, Graham, Logan, Norton, Osborne, Phillips, Rawlins, Rooks, Sherman, Smith, Thomas, Trego, and Wallace
Cheyenne, Ellis, Finney, Greely, Gove, Hamilton, Kearny, Lane, Logan, Ness, Rawlins, Rush, Russell, Scott, Sheridan, Sherman, Thomas, Trego, Wallace and Wichita
Clark, Comanche
Clark, NV (2 Responses)
Clay (11 Responses)
Clay and Jackson
Clay and Johnson
Clay and Ray counties for one job (school job). I work in downtown Kansas City at Children's Mercy where we serve a wide range of counties from both Kansas and Missouri.
Clay, Cloud, Geary, Jewell, Johnson, Mitchell, Pottawatomie, Republic, Riley, Washington, and Wyandotte
Clay, Cloud, Geary, Jewell, Marshall, Mitchell, Pott, Republic, Riley, and Washington
Clay, Cloud, Marshall, and Republic
Clay, Cloud, Marshall, Republic, Riley, Washington
Clay, Cloud, Washington, Mitchell, Republic
Clay, Dickinson, Geary, Marshall, Morris, and Riley
Clay, Dickinson, Geary, Pottawatomie, Republic, Riley, and Washington
Clay, Dickinson, Lincoln, Ottawa, and Saline
Clay, Jackson, and Johnson (4 Responses)
Clay, Jackson, and Platt
Clay, Jackson, Johnson, and Platte
Clay, Jackson, Johnson, Platte, and Ray
Clay, Jackson, Johnson, Platte, and Wyandotte
Clay, Jackson, Platte, and Wyandotte
Clay, Jackson, Ray in Mo and Johnson and Wyandotte in Kansas
Clay, Johnson, and Wyandotte
Clay, Johnson, Lawrence, Platte, Shawnee, and Wyandotte

Clay, MO, and Johnson, KS (2 Responses)
Clay, Phillips, and Riley
Clay, Pottawatomie, and Riley
Clay, Ray, and Platte counties in Missouri
Clay, Washington, Riley, Marshall, Republic, Cloud
Cloud (3 Responses)
Cloud and surrounding 64 counties.
Cloud republic
Cloud, although telehealth in Kansas
Cloud, Dickinson, Ellsworth, Kingman, Lincoln, McPherson, Saline, and Sedgwick
Cloud, Geary, and Riley
Cloud, Harvey, Lincoln, Marion, Republic, and Saline
Cloud, Jewell, Lincoln, Mitchell, and Republic
Coffee, Jackson, Lyon, Riley, and Shawnee
Coffey (2 Responses)
Coffey and Lyon
Contiwa, Greene, Phelps, and St. Louis
Cook, IL
Cowley (15 Responses)
Cowley and Montgomery
Cowley and Sumner
Cowley, Chautauqua, Montgomery
Cowley, Crawley, Ellis, Harvey, Reno, Sedgwick, and Sumner
Cowley, Elk, Montgomery, and Wilson
Cowley, Sedgwick, and Sumner
Cowley, Sumner (3 Responses)
CQ and Elk
Crawford (26 Responses)
Crawford and Cherokee
Crawford, Bourbon, Linn
Crawford, Johnson, and Wyandotte
Crawford, Montgomery, and Neosho
Crowley, Harvey, Sedgwick, and Sumner
Cumberland, ME
Currently employed as a Nurse not a Social Worker
Currently live overseas as a military spouse
Currently not practicing (4 Responses)
Currently not practicing. Spouse is active-duty military and we live out of state
Currently out of state
currently out of state. looking for telehealth options
Currently, none.
Dallas
Daviess, Grundy, Livingston, Caldwell, Caroll, Linn, Harrison (MO)

Decatur
Denton
Denton, TX
Denver
Dickenson, McPherson, Ottawa, and Saline
Dickinson (3 Responses)
Dickinson, Ellsworth, Ottawa, and Saline
Dickinson, Geary, and Riley
Dickinson, Geary, Potawatomie, and Riley
Dickinson, Geary, Sedgwick
Dickinson, Johnson, Leavenworth, McPherson, Saline, and Wyandotte
Dickinson, Saline, Geary, Clay
Do not practice in Kansas.
Douglas (134 Responses)
Douglas and Franklin
Douglas and Jackson
Douglas and Jefferson (2 Responses)
Douglas and Johnson (12 Responses)
Douglas and Leavenworth
Douglas and Miami
Douglas and Shawnee (8 Responses)
Douglas and throughout Belgium, Spain, and Portugal.
Douglas, but Jefferson and Shawnee people come to the office
Douglas, Ellis, Johnson, and Wyandotte
Douglas, Franklin, Jackson, Jefferson, Johnson, Leavenworth, Miami, Shawnee, Wabaunsee, and Wyandotte
Douglas, Franklin, Jefferson
Douglas, Franklin, Johnson, and Miami (2 Responses)
Douglas, Franklin, Johnson, Leavenworth, Linn, Miami, and Wyandotte
Douglas, Franklin, Johnson, Leavenworth, Miami, and Wyandotte
Douglas, Franklin, Johnson, Linn, and Miami
Douglas, Franklin, Johnson, Osage, Wyandotte
Douglas, Geary, Johnson, Riley, and Shawnee
Douglas, Geary, Johnson, Shawnee, and Wyandotte
Douglas, Geary, Marshall, Riley, and Shawnee
Douglas, Harvey, Leavenworth, Sedgwick, and Sumner
Douglas, Jackson, and Johnson
Douglas, Jackson, Jefferson, and Shawnee
Douglas, Jackson, Johnson, and Shawnee
Douglas, Jackson, Johnson, Shawnee, and Wyandotte
Douglas, Jackson, Osage, and Shawnee
Douglas, Jackson, Osage, Shawnee, and Wabaunsee
Douglas, Jefferson, and Shawnee (2 Responses)

Douglas, Johnson, and Wyandotte (4 Responses)
Douglas, Johnson, Leavenworth, and Shawnee
Douglas, Johnson, Leavenworth, and Wyandotte
Douglas, Johnson, Lyon, Pottawatomie, and Shawnee
Douglas, Johnson, Miami, Potawatomie, and Shawnee
Douglas, Johnson, Pottawatomie, Shawnee, and Wabaunsee
Douglas, Johnson, Reno, Scott, Shawnee, Wyandotte
Douglas, Johnson, Riley, Shawnee, and Wyandotte
Douglas, Johnson, Sedgwick, Franklin, Shawnee
Douglas, Johnson, Shawnee, and Wyandotte
Douglas, Leavenworth, and Shawnee
Douglas, Leavenworth, and Wyandotte
Douglas, Osage, and Shawnee
Douglas, plus Iowa and Nebraska.
Douglas, Shawnee, Johnson, Wyandotte, Edwards
Douglas, Wyandotte, Johnson
Edwards (3 Responses)
Edwards and Ford
Ellis (10 Responses)
Ellis and Trego
Ellis, Ellsworth, Russell, and Rush
Ellis, Ford, Phillips, Russell, and Rush
Ellis, Morris, Neosho, Pawnee, Reno, and Sedgwick
Ellis, Norton, Osborne, Phillips, and Smith
Ellis, Norton, Osborne, Russell, and Smith
Ellis, Phillips, Thomas
Ellis, Sedgwick, Wyandotte
Ellsworth
Ellsworth, Ottawa, and Saline
Ellsworth, Saline, and cover other counties as needed.
Entire State
Federal level
Finney (17 Responses)
Finney and Ford
Finney, Ford, Grant, and surrounding.
Finney, Gray, Scott, Lane, Kearny, Hamilton, Ford Hodgeman
Finney, Kearney, Hamilton
Finney, Scott
Finney, Scott, and Thomas
Finney, Scott, Ford, Greeley, Wichita, Lane
Finney, Seward, Lane
Florida (2 Responses)
Ford

Ford (7 Responses)
Ford and Gray
Ford and Sedgwick
Ford and Shawnee
FR, CF, OS, AN, MI, LN, BB
Franklin (5 Responses)
Franklin and Miami
Franklin and Wyandotte
Franklin, Anderson, Coffey and Osage counties
Franklin, Harvey, Johnson, and Wyandotte
Franklin, Johnson, Leavenworth, Miami, and Wyandotte
Franklin, Lyon, and Osage
Franklin, Miami, Osage, Anderson, Allen, Linn, Coffey, Neosho, Woodson, Wilson, Bourbon, Crawford, Cherokee, Labette, Montgomery, Chautauqua
From Geary Co east to the state line, and from Nebraska to Oklahoma
Geary (25 Responses)
Geary and Manhattan
Geary and Riley
Geary and Riley (7 Responses)
Geary, Lyon, and Morris
Geary, Lyon, Riley, and Saline - wherever I am needed.
Geary, Marshall, Morris, Pottawatomie, Riley, and Wabaunsee
Geary, Marshall, Pottawatomie, and Riley
Geary, Morris
Geary, Pottawatomie, and Riley
Geary, Riley, and Shawnee
Geary, Riley, Pottawatomie
Geary, Riley, Wabaunsee
Grant, Johnson and surrounding areas
Gray
Greene
Greenwood
Greenwood, Lyon, Osage, and Wabaunsee
Harper
Harper, Kingman, and Sedgwick
Harvey (19 Responses)
Harvey and McPherson (2 Responses)
Harvey and Reno (2 Responses)
Harvey and Sedgwick (9 Responses)
Harvey, Kingman, Lyons, McPherson, Reno, and Stafford
Harvey, Marion, and McPherson (4 Responses)
Harvey, Marion, and Saline
Harvey, Marion, McPherson

Harvey, Marion, McPherson, and Sedgwick (2 Responses)
Harvey, Marion, McPherson, Reno, and Rice
Harvey, Marion, McPherson, Reno, Rice, and Sedgwick
Harvey, Reno, and Sedgwick
Hawaii
Hays
I am dual licensed and work on the Missouri side.
I am in Jackson, MO, and I practice on zoom in KS and MO, where I am licensed.
I am not currently employed as a social worker but continue to hold my license.
I am telehealth only in Kansas, based in St Louis MO
I currently work out of state.
I do not currently practice because I am parenting/ living in TX.
I don't practice in Kansas.
I Live in New Mexico. I am retired.
I practice in Colorado Springs but am licensed in both Colorado and Kansas. El Paso, CO.
I practice in Jackson Co. Missouri
I retired from DCF but will answer because I maintain my license and will continue to earn CEUs to maintain license.
I work for the Federal Government so I practice on military installations
I work virtually.
I work virtually so I can see clients in every Kansas county, but I am in Sedgwick.
I'm not practicing at this time.
I'm retired but maintain my license. I spent my last 21 years working in Reno.
I'm licensed but don't currently practice SW.
In Kansas Johnson Co in Missouri several counties.
Jackson (57 Responses)
Jackson (MO), Johnson, and Wyandotte
Jackson and Johnson (10 Responses)
Jackson and Platte Counties in MO - I serve MO and KS patients.
Jackson and Pottawatomie
Jackson and Shawnee (3 Responses)
Jackson and Wyandotte
Jackson MO telehealth
Jackson primarily (2 Responses)
Jackson, Jefferson, Shawnee, and surrounding.
Jackson, Johnson, and Leavenworth
Jackson, Johnson, and Wyandotte
Jackson, Johnson, and Wyandotte
Jackson, Johnson, and Wyandotte (2 Responses)
Jackson, MK, and Johnson, KS
Jackson, MO (24 Responses)
Jackson, MO and Leavenworth, KS
Jackson, MO, and Johnson, KS (20 Responses)

Jackson, MO, and Wyandotte, KS
Jackson, MO, Johnson, and Wyandotte
Jackson, MO, Telehealth Johnson, KS
Jasper (2 Responses)
Jefferson (5 Responses)
Jefferson and Shawnee (2 Responses)
Jefferson, Johnson, Shawnee, and Wyandotte
Jefferson, Ks, but I am an online practitioner, so I have clients from all over the state.
Jefferson, Leavenworth, Shawnee, Douglas, and Wyandotte
Jewell
JO, WY, DG, LV, AT
John
Johnson (348 Responses)
Johnson and JA, MO
Johnson and Leavenworth (2 Responses)
Johnson and Miami
Johnson and Miami
Johnson and Overland Park
Johnson and Sedgwick
Johnson and Shawnee (7 Responses)
Johnson and surrounding counties
Johnson and Wilson
Johnson and Wyandotte (50 Responses)
Johnson Douglas Franklin Miami Wyandotte
Johnson Douglas-in Kansas and Jackson-in Missouri
Johnson mostly
Johnson primarily but I am clinically licensed in KS and MO.
Johnson, but I have staff across northeastern Kansas.
Johnson, Douglas, Franklin, Leavenworth, Miami, and Wyandotte
Johnson, Kingman, and Wilson
Johnson, KS, and Clay, MO
Johnson, Leavenworth, and Wyandotte (5 Responses)
Johnson, Leavenworth, Linn, Miami, and Wyandotte
Johnson, Leavenworth, Wyandotte (2 Responses)
Johnson, Leavenworth, Wyandotte, Jackson (MO)
Johnson, Lyon, Osage, and Shawnee
Johnson, Miami (2 Responses)
Johnson, Miami, and Wyandotte
Johnson, Miami, and Wyandotte (5 Responses)
Johnson, Ray, Clay, and Platte, MO
Johnson, Sedgwick, and Shawnee (2 Responses)
Johnson, Shawnee, and Wyandotte (3 Responses)
Johnson, St. Louis, Wyandotte

Johnson, Wyandotte, and others
Johnson, Wyandotte, KC Metro
Johnson, Wyandotte, whole KC metro
Kansas (16 Responses)
Kansas and Missouri
Kansas City, KS
Kansas City, MO (previously Johnson Co)
Kansas remote
Kansas Telehealth
Kansas, Missouri
Kansas-retired
KC metro
KC MO and KC KS metro areas and surrounding
Kearny
Kingman (2 Responses)
Kingman and Pratt
Kiowa
KS and AZ
KS and Missouri. Office in Johnson
Ks and MO counties. Mainly metro KC area
Labette (12 Responses)
Labette and Neosho
Labette and Newton
Labette, Montgomery, and Neosho
Lake
Lane
Lauren
Lawrence
Leavenworth (32 Responses)
Leavenworth and Ellis
Leavenworth and Shawnee (4 Responses)
Leavenworth and Wyandotte (2 Responses)
Leavenworth, Sedgwick, and Shawnee
Licensed in KS. Working in MO.
Lincoln
Lincoln and Russell
Logan and Sheridan
LV, DP, JO, AT, WY, DG, FR
Lyon (10 Responses)
Lyon and Greenwood
Lyon and Osage
Lyon, Morris, and Shawnee
Lyon, Pottawatomie, and Shawnee

Mainly Reno but can reach all in Kansas.
Manatee
Many, I work virtually.
Many.
Marion (5 Responses)
Marion and McPherson
Marion and Shawnee
Marion, McPherson, and Reno
Marion, Reno, Saline, and Sedgwick
Marshall (2 Responses)
Marshall and Nemaha
Marshall and Washington
Marshall primarily and others via telehealth as needed/requested.
Marshall, Nemaha, Pottawatomie, Shawnee, and Wabaunsee
McPherson (11 Responses)
McPherson and Reno (2 Responses)
McPherson, Reno, and Saline
Meade and Seward
Miami
Miami (18 Responses)
Miami and Franklin
Missouri (9 Responses)
Missouri Clay Platte Ray
Missouri- Clay, Platte, Jackson. Occasionally Shawnee, KS
Missouri, US
Mitchell (3 Responses)
MO, KS, SD, IA
Monmouth
Montgomery
Montgomery (2 Responses)
Montgomery and Wilson
Montgomery, Cowley, Wilson, Elk, CQ
Montgomery, MD
Morris
Morris and Shawnee
Most of Kansas (2 Responses)
Mostly in the KC area, I just got licensed in Missouri as well due to the proximity, but I haven't needed to utilize it yet.
Multiple -- all for metro KC
Multiple (4 Responses)
My office is in Saline. I see people from the surrounding area via telehealth, e.g., Ellsworth, Finney, and Lincoln.
My team practices across Kansas

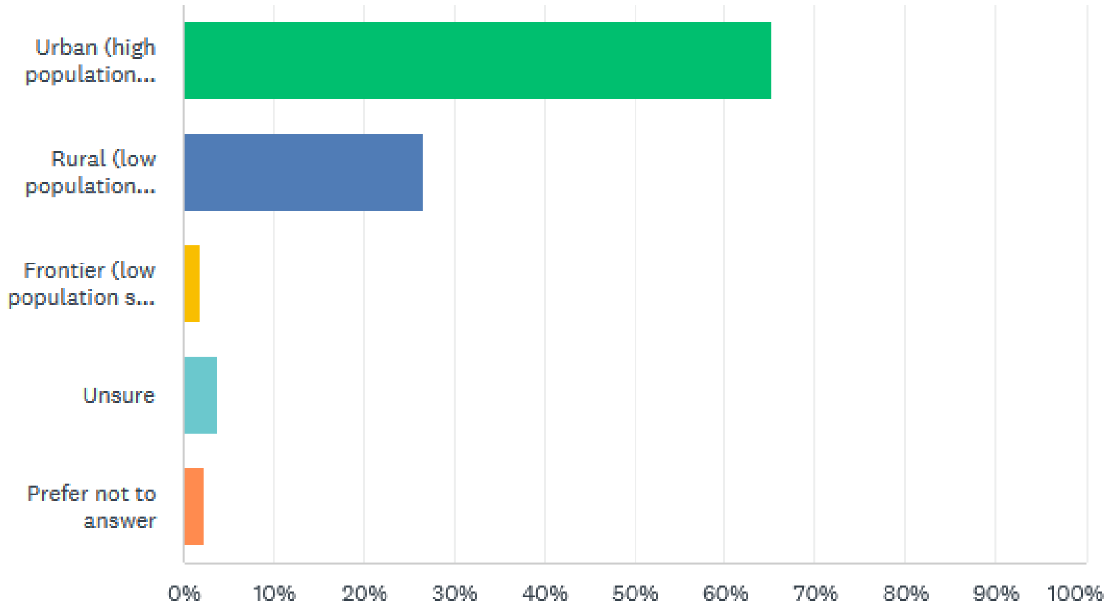
N/A - not currently practicing (2 Responses)
N/A (10 Responses)
Nassau Florida
NE Kansas, Douglas, Johnson, Osage, and Shawnee
Nebraska (DCF PRC part time work)
Nemaha (2 Responses)
Neosho (2 Responses)
No longer practice.
None (11 Responses)
None (Out of State)
None in KS. I am in Indiana right now.
None right now
None, currently. I just moved back from practicing in North Carolina.
None. Retired. (3 Responses)
None-currently retired, volunteer with common table
North central
Northeast Kansas Counties (primarily Johnson, Leavenworth, and Wyandotte)
Norton (2 Responses)
Norton, Phillips, Rooks, Sherman, Smith, and Thomas
Not currently employed/practicing (5 Responses)
Not currently practicing/disabled
Not currently practicing; retired from DCF in 2023
Not in KS just keep license.
Nowata
NT, GH, TR, DC, SD, GO, LO, TH, RA, CH, SH, WA
Oklahoma, OK
Osage (3 Responses)
Osage and Shawnee
Osage and Shawnee (2 Responses)
Osage, Riley, and Shawnee
Osborne, Phillips, Rooks, Russell, and Smith
Ottawa (3 Responses)
Out of state (2 Responses)
Out of State, practice out of Ohio (Cuyahoga)
Outside of Kansas - Fairfax, VA
Oversee multiple staff serving Wyandotte, Johnson and majority of counties in Missouri.
Pawnee (7 Responses)
Phillips (2 Responses)
Physically work in Geary but serve counties across the state via telehealth.
Pinellas
Platte (5 Responses)
Pott and Riley
Pottawatomie (4 Responses)

Pottawatomie and Riley
Pottawatomie and Riley (5 Responses)
Pottawatomie and Shawnee
Pottawatomie and Wabaunsee
Pottawatomie and Wabaunsee
Practiced in Reno
Pratt (2 Responses)
Pratt Kiowa Stafford Rice
Primarily Clinical SW in Douglas, Jackson, Johnson, and Shawnee
Primarily Douglas
Primarily in Missouri
Primarily in the state of Maine, but also Douglas, Rawlins and Morris in Kansas, Boulder in Colorado
Primarily Jefferson- occasionally Shawnee
Primarily Johnson and Wyandotte
Primarily Johnson for my main job. I also work as a virtual therapist and have clients throughout KS and MO.
Primarily Sedgwick, Reno
Remote only
Reno (38 Responses)
Reno and Sedgwick (4 Responses)
Reno, McPherson, Rice, Stafford, Harvey
Reno, Rice, McPherson (2 Responses)
Reno, Rice, McPherson, Barton, Pawnee, Stafford
Retired (5 Responses)
Retired Johnson
Retired still have active license Barton.
Retired was Sedgwick.
Retired/Western Ks previously
Rice (2 Responses)
Riley (52 Responses)
Riley and Pottawatomie (2 Responses)
Riley and Shawnee (2 Responses)
RN, SG,KM, LY, Pt, hV others as assigned
Rural counties in Kansas
Rush
Russell
Saint Louis
Saline (35 Responses)
Saline and surrounding- also MO
Saline primary and multiple other
Saline, Shawnee, and statewide by telemedicine
Sedgwick (396 Responses)

Sedgwick and others with teletherapy
Sedgwick and Shawnee (2 Responses)
Sedgwick and surrounding
Sedgwick, Butler (8 Responses)
Sedgwick, live in Kingman.
Sedgwick, Telehealth across Kansas
Several
Several in SW Kansas, mostly in Ford
Seward (3 Responses)
SG and BU
SG, BU, Harvey, SU, CL, Reno
Shawnee - KS; Travis - TX
Shawnee (193 Responses)
Shawnee and surrounding counties (2 Responses)
Shawnee and Wabaunsee
Shawnee and Wyandotte
Shawnee -not working at this time
Shawnee, Kansas in general via telehealth.
Shawnee, physical location & see clients virtually all over Kansas.
Sheridan
Sherman (3 Responses)
Southeast Kansas (3 Responses)
Southwest Kansas (2 Responses)
Stafford
State of Kansas
Statewide supervision
Statewide but based in Douglas.
Statewide via Telehealth
Stay at home mom, applying to MSW program.
Sumner
Sumner (4 Responses)
Telehealth
Telehealth so all are possible. Johnson currently.
Telehealth throughout the state (2 Responses)
Telehealth, all counties
Terrent, TX
The United States
Thomas (2 Responses)
Topeka/statewide
United States (50 Responses)
USA/ Riley
Utah
Various

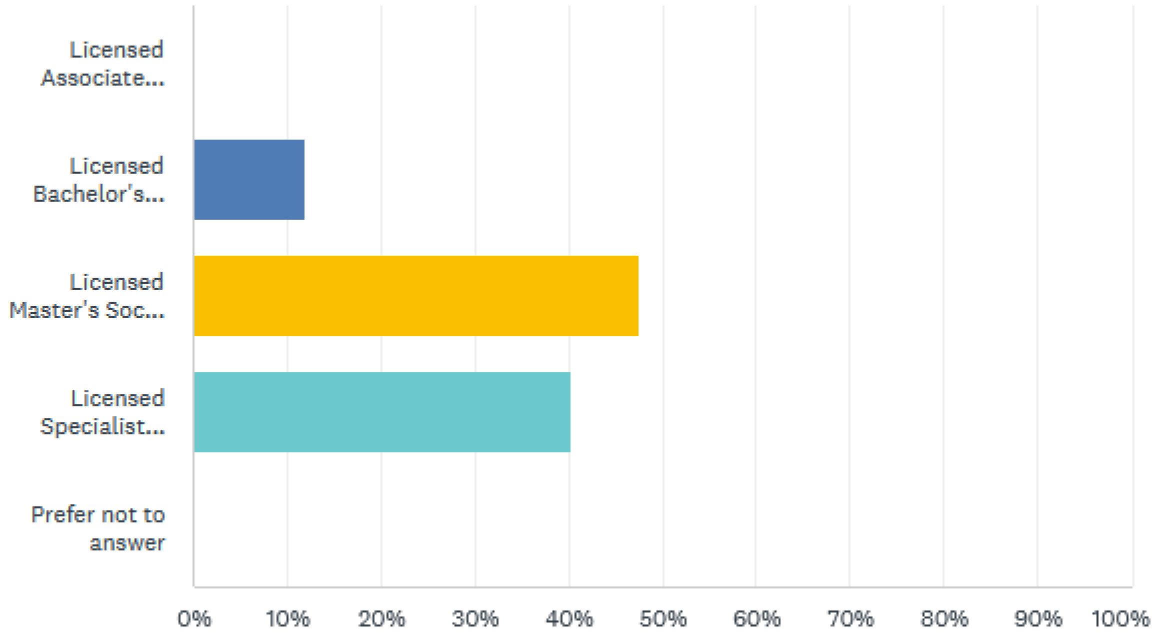
Virtual (2 Responses)
Wabaunsee
Washington, DC
Western 65 counties of Kansas
Western half of Kansas
Western Kansas
Western Kansas counties
Wichita
Williamson
Wilson
Woodson
Working through remote/telehealth in Douglas through an agency that serves Brown, Doniphan, Jackson, and Nemaha
WY JO FR MI DG
WY/JO/DG/LV/AT
Wyandotte (95 Responses)
Wyandotte (but support KS patients from many counties)
Wyandotte primarily

Question 2. Do you practice in a predominantly urban area, rural area, or frontier area?



ANSWER CHOICES	RESPONSES	
Urban (high population size)	65.23%	1,756
Rural (low population size)	26.63%	717
Frontier (low population size and high geographic remoteness)	2.01%	54
Unsure	3.75%	101
Prefer not to answer	2.38%	64
TOTAL		2,692

Question 3. What is the highest level of social work license you have attained in Kansas?

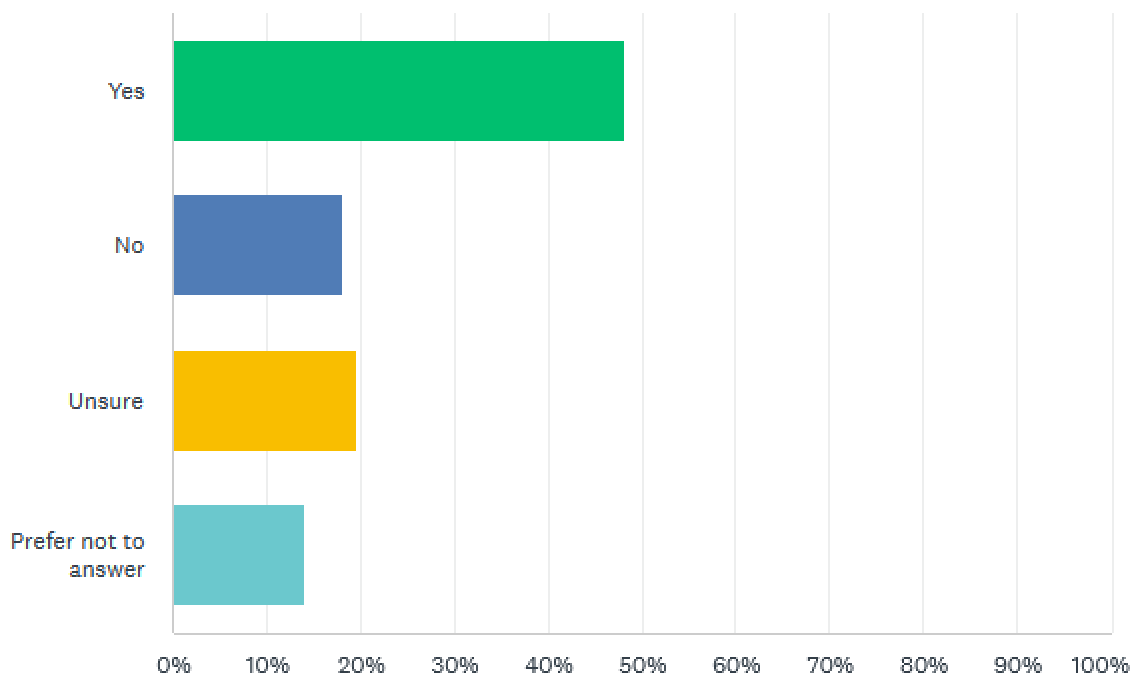


ANSWER CHOICES	RESPONSES	
Licensed Associate Social Work (LASW) license	0.11%	3
Licensed Bachelor's Social Work (LBSW) license	11.91%	323
Licensed Master's Social Work (LMSW) license	47.51%	1,288
Licensed Specialist Clinical Social Work (LSCSW) license	40.21%	1,090
Prefer not to answer	0.26%	7
TOTAL		2,711

Question 4. <u>This question is for bachelor's-level social work licensees.</u> *2024 HB 2484 would add Kansas to a multi-state compact for the social work profession, which would allow Kansas to continue to offer single-state licenses (for practice in Kansas only) or multi-state licenses (which would allow a licensee to practice in Kansas AND all other states that join the multi-state compact.*

According to information on the social work compact website swcompact.org, the primary eligibility requirements for an individual to hold a LBSW multi-state license includes: (1) attaining an accredited bachelor of social work degree or higher; (2) passing a qualifying national exam; (3) holding or being eligible for an active, unencumbered license in the home state; (4) payment of any applicable fees; and (5) passage of a background check conducted by the home state.

Currently, the price of an original LBSW license in Kansas is $100 and the price of a two-year license renewal is $50. ***If totals remained consistent for a single-state license, and prices for multi-state licenses totaled $200 for an original license and $100 for a 2-year license renewal, would you be interested in moving from a single-state license to a multi-state license?***

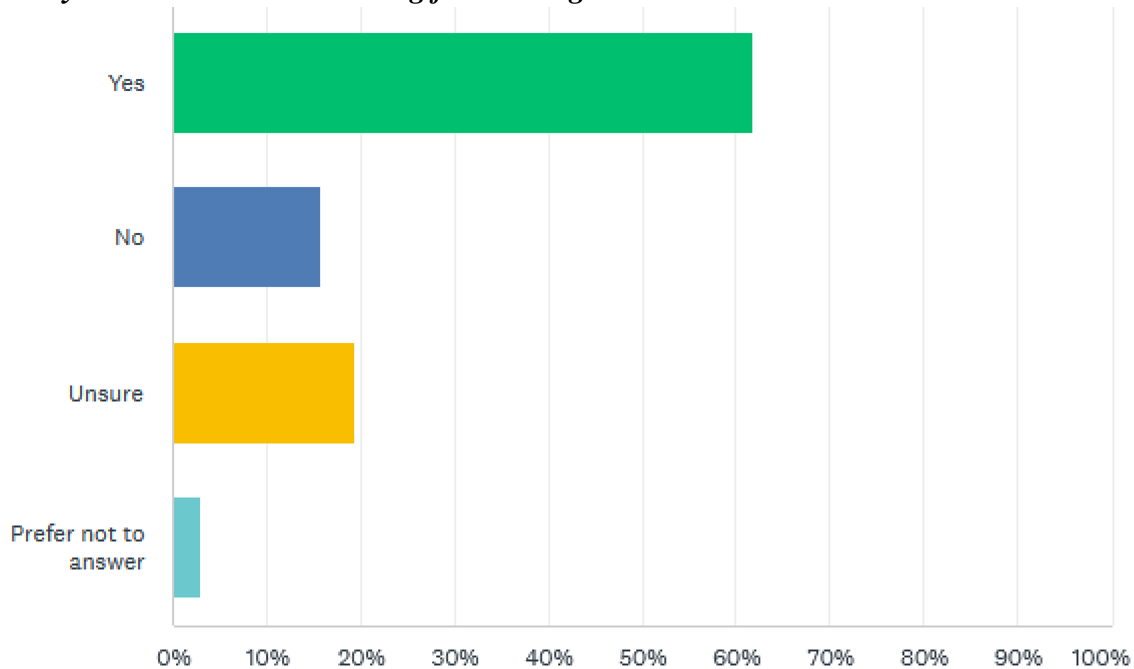


ANSWER CHOICES	RESPONSES	
Yes	48.18%	265
No	18.18%	100
Unsure	19.64%	108
Prefer not to answer	14.00%	77
TOTAL		550

Question 5. ***This question is for master's-level social work licensees.*** *2024 HB 2484 would add Kansas to a multi-state compact for the social work profession, which would allow Kansas to continue to offer single-state licenses (for practice in Kansas only) or multi-state licenses (which would allow a licensee to practice in Kansas AND all other states that join the multi-state compact.*

According to information on the social work compact website swcompact.org, the primary eligibility requirements for an individual to hold a LMSW multi-state license includes: (1) attaining an accredited master's of social work degree or higher; (2) passing a qualifying national exam; (3) holding or being eligible for an active, unencumbered license in the home state; (4) payment of any applicable fees; and (5) passage of a background check conducted by the home state.

Currently, the price of an original LMSW license in Kansas is $150 and the price of a two-year license renewal is $75. ***If totals remained consistent for a single-state license, and prices for multi-state licenses totaled $300 for an original license and $150 for a 2-year license renewal, would you be interested in moving from a single-state license to a multi-state license?***

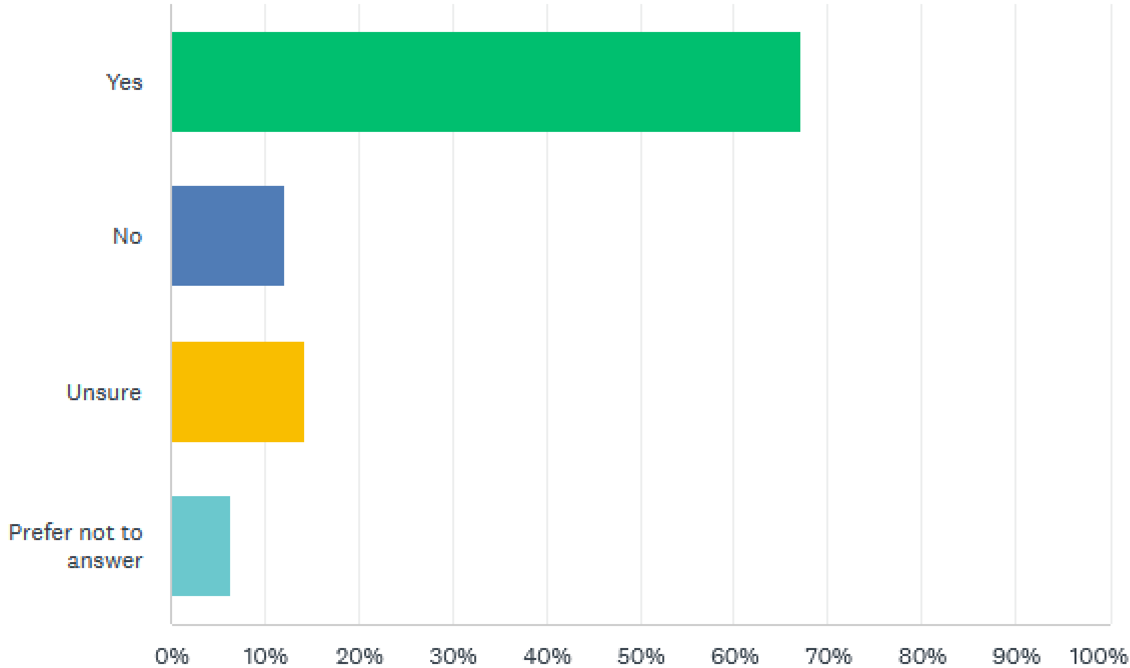


ANSWER CHOICES	RESPONSES	
Yes	61.84%	977
No	15.70%	248
Unsure	19.49%	308
Prefer not to answer	2.97%	47
TOTAL		1,580

Question 6. <u>This question is for clinical-level social work licensees.</u> *2024 HB 2484 would add Kansas to a multi-state compact for the social work profession, which would allow states to continue to office single-state licenses (for practice in Kansas only) or multi-state licenses (which would allow a licensee to practice in Kansas AND all other states that join the multi-state compact.*

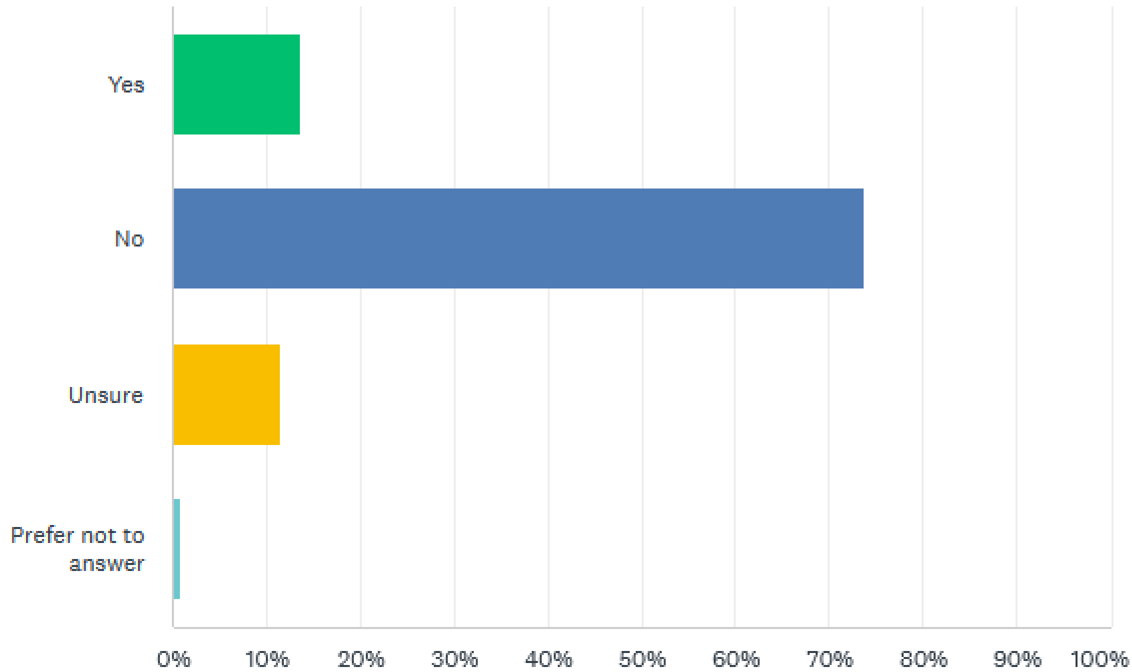
According to information on the social work compact website swcompact.org, the primary eligibility requirements for an individual to hold a clinical social work multi-state license includes: (1) attaining an accredited bachelor of social work degree or higher; (2) passing a qualifying national exam; (3) completion of 3,000 hours or 2-years of post-graduate supervised clinical practice; (4) holding or being eligible for an active, unencumbered license in the home state; (5) payment of any applicable fees; and (6) passage of a background check conducted by the home state.

Currently, the price of an original clinical social work license in Kansas is $150 and the price of a two-year license renewal is $100. ***If totals remained consistent for a single-state license, and prices for multi-state licenses totaled $300 for an original license and $200 for a 2-year license renewal, would you be interested in moving from a single-state license to a multi-state license?***



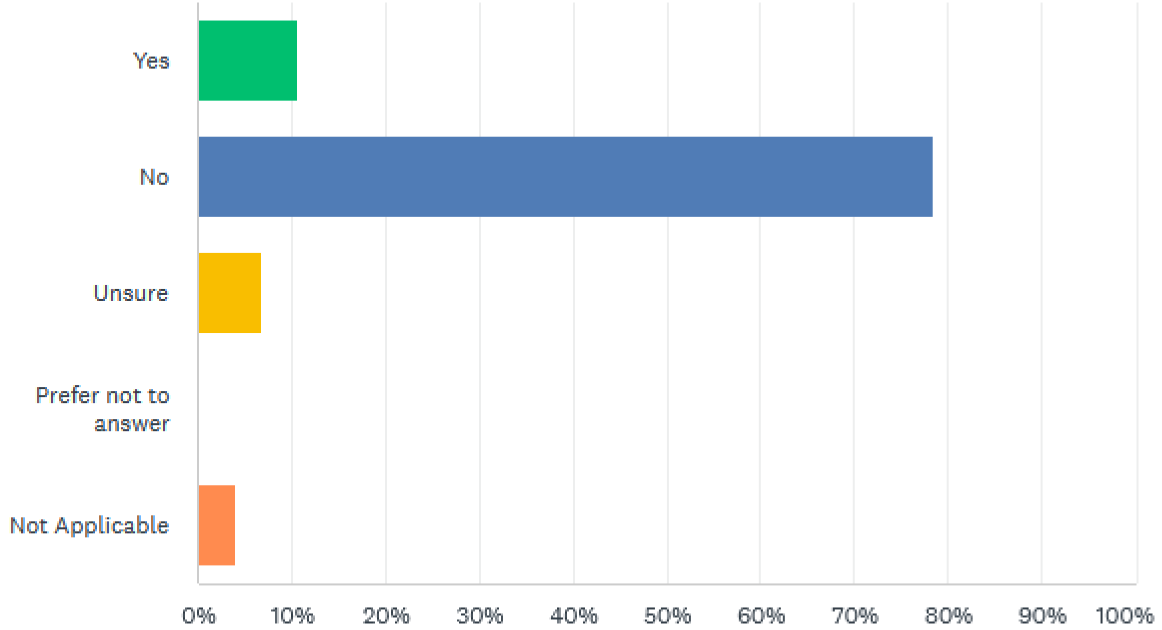
ANSWER CHOICES	RESPONSES	
Yes	67.06%	855
No	12.24%	156
Unsure	14.35%	183
Prefer not to answer	6.35%	81
TOTAL		1,275

Question 7. <u>This question is for all social work licensees.</u> Should Kansas discontinue requiring passage of a national examination as a license requirement for a bachelor's-level permanent social work license? *(Note: A change to this requirement would require a change to law. Also, the social work multi-state compact requires passage of a national examination for this level of license.)*



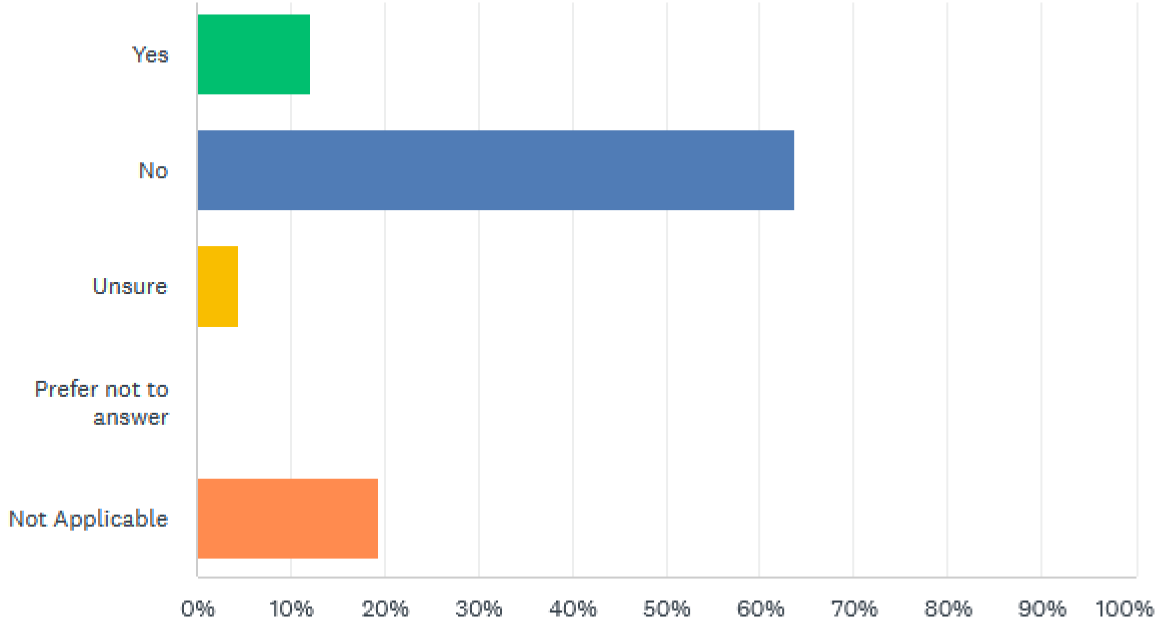
ANSWER CHOICES	RESPONSES	
Yes	13.71%	360
No	73.80%	1,938
Unsure	11.54%	303
Prefer not to answer	0.95%	25
TOTAL		**2,626**

Question 8. <u>This question is for master's-level and clinical-level social work licensees.</u> Should Kansas discontinue requiring passage of a national examination as a license requirement for a master's-level permanent social work license? *(Note: A change to this requirement would require a change to law. Also, the social work multi-state compact requires passage of a national examination for this level of license.)*



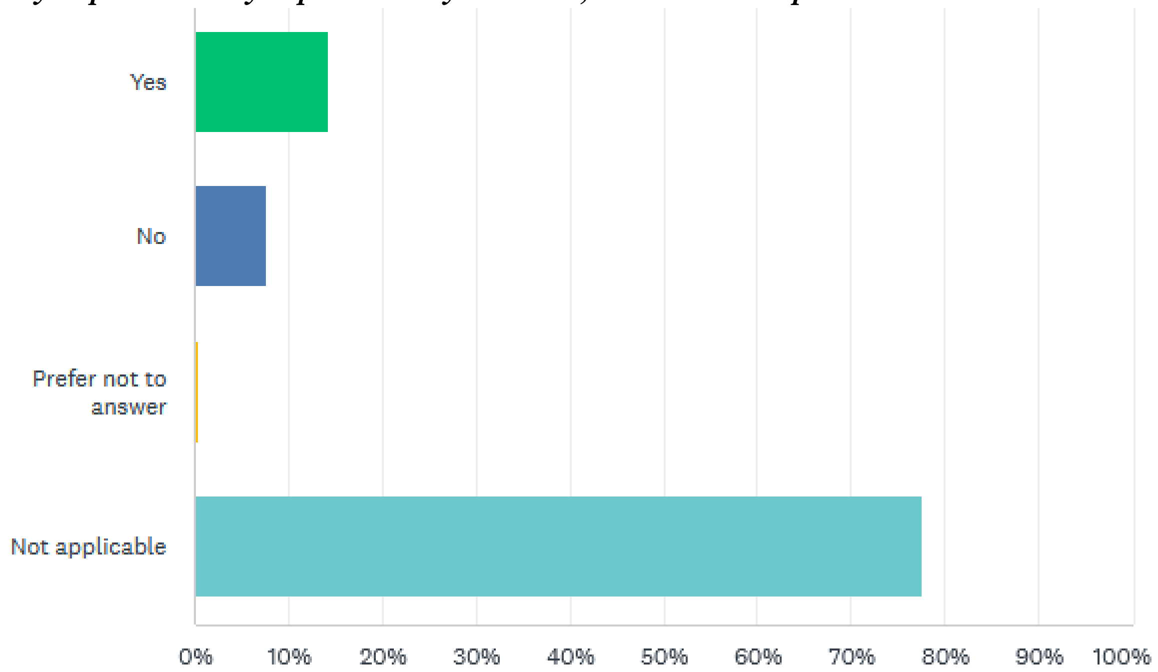
ANSWER CHOICES	RESPONSES	
Yes	10.57%	250
No	78.36%	1,854
Unsure	6.85%	162
Prefer not to answer	0.21%	5
Not Applicable	4.02%	95
TOTAL		**2,366**

Question 9. <u>This question is for clinical-level social work licensees.</u> Should Kansas discontinue requiring passage of a national examination as a license requirement for a clinical-level permanent social work license? *(Note: A change to this requirement would require a change to law. Also, the social work multi-state compact requires passage of a national examination for this level of license.)*



ANSWER CHOICES	RESPONSES	
Yes	12.11%	212
No	63.85%	1,118
Unsure	4.57%	80
Prefer not to answer	0.17%	3
Not Applicable	19.30%	338
TOTAL		**1,751**

Question 10. If you provided clinical-level supervision to practitioners over the past two years, have you provided any supervision by televideo, rather than in-person?



ANSWER CHOICES	RESPONSES	
Yes	14.30%	277
No	7.64%	148
Prefer not to answer	0.41%	8
Not applicable	77.65%	1,504
TOTAL		**1,937**

Question 11. If you provided clinical-level supervision by televideo over the past two years, based on your experiences, do you believe this flexibility has resulted in mostly positive changes, mostly negative changes, or something else? Based on what you have observed, has the ability to provide supervision remotely helped individuals better access supervision? Please explain: *(Note:* Individual text responses were provided by survey responders, which are included below (answers with the same response were grouped together and are bolded):

1. 100% positive, removes many barriers
2. A specified amount of in person time necessary.
3. Absolutely critical to allow televideo supervision given our rural and frontier practice area
4. Absolutely improved access to supervision and feels important for those who may work in more rural locations and lack access to appropriate supervision.
5. Absolutely it creates better access.
6. Absolutely positive in terms of flexibility and not cutting in to service time with commuting.
7. Absolutely! Combining in-person with video allowed for more flexibility in scheduling. I like doing a mix of the two and definitely appreciated saving the drive time during me busier months.
8. Absolutely. Supervision has been very successfully through televideo. I provide both supervision in person and through video and there has been no difference in quality of supervision. It has been extremely helpful for my supervisees in regard to money spent traveling to me, and trying to find childcare.
9. Absolutely. The ability to use televideo supervision has reduced accessibility issues, allowed for more schedule flexibility, and in general been helpful for more options.
10. All positive
11. All positive. It provides for flexibility in scheduling for all parties. It also allows access to a supervisor across the state.
12. Allows to reduce travel or exposure to illness. Please do not reverse.
13. Based on my experience, this increased flexibility has resulted in positive change demonstrated by reduced disruption in the supervision schedule and increased access to supervisors in other parts of the state.
14. Being able to offer televideo has made clinical supervision so much more accessible and offers more options to people in rural areas. Televideo is 100% successful and has been a game changer for social work supervision. Never take this option away - it would be detrimental to our field.
15. Being able to provide supervision via televideo has been extremely positive. I provide supervision for those social workers who see clients from a very specific population. Providing specialized supervision allows them to see an LSCSW who is more familiar with relevant issues within the population etc and they aren't' forced to try and find an in person LSCSW around them. Televideo has done amazing things for therapy and therapy access and it's doing the same things for supervision. Increasing access to good supervision is how we get more social workers and rise to meet the needs in our community.
16. Being able to use remote for supervision has increased flexibility.
17. Better access
18. Better experience with flexibility and positive changes
19. completely benefited. Can literally not think of a negative reason to not allow it.

20. Considering drive time for some to meet, and if there's an unexpected cancellation, its MUCH easier to reschedule and meet virtually. It just allows for greater flexibility scheduling and overall access. Changes have felt positive for me.
21. definitely a positive impact
22. Definitely helped with accessibility of supervision and has made scheduling sessions easier without drive time or the supervisee having to leave work or home. I have been able to provide supervision for social workers who live in areas where supervision is less available.
23. Definitely positive. It’s as effective as in person and provides flexibility and ease of commitment.
24. Did not provide any clinical-level supervision in past two years.
25. Due to COVID, supervision could continue even if there were health related concerns on either end--supervisor or supervisee. It also allowed for working supervisee's to not have to miss a larger chunk of work time to receive their supervision--lunch hour, etc. The quality is unchanged whether you are in person or on telehealth--just make it easier, cheaper, and benefits both parties.
26. Especially in rural areas, cutting “windshield “time is a significant quality of life improvement. When self-care is optimal, learning is also optimized. in both therapy and in supervision, individuals who are vested in learning and moving forward, will do so whether they do it face-to-face or in a telehealth platform.
27. Harder to judge emotions at times
28. Has made access to supervision more convenient and has not impacted quality/outcome.
29. Have not
30. Helped
31. I believe it absolutely results in positive changes making it easier for supervisor schedule and supervisee scheduling. I do prefer in-person but my work schedule doesn't always allow that. I do include in-person supervision regularly.
32. I believe it provides the flexibility needed which allows better access to those who are not able to receive quality supervision in their area.
33. I believe past covid that the accessibility to televideo helped with time constraints and with the needs of supervisees to complete their work/employment without travel concerns.
34. I believe that the televideo supervision is a great advantage for both the supervisor and the supervisee. It cuts down on travel expenses and allows for both to have additional time to see clients if needed.
35. I believe the availability of televideo has increased access to supervision for supervisees. I believe it is a functional method of providing supervision and will continue to utilize televideo.
36. I believe this has been a great change. In group sup, it allows SWKs from multiple places to work together and discuss issues.
37. I didn't provide clinical level supervision over the past two years.
38. I do a combination of both in-person and online supervision sessions. I feel it has offered the most flexibility to clinicians trying to pursue their clinical licensure.
39. I do believe that the option of virtual supervision makes the service more accessible and gives licensees more options. It also, unfortunately, can then make supervision of these clinicians more difficult if they are in a private practice setting. If the licensee is receiving oversight as part

of a larger practice, then I 100% support virtual. However, without that oversight, I have concerns...based on my current experience with a licensee.
40. I feel it has given people the flexibility with their job and time. It does have its negative impact on people who struggle with the discipline it takes to work remotely. But I find I'm more available online to help my staff.
41. I feel it is positive as it allows for flexibility but continues to offer high standard of interactions
42. I feel it was a very positive experience.
43. I felt it was positive. We met remotely when I was out ill.
44. I have an intern and we do supervision via teams weekly. It's easy to connect and screen share etc.
45. I have done a blend of in person and video. This has increased access for supervision in highly rural areas.
46. I have done this under my MO license, not my KS license but it definitely provides better access to supervision in either case.
47. I have had no problems with supervision remotely and people have responded positively
48. I have not but I would not be opposed
49. I have not supervised anyone in the past 2 years for a social work license but am supervising social workers for gambling counselor certification using tele-video sessions.
50. I have observed positive changes, allowing individuals to attend supervision when it may have been canceled in the past (due to work schedule with travel restrictions, transportation struggles etc). Also, clinicians who have moved to a different city have been able to continue supervision with a change to a different supervisor.
51. I haven't but having this flexibility is important. Telehealth is valid. Supervision via televideo is valid.
52. I oversee clinical programs at the agency in which I am employed. Others do provide clinical supervision. With shortage of eligible therapist in Kansas, the ability to connect virtually has been beneficial and mostly positive.
53. I prefer live face to face supervision, but I have met with Clinical candidates via Televideo when I was sick or out of town or the candidate was out of town. This allowed for myself and my Clinical candidates to not have to make up missed days of supervision.
54. "I provide my most recent clinical supervisee initial in-person supervision until the pandemic and the notification from BSRB that supervisors could provide supervision via HIPPA compliant telehealth platforms. I used a HIPPA compliant platform called Simple Practice which was great. I found televideo supervision sessions to be very useful communication-wise and truly allowed my supervisee to gain much better access and often allowed less time away from their social work employment because of the travel time to meet in-person. NOTE: I really appreciate that BSRB reached out to social workers in order to understand and share our perspectives. This is certainly a more equitable organizational action. Thank you!!"
55. I provide supervision in Missouri and have for 5 years. I have done that via video even before COVID. It is the only way to coordinate schedules and allow for access.

56. I see televideo supervision as mostly positive. I have consistently supervised LMSWs over the past several years, and I find that eliminating the travel time associated with in-person supervision is a significant benefit to me and my supervisees.
57. I think it is the key to growing our Mental health force in the nation.
58. I think it offers an opportunity for more familiarity with Telehealth
59. I think it was a useful option.
60. I think televideo helps clinicians receive the supervision they need, especially when their current job cannot provide clinical supervision. It has only been a positive experience.
61. I think this has allowed positive changes to occur. This allows for people in outlying counties to seek supervision and not spend hours of their day driving to and from. It has helped us retain employees as we are able to offer supervision.
62. I use televideo when convenient due to various reasons. Car trouble, having a cold, etc. A time saver in general related to travel. I see very little differences, although most people including myself, prefer in-person
63. improved access- rural communities especially need flexibility of televideo- saved so many hours of driving time and created opportunities for student and new social workers to proceed with education and obtaining licenses
64. In person is better.
65. In the last two years, I have only done supervision in the same room but provided it through televideo extensively in the past. I see no difference in the quality of supervision between the two modalities. It makes it possible for social workers in remote areas to access supervision.
66. In the past 2-3 years, supervision has mostly consisted of master's level social work students and the occasional master's level student. The few times illness or poor weather required tele-meetings, the process ensued with little disruption to our usual meet-ups. That said, I would not prefer to conduct tele-supervision on a regular basis. Too much information/understanding, etc. can missed. And for many students, they want the 1:1, in-person, feeling of really "being heard"!
67. Increased access to supervisors with expertise in specialized populations such as eating disorders
68. Indifferent
69. It 100% has provided positive changes due to the flexibility and consistency for my supervisee's. I've had one supervisee move from the local area and televideo allowed us to continue our work and progress together. Televideo has also allowed me to continue work with another supervisee who is undergoing chemo and needs to isolate at home.
70. It allowed for better access to supervision and continuity.
71. It allows to continue getting supervision in all weather and health conditions, also helps while working if our schedules are too busy.
72. It certainly has been positive and flexible.
73. It has absolutely been a positive experience. I believe social workers should be at the forefront if not leading the way to changes. We have to figure out ways to meet people where they are.
74. It has absolutely improved access to supervision! I would t have been able to provide supervision more often than not if it wasn't an option.

75. It has been a generally positive experience. I have been able to provide more frequent supervision at various accessible times.
76. It has been a mostly positive change. It allows supervision to occur more often with less invasion into work time, and less cancellations.
77. It has been a necessary evil. The supervisor and supervisee cannot be as present under such circumstances as they can in person.
78. It has been a positive experience as it has removed barriers: cost of gas, traveling time, schedule problems, inclement weather conditions that could have disrupted supervision.
79. It has been a very positive change and helps individuals more easily access supervision without question.
80. It has been mostly positive. The majority of supervision sessions were conducted in person however due to scheduling conflicts or being out of town, the option to do televideo allowed supervision to occur without any interruptions.
81. It has been positive, allowing for more flexibility.
82. It has been positive, due to my supervisee and I working in two different office locations within our group practice.
83. It has been positive. We were able to meet when one or both of us were out of town and/or sick and the quality of supervision was the same. Both of us were prepared for session and created a private/confidential space to focus on supervision tasks, skill building, etc.
84. It has definitely been positive and has improved access.
85. It has markedly increased access and consistency of attendance.
86. It has resulted in positive changes, allowing for more flexibility and allowing supervisees to have more options in selecting a supervisor that is a good fit for them
87. It increases flexibility which is nice. I don't believe anything is lost.
88. It is convenient in cases of illness or other complications, but my supervisees continue to prefer in-person. I'm in an urban area, though, and I can see it benefiting those in rural areas.
89. It was a convenient way to get supervision in as we are in different states
90. It was a very helpful option to have. Normally we met in-person but it allowed supervision to happen even if one person had a cold or was feeling a little unwell.
91. It was helpful on being flexible with schedules on both individuals. It helped also when there was illnesses and were able to still meet and meet their minimum requirement.
92. It was not as good as in person.
93. It works for supervision, but not for direct service provision to consumers.
94. It would help immensely in the frontier areas.
95. It's been positive. Provides more opportunities for SW who don't have access to supervisors in their area. Offers more flexibility in scheduling. Less gas money/time spent traveling. Occasional technical issues can be annoying, but tolerable.
96. I've found this to be a positive change that allows for greater flexibility in scheduling my supervisees, particularly those that reside in rural communities.
97. more availability. I think the standard needs to be there, but now people can do it without issues of distance and time constriction.
98. Mostly positive (4 Responses)

99. Mostly positive - has allowed me to provide supervision even while traveling for work and made me more willing to be a supervisor for master's level social workers seeking supervision
100. Mostly positive - this assists with time management covering material and insight from group supervisions
101. Mostly positive and better access
102. Mostly positive and better access.
103. Mostly positive as it has reduced the difficulty of participating and increased access on a mor consistent basis.
104. Mostly positive by far - the flexibility it provides myself and my supervisees far outweighs any small technical issues that rarely arises. It cuts commute time and expenses for both parties and maintains work/client schedules much easier for each party as well.
105. Mostly positive change, yes it has helped individuals better access supervision.
106. Mostly positive changes (2 Responses)
107. mostly positive changes and has increased access
108. mostly positive changes, flexibility- even for those in the same area- but in different office locations, or if one is out sick due to COVID/quarantine
109. Mostly positive changes, gives easier access to supervision in rural areas where you may have to travel for in-person resulting in possible significant loss of billable services.
110. Mostly positive changes. Individuals have more access and can acquire the hours needed
111. Mostly positive changes. It allows greater flexibility with differing schedules, time off etc. Allows supervisors to reach students who love far away without traveling costs.
112. Mostly positive changes. The world is much different since after covid and being able to meet via televideo is essential. It is also helpful for clinicians in rural areas where they would have to drive significant miles to meet with a supervisor in person.
113. "Mostly positive changes. All LMSW's I supervised lived in the same town that I practice, but during COVID the Telehealth option provided a safe and effective way to continue their clinical hours. It also provided flexibility with scheduling and attending individual and group supervision appointments."
114. Mostly positive changes--supervisees have worked on the other side of town as me and have had less travel time as well as ability to meet with me over a lunch period.
115. Mostly positive due to SW Kansas having limited access for LMSWs to receive supervision.
116. "Mostly positive”
117. MOSTLY POSITIVE. Being able to provide virtual clinical supervision allows a supervisee to find the right skilled professional to supervise when without a geographical limitation and improves the attendance weekly for supervision.
118. Mostly positive, allowing for more regular and impromptu supervision when needed. Also allowed for supervision in areas where clinical supervisors are generally unavailable geographically.
119. Mostly positive, better ability to meet needs in the moment, able to respond faster to clinical needs.
120. mostly positive, easier access, less travel time and expense

121. Mostly positive, especially for rural social workers. The savings in energy, fuel, travel, hours of windshield time, and exposure in some cases to pockets of influenza risk are a plus.
122. Mostly positive, gave access and convenience to the supervisee
123. Mostly positive, virtual meetings tend to cause a lack of participation because people try to multitask, and don't give their full attention. So, keeping participants engaged is key.
124. mostly positive. It allows for remote access to supervision since it doesn't require in-person attendance. Is as effective for the supervision to occur remotely as in-person
125. Mostly positive. Helps with busy schedules and distance. Bigger area of rural Kansas but as people move farther West in person could require 1-2 hours of travel, which may not be realistic.
126. Mostly positive. Increased capability.
127. Mostly positive. It allows flexibility and reduces the amount of time/money spent for travel.
128. Mostly positive. It has reduced the number of times an individual had to reschedule supervision because televideo allows more flexibility.
129. Mostly positive; In rural areas it's hard to find clinical therapists who provide supervision.
130. mostly positive-improved access to quality supervisors, decreased travel cost and supervisors don't have to factor the cost of the office space into the rate that they charge.
131. My experience is the supervision by televideo has not been negatively affected, does provide better access to supervision.
132. My experience was it being a hybrid supervision -- at times in person and at times by video. It worked well, in part because it parallels what is happening in the clinical realm.
133. "N/A re: clinical supervision. Very effective clinical telehealth therapy with private cts utilizing a range of modalities."
134. Neutral to positive
135. Not provided
136. Oh yes, very much so! It makes it easier accessible to supervisees! It's an added bonus when hiring staff.
137. Positive (9 Responses)
138. Positive allows for more flexibility in scheduling No different than meeting in person
139. Positive - flexibility.
140. Positive - has helped access supervision
141. Positive and yes it gave improved access
142. Positive as military spouse this allows me to keep providing supervision no matter where my spouse's job takes us.
143. Positive because it has resulted in more flexibility for the staff and thus is emphasizing self care. For example, it is still important for staff to stay home from work if they are sick. With covid, for example, sometimes your symptoms are mild and you're able to continue to work and prevent the spread to our vulnerable staff or clients. Telehealth is a necessity.
144. Positive change and allows more access to more qualified providers and ability for those working within the field to maintain work/financial ability to provide for family and ability to access supervision outside of traditional work schedules m-f 8-5 pm
145. Positive change, allows clinicians to better fit supervision in their schedule if they are providing virtual sessions to clients.

146. Positive change. Easier to schedule supervision. Televideo has been helpful for the practice of social work.
147. Positive changes (3 Responses)
148. Positive changes as being face to face for supervision is not necessary at all for learning, opened up opportunities for supervision of staff is rural or remote areas
149. Positive changes have included being more consistent with supervision times when done via video calls and more access to supervision for supervisees who may live/work far away from supervisors.
150. Positive changes including better access although I prefer face to face supervision
151. Positive changes when access to supervision was limited due to Covid lack of anyone who could provide supervision. In addition, driving time from location to location could be reduced or eliminated by TeleVideo supervision, a win-win situation.
152. "Positive changes, as someone who had supervision in person to begin with and then moved to remote, there was no chance in the quality of the supervision and if remote hasn't been an option, I would have had to find a new supervisor in the middle of my hours.
153. As a clinical supervisor through my employment, the agency would not be able to meet the need for those looking for supervision. "
154. Positive changes, I work for an organization with several sites. It would be more challenging to complete clinical supervision without televideo options. Additionally, its allowed for my supervisee to outreach immediately when needed.
155. Positive changes, yes
156. Positive changes. Able to meet during normal business hours. Decrease on travel time and less stress finding locations. Some of my supervisees are over an hour away.
157. Positive changes. Definitely has made access easier for both me as supervisor and my supervisee. I appreciate being able to use televideo as needed for supervision.
158. Positive changes. Folks from across the state can more easily access clinical supervisors in other areas. This has been great.
159. Positive changes. It allows for greater flexibility in scheduling and is just as effective.
160. Positive changes. It allows supervisee to get supervision with less impact on their busy workday, so they can better care for clients and themselves.
161. Positive changes. It allows us to have more flexibility and opportunities to meet.
162. Positive changes. This has reduced barriers for access to supervision.
163. Positive due to flexibility in overcoming travel barriers (e.g., snow, prohibitive distance)
164. Positive experience and more accessible to all.
165. Positive experience. Allows supervisor and supervises better access to supervision and the ability to be more flexible. I still so at least 1 time a month in person.
166. Positive- Helps in rural and frontier areas to be able to consistently see staff as required. Helps to be flexible to reschedule more easily if needed at times due to taking out the travel time.
167. Positive in regard to clients being able to attend sessions without hardship.
168. Positive! Yes, it has really helped Rural areas such as Hayes, Andover etc
169. Positive! It's absolutely helped individuals better access supervision and been very helpful to supervisees with limited transportation or childcare support.

170. Positive! We've got to keep up with technology! Allowing us to provide supervision despite physical proximity has been game changing. Allowing me to supervise more people and keep up with my work!
171. Positive, allows for flexibility so I can have the time to provide supervision in my workplace
172. Positive, much greater access and even more frequent support as needed.
173. positive, sometimes it is very difficult for clinicians to find local supervision, and, during the pandemic it was crucial for that to continue (clinical supervision).
174. Positive, yes, being able to access supervision due to distant location or more privacy allows for growth. (If my supervisor is not in my circle of people as sometimes happens in smaller communities, it can be easier to be vulnerable with the process.)
175. Positive. It requires less driving and allows supervisees to find a good fit for supervisor, even if that person is not geographically nearby.
176. Positive. Tele video is a flexible, efficient, and supportive practice.
177. Positive. Yes, it provides better access. I have met in person with everyone I provide televideo supervision to before we start to meet remotely.
178. Positive. Better access. Better overall. Continue to allow televideo!
179. Positive. It’s great for providers that are far from the office, and it works just as well. Better attendance.
180. Positive. Removes barriers to weekly supervision as we mostly work remotely and in the community.
181. Positive. Weather, traffic and illness doesn’t prevent SW from accessing supervision.
182. Positive. Yes. When distance or illness are an issue, virtual is a great option.
183. Positively impacted. Telehealth option is necessary in our mobile world we live in. Not allowing remote would be an unnecessary step backward.
184. Primarily positive experience.
185. Provided televideo supervision in 2020-21 related to the pandemic. Worked ok, though not as ideal as in person training, in my opinion. A hybrid model might be equally effective.
186. Provision of supervision via telehealth simply allows for flexibility of scheduling. This allows for improved consistency in attendance.
187. Remote supervision accommodated my physical disability and geographic barriers to meeting in person.
188. Televideo allows for more flexibility to complete supervision sessions consistently with less interruption from patient care
189. Televideo has been helpful for me. It helps to view materials when screen sharing. It saves on printing. It helps if individuals are at different locations and do need to commute. It helps when the weather is bad and when outbreaks occur that caused social distancing.
190. Televideo has increased the ability for LMSW's to access supervision, both in terms of availability of supervisors and time management (not having to drive long distances to the supervisor’s location)
191. Televideo has resulted in positive changes, especially in rural Kansas where people might not have access to an LSCSW who is willing to provide supervision in their community or have

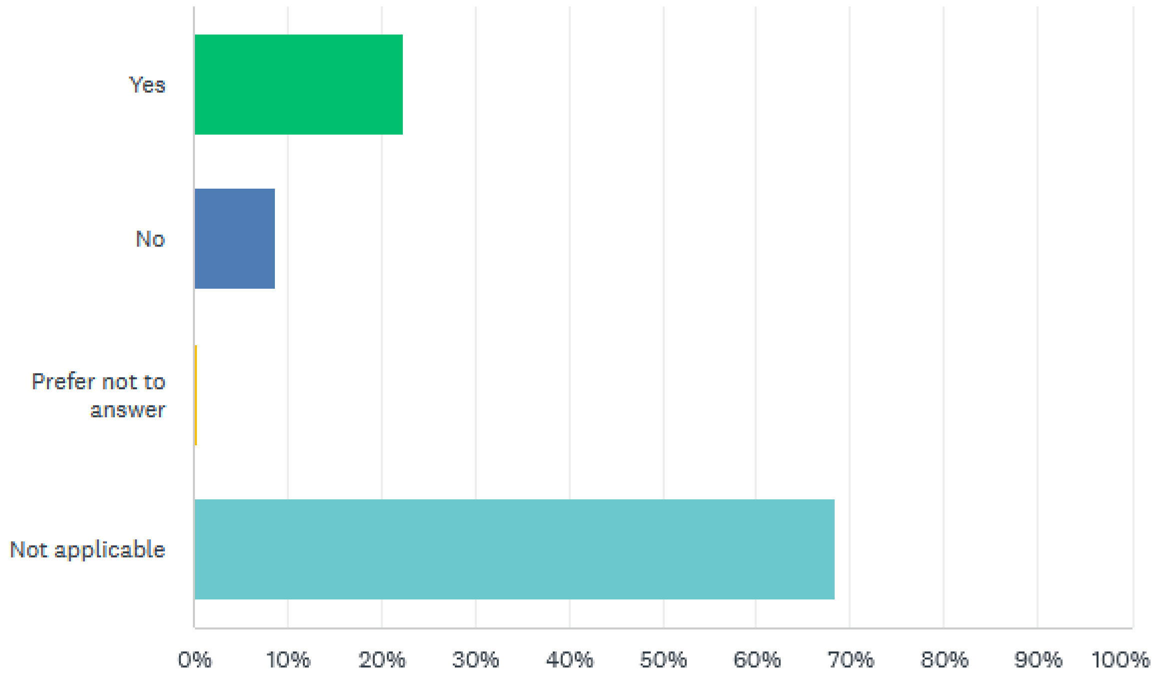
an extensive distance to drive for supervision. The only negative is when people do not have a solid internet connection.
192. Televideo helps to provide access to supervision especially in rural and frontier area. I do believe a combination of in person and televideo is most helpful.
193. Televideo supervision has expanded availability to rural areas. In a time of high demand, this tool has been a real time-saver. More effective use of time plus better ability to overcome obstacles such as weather or exposure to illness of all communicable types.
194. televideo supervision in my experience has improved accessibility, scheduling conflicts, and all-around reduced barriers to getting/providing supervision weekly.
195. the content of supervision session remained unchanged in relation to the mode of supervision. It has kept my supervisee safe as she has not had to travel in icy weather.
196. The flexibility of televideo has significantly improved the availability of social work services, including supervision.
197. This allowed greater flexibility for scheduling when an agency has multiple locations and ability to work from home some days.
198. This allows a broader selection of practitioners. I find remote work very effective.
199. This depends on the supervisee. Some use it as a crutch and others as when they absolutely need it. I feel that I want to put requirements for my supervisees, but not sure if that can be done since it is my preference. The sessions are more in depth with information in person.
200. This has allowed consistent meetings for me and my supervisees. Our schedules don't always allow for drive time to offices.
201. This has allowed me to supervise SW in a more accommodating environment to ensure they can complete their goals
202. This has been positive and has allowed people more flexibility to achieve their clinical licenses
203. This has created positive changes. It would have been a time and location barrier to meet in person weekly for supervision. Televideo supervision has allowed me to meet my supervisee's weekly supervision needs.
204. This has had a very positive impact on my supervisees.
205. this is a great step forward. It has absolutely improved access for supervisees
206. This has been beneficial because it allowed for flexibility for both myself and the candidate. We were able to utilize technology to review things much easier as well.
207. This opportunity allowed my supervisee who lived in a different town to be able to avoid the travel expense along with cost of supervision. We did meet in person from time-to-time to review records on clinical cases on which I signed off.
208. This positive change has allowed for providing supervision when it would otherwise not be possible.
209. This type of supervision allows the Social Worker to be matched with specialists and people who match their clinical need. I believe this is highly beneficial.
210. Travel distance would have been a prohibitive factor for one of my supervisees.
211. very beneficial to being able to provide necessary supervision in rural areas. Particularly during COVID and bad weather.

212. Very positive and just as effective as in-person supervision. Here’s a tip: stop allowing non-clinically licensed LMSW’s or any non-clinical master’s of any profession starting their own practices without on-site clinical supervision! This negatively affects clients and our profession.
213. Very positive changes. I have been able to provide supervision to clinicians working and living remotely even though I do not.
214. Very positive- has been extremely helpful in accessing supervision with minimal to no problems
215. Very positive. This has expanded the reach of supervision and allowed those in rural and frontier areas to receive this crucial support.
216. Virtual meetings are becoming a standard in all areas in a modern world. I use a combination of televideo and in person sessions throughout the extensive time supervision is required. I believe having completed training towards becoming a nationally certified telehealth provider was most beneficial.
217. with having telehealth providers, it is much more convenient
218. Yes (7 Responses)
219. Yes - just as effective as face to face.
220. Yes because it not only improves access to a supervisor, it allows for more flexibility and scheduling
221. Yes because less travel time is involved, and one can see supervisees in a day. It is helpful to social workers who cannot find supervisors in a more rural area.
222. Yes, I do.
223. Yes it has helped especially if someone is ill or recovering from covid we can still meet
224. Yes it has made supervision easier for the supervisee and supervisor.
225. Yes- it makes Supervision much more accessible and practical.
226. Yes, its helped rural social workers receive supervision
227. Yes telehealth has made supervision much easier in rural areas
228. Yes, they were able to participate and be flexible and manage time better without having to try and get somewhere
229. Yes this affords both parties to be more flexible with time and overall availability
230. Yes this meets the needs with ever changing needs and allows for quality care for supervision
231. Yes to all of the above. It has been a mostly positive change and has helped significantly with access.
232. Yes! The counties in which myself and my supervisees work are all rural/frontier. Without telehealth, clinical supervision would not be possible for any of them as I am the only LSCSW currently in the organization. It also increases efficiency and maintains more time for clients as there is no additional travel time.
233. YES!! Only positive benefits that I have noted.
234. Yes, ability to meet remotely helps when supervision sessions need rescheduled or when weather is bad.
235. Yes, as is true for therapy sessions as well. My supervisee was able to continue during covid, during illness which was not debilitating but which was infectious.

236. Yes, being able to provide supervision via televideo was beneficial in my situation. It allowed me to provide supervision regularly while maintaining a busy schedule. I continued to meet in-person with the supervisee on a regular basis to maintain contact and relationship.
237. Yes, better flexibility, better access to resources and better time management.
238. Yes, by reducing travel time and having more options across the State.
239. Yes, can meet more regularly
240. Yes, during the height of pandemic was very valuable and in general worked well.
241. Yes, easier access and more flexibility has resulted in highly positive changes.
242. Yes, has allowed collaboration across state lines and enhanced overall quality of service.
243. Yes, I do believe the televideo option allowed for greater flexibility and gave those in rural areas working on their clinical license a more diverse choice of clinical supervisors.
244. Yes, I live in a r
245. Yes, I was able to provide supervision throughout the pandemic and the one who has completed their hours passed their exam and has had a clinical license since this past fall. I believe an effective supervisor offers a mixture of modalities including in-person and televideo and group (when able). I believe some sessions still need to be in-person but televideo if in-person is not accessible.
246. Yes, increased flexibility for many reasons.
247. Yes, it allows for flexibility
248. Yes, it allows you to provide supervision more easily and conveniently.
250. Yes, it had made it easier even with those near because of time demands and costs with travel.
251. yes, it has been effective. i would add it is best if you have some kind of prior relationship/knowledge of staff you are working with.
252. Yes, it has definitely been a positive for access to supervision.
253. Yes, positive it slows more flexibility
254. Yes, prior to providing any telehealth services, I was experiencing an abundance of reschedules or cancellations for transportation, weather, illness etc. Telehealth has afforded more flexibility and more consistency with all services across the board.
255. Yes, televised supervision has been a positive change and does not impact the ability to appropriately supervise.
256. Yes, the ability to provide supervision remotely has created greater access for those working on a clinical license to receive supervision from a clinical licensed social worker
257. yes, the results have been positive
258. Yes. Geographic distance is made irrelevant, which means persons in rural or frontier areas can choose from more options for supervision.
259. Yes. It allows for more scheduled supervision since it can be done from anywhere and at any time.
260. Yes. It is effective and very important in frontier counties.
261. Yes. Supervisee moved to another state. Zoom made it possible to continue meeting.
262. Yes. The option is needed and access to supervisors very helpful. I think it's still very effective just as teletherapy can be.

263. “Yes. The world has changed since Covid. Also, generational changes are occurring, and a lot of services take place online.”
264. Yes. Easier access and less time constraints
265. Yes. Good alternative when weather strikes or possible illness/exposure.
266. Yes. I am in a large community, and I have multiple office locations as do my supervisees. We rarely are at the same location, and while we try to meet in person as often as possible, having this flexibility to change to televideo on occasions has been extremely helpful to maintain the consistency of our scheduled sessions.
267. Yes. It should be an option to do in person and video supervision.
268. Yes. Yes. Yes! The option for tele health improves access to clinical supervision at times that are needed beyond scheduled weekly supervision when the supervisee is in a different office or location. It improves access if the supervisor or supervisee is sick (contagious) but able to ask work or function. It opens a variety of options for supervisees to identify a social worker that might work somewhere else in the state who has a specific specialty.
269. Yes...it helps with the ability to coordinate schedules, is more flexible, provides access to Social Workers in rural areas, is less time consuming when removing transportation requirement.

Question 12. If you received clinical-level supervision over the past two years, have you received any supervision by televideo, rather than in person?



ANSWER CHOICES	RESPONSES	
Yes	22.42%	444
No	8.69%	172
Prefer not to answer	0.35%	7
Not applicable	68.54%	1,357
TOTAL		1,980

Question 13. If you received clinical-level supervision by televideo over the past two years, do you believe the quality of supervision provided remotely has been mostly positive, mostly negative, or something else? Has the ability to receive supervision remotely helped with accessing supervisors? Please explain: (*Note:* Individual text responses were provided by survey responders, which are included below (answers with the same response were grouped together and are bolded):

1. 100% positive
2. A majority of my supervision has been in person. I am indifferent to in-person or tele-video.
3. Absolutely helped the availability, consistency and quality of supervision received.
4. Absolutely! It is helpful to be able to schedule when it's convenient for all involved.
5. Accessibility has been easier. I have never had in person supervision so I cannot compare.
6. Accessing supervision via televideo has provided a flexibility assuring meetings can happen as frequent as needed, reduces travel time, and allows more options for when supervision can occur.
7. All positive.
8. All positive. It's easier and less barriers to in person (schedules, travel, etc.)
9. Almost identical to in person supervision. Better in that we have more ability to meet and flexibility around scheduling.
10. Attending supervision via telehealth is still very effective and as allowed a great flexibility change for my schedule. It allows me to have more time to see clients as well
11. Being able to access supervision remotely increased access and provided extremely positive results in my experience.
12. Being able to receive supervision remotely has been a wonderful experience because the quality (in my opinion) is the same in person but more accessible for my supervisor who is incredibly busy and allowed me to spend the I would have to drive being able to see clients.
13. Being in the same facility but different locations has made meeting in person difficult at times of high work volume. Being able to reach out virtually has increased accessibility
14. By being able to access supervision via televideo, it has greatly improved my experience. Since I am in a more rural area, I am very limited as to who in my town would be able to provide clinical supervision. By engaging in supervision via televideo, I have been able to connect with a supervisor from a different town who has been an amazing and positive support. It's the best supervision I've ever had hands down and I wouldn't have been able to travel to her otherwise.
15. Comparable to in-person
16. Completely positive and absolutely!!
17. Completely positive, I prefer meeting on television for ease of scheduling with my clinical supervisor.
18. Definitely positive. I am currently in clinical consultation (supervision) with a clinician from New York City who is a professor in a certificate program I'm enrolled in. Without televideo, I would be unable to further my clinical education in this way and would be unable to benefit from the greater experience and expertise of clinicians outside my geographic area.
19. Did not change quality, made it easier to access
20. differs
21. Essential given geographical constraints
22. Extremely positive

23. Generally, I’ve had a positive experience and remote supervision has been especially helpful given the length of travel from working in such remote communities to accessing my supervisor.
24. Good
25. Having televideo options for supervision has been extremely helpful and a positive experience!
26. Helped
27. Helpful. I have mostly done group supervision by telehealth. I find it helpful to access supervision and peer support.
28. High quality, particularly helpful during the pandemic.
29. I believe it definitely is better in person but due to weather or location might not be possible for some.
30. I believe it has been mostly positive. I enjoyed supervision via video and is easier to schedule supervision times via video.
31. I believe my clinical supervision was equally beneficial when in person and via televideo. I didn't feel there were any barriers to quality. While both clinical supervisors I worked with were based in my work setting, my work setting has continued to allow us to have a limited hybrid schedule (3 days in office and up to 2 days working from home). This enabled my clinical supervisor and I to meet on our desired day and time even though there were times that our in office/ WFH schedules didn't match up.
32. I believe televideo supervision is a fantastic option! Many times both my supervisor and I were in between client appointments. Being able to televideo was a great convenience.
33. I believe that it was positive and quite beneficial. Conversations were not as time limited as face to face due to a more flexible, slightly more casual and comfortable interaction.
34. I believe that Telehealth and video conferencing are effective and efficient and definitely relatable to client work
35. "I believe the quality of supervision has been positive, and that receiving remote/telehealth supervision has not in any way diminished the quality and effectiveness of supervision.
36. Due to a physical condition (complex connective tissue disorder) and my need to work from home (I would be physically unable to work outside of my home), remote/telehealth clinical practice and supervision have made it possible for me to contribute and provide services to people in need. I am, though, still under supervision since I don't yet have my LSCSW). "
37. I can now see my supervisor for my 1099 via zoom without traveling 200 miles.
38. I currently receive mostly remote supervision, but the last year I received in person supervision. My supervision experience with my remote supervisor is a much more positive one than my previous supervisor. I believe this is because I was able to find one in a more populated area, so I had more quality options for supervision.
39. I didn't receive clinical level supervision over the past two years.
40. I do not believe televideo has offered anything different than in person would have offered. It does offer most availability to supervisors.
41. I do not think the telehealth aspect of the supervision was what negatively impacted the quality of supervision received. I think a quality supervisor can provide quality supervision via telehealth. I like that supervision can be available via telehealth but do prefer to attend in person whenever possible.

42. I don’t think it’s as good of an experience as in person, however most social workers have busy schedules therefore video is the most convenient.
43. I feel it is very positive. The number of LSCSW's willing to offer supervision is limited; therefore, access to well qualified, reliable LSCSW's increases with the use of televideo meetings.
44. I feel like this level of supervision has been mostly positive as it has aided in accessibility for both me and my supervisor. We are able to meet on a flexible basis if necessary, which we would not be able to do without meeting over televideo.
45. I feel the interactions with my supervisor are the same quality via telehealth as in person. This is huge for ease of scheduling supervision!
46. I find it easier to get on and talk and get things accomplished.
47. I graduated in 2020 so I had to do a lot of supervision through Telehealth. I also currently receive play therapy supervision via Telehealth. I find that I am able to receive the same level of supervision in person as through Telehealth.
48. I had a mostly positive experience with clinical supervision via tele-video. It assisted in continuing supervision during the COVID crisis.
49. I have completed clinical supervision years ago, but I meet with my Director via this method effectively. Access is improved across multiple offices and locations.
50. I have had a positive experience with televideo. It allows for more flexibility.
51. I have had less than a couple months of clinical supervision mostly remote and my experience has been very positive. Having the option to do remote allows more time in my already hectic schedule. It has definitely made it much easier in accessing clinical supervisors.
52. I have not provided I am being supervised and it has been wonderful and quick access.
53. I have not used televideo yet but appreciate this option
54. I have only received in person supervision
55. I have received post clinical supervision for additional certification and televises has been key to getting great quality supervision. Getting good supervision may mean you need access to someone who doesn’t live close enough to easily see them. But also, there are circumstances where televideo is very helpful even when they are close by because life happens!
56. I have utilized zoom for supervision, and it has helped with connecting supervisors and other therapists. It is effective.
57. I offer televideo and it has been all positive feedback from supervisees.
58. I only received supervision via virtual methods if my supervisor or I was unable to be there in person, which was fairly limited overall. I thought it was fine because I already had an established relationship with my supervisor at the time.
59. I oversee clinical programs at the agency in which I am employed. Others in the programs I oversee do receive clinical supervision virtually. With shortage of eligible therapist in Kansas, the ability to connect virtually has been beneficial and mostly positive.
60. I prefer in-person interaction, but I do not feel that televideo supervision was negative in any way. It allowed me to continue supervision when my supervisor and I were not in the same place.
61. I think it was beneficial. I wish there was more structure to the supervision though. Like what exactly the expectations are.

62. I think it would have been about the same or maybe even easier. It is easier to coordinate schedules via phone than in person.
63. I was fortunate to receive supervision in person AND remotely which promoted convenience and quality.
64. I would say mostly positive, with a young child, a private practice and second employment, the flexibility of remote supervision has been extremely important in assisting with completing my hours!
65. I'd like to comment on the exam issue but there's no place to do that. I would like the KS law to still require an exam for every level of licensure, but it would be helpful to re-word it so that KS could provide an alternate exam if that's warranted. I know ASWB is making some changes, and hopefully they'll be good, but I don't wish for us to be locked into their exam only. Also, I don't think that lowering the CE requirement to 30 hours would negatively affect practice, but I am loathe to lower the requirements. I still remember when it used to be 60 hrs.
66. I'm a doctoral student at Smith College School for Social Work. I met my current clinical supervisor participating in a (previous) certificate program at this SW School. This was conducted in person and through ZOOM meetings. When I started doctoral training this summer, I met her in person a second time to determine if we were going to work together. All clinical supervision that's occurred by ZOOM occurred after the working relationship was decided on. Televideo sessions since this time have been very positive.
67. In my experience it has been positive. It allows me to ensure I get my weekly supervision while at the same time it doesn't take too much away from my other responsibilities (ex. work, family, etc). Even if it saves 20-30 minutes of travel time, it is helpful if necessary.
68. It allowed for being able to meet when physically it would have presented too many challenges to name to meet consistently
69. It allowed us to meet, even when one of us was out of town.
70. It has absolutely helped with getting supervision. The quality has been the same as in person meetings and at times made discussing challenging cases almost immediate compared to scheduling in person meetings.
71. It has been a very positive experience, and my access to a supervisor widened tremendously!
72. It has been beneficial at times due to schedule, weather or other factors but I prefer in person. I do think it makes it easier to find a supervisor though.
73. It has been incredibly positive. It has vastly increased accessibility of supervisors and time that we can meet and also makes our time better able to be focused on clinical work.
74. It has been most sufficient and positive experience.
75. It has been mostly positive as it allowed me to still have supervision even if I was feeling unwell, had a client schedule right after, or needed to go out of town on the scheduled day. There was no significant change in the supervision quality.
76. It has been mostly positive. Receiving supervision remotely was absolutely necessary to accessing a supervisor.
77. It has been mostly positive. It has helped my ability to access supervisors.
78. It has been positive and helpful.
79. It has been positive because it has allowed my supervisor to be more accessible to me. We have been able to find supervision times more easily than if we had to do in-person

80. It has been positive. It is incredibly helpful to have televideo supervision as all people involved are busy and maintain their office in different locations. This makes it easy to join in without getting to a conference room.
81. It has been very helpful and a positive experience for me. It has also saved me a lot of time not having to commute to elsewhere to see someone in person.
82. It has been very positive and absolutely helped in terms of access!
83. It has been very positive and convenient.
84. It has been very positive.
85. It has definitely been more positive. Not being able to do televideo supervision would have significantly impacted my ability to work toward my clinical license. I have done both in person and televideo and do not believe I am missing out on anything by doing mostly televideo. Group supervision has been more easily accessible as well which adds positively to the learning experience.
86. It has helped maintain the supervision requirements with the added flexibility with the option to participate remotely.
87. It has helped me in many moments as it reduces the pressure to coordinate schedules so tightly and allows for different experiences and timing of meetings to be available.
88. It has helped me so much because I have 3 children at home. Telehealth has been positive!
89. It has helped my peers pursuing clinical licensure significantly.
90. it has helped with accessibility / flexibility of scheduling supervision meetings
91. It has increased my ability to participate regularly in supervision. Remote supervision has greatly increase access for me personally and removed a dig barrier for me.
92. It has still been just as beneficial as when i did it in person.
93. It helps to access at times, but I feel there is more richness to in person supervision
94. It isn't a common practice to receive supervision this way. Mainly I have received it when one of us needed that as an option to stay in compliance. It is an extremely beneficial option when needed.
95. It was a little over two years ago. I completed 1 or two sessions over televideo. It was convenient and no different than in person.
96. It was a positive experience and it absolutely helped me access supervision.
97. It was a positive experience to meet by televideo. We are all busy and being able to adapt and meet in person and by televideo is important.
98. It was a positive experience. It provided flexibility when I couldn’t attend in person.
99. It was during 2020-2022 due to concerns related to covid and masking/social distance mandates for those facilities/environment
100. It was fine and allowed me to obtain clinical license.
101. It was helpful in maintaining consistency when weather/health would have prevented meeting.
102. It was just as helpful as in person
103. It was more convenient than meeting in person with work schedules, traffic ect
104. It was positive and helpful that I didn’t have to miss work to have to drive to her office
105. It was positive, and this is very beneficial for people who would otherwise have difficulty accessing supervision.

106. It was positive, but I did not continue it.
107. It was very helpful and instances when one of us was working out of state or temporarily attending a conference. This way I had no break in supervision and my supervisor was consistent
108. It was very positive and more easily accessible to receive supervision with telehealth as an option! I'm so grateful for the change.
109. It was very positive as this happened seldom but was effective
110. It's been positive and allowed for flexibility with the supervisor so that they can provide supervision as well as pursue their other endeavors, I.e. their own clients, etc. As a supervisee, it opens up more opportunities to gain supervision.
111. It's been positive and it helped to be remote
112. It's made it a lot easier to schedule appointments that work with my schedule and my supervisor's schedule.
113. Most of my supervision sessions are remote, and they have all been positive and effective. I am in Salina and my supervisor is in Wichita. She is quality and trustworthy, and I don't think I'd be able to find anyone like her in Salina. So, televideo has been crucial for my ability to access my supervisor!
114. Mostly helpful
115. Mostly positive (25 Responses)
116. Mostly positive - it has allowed me to access a great supervisor with a schedule similar to mine.
117. Mostly positive - it is convenient and takes away barriers of the time and resources required for a commute, and it does not take away from supervision quality. I did appreciate meeting in person every so often, but televideo was extremely helpful.
118. Mostly positive - the ability to receive supervision remotely has helped tremendously in accessing supervision. It has allowed continued supervision despite busy, conflicting schedules and when one of us has been out of town. It has also allowed for meetings when one of us has been ill or recently exposed to COVID-19 or other contagious viruses. At times there have been connectivity issues however I feel the benefits of receiving supervision remotely has far outweighed any positives.
119. Mostly positive - we're able to staff cases sufficiently via televideo.
120. Mostly positive allowing greater flexibility and access to supervisors, and limiting time commuting for supervision services (i.e. I can fit supervision between other appointments). Only negative is difficulty reviewing paperwork/documentation together is more difficult.
121. Mostly positive and allowed me to get more supervisions without worrying about transportation.
121. Mostly positive and allows meetings to happen with less stress.
122. Mostly positive and definitely made supervision more accessible and affordable
123. Mostly positive and extremely helpful in accessing supervisors
124. Mostly positive and has helped with accessing supervisor.
125. Mostly Positive and it has help with access
126. Mostly positive and it has made it easier to access supervision without giving up time for clients.
127. Mostly positive and made availability to di supervision easier as well.

128. Mostly positive and made supervision immensely more accessible.
129. Mostly positive and makes access easy and effective reducing time barriers
130. Mostly positive and remote access helped accessing supervisors
131. Mostly positive and yes, I would say it has helped me to access supervision i otherwise would either have to travel for or not receive.
132. Mostly positive as it opens up more opportunities to meet during busy schedule times.
133. mostly positive- has worked better with schedules and still being able to have the full supervision session
134. Mostly positive- more flexible, can still meet if ill, etc.
135. Mostly positive- Yes, in person is challenging at times with the daily demand of our jobs.
136. Mostly positive, absolutely helps with access and loss of time traveling to meet in person.
137. Mostly positive, allowed me to have supervisor in my clinical specialty even though we were ~1 hour apart. No difference in quality of interaction over video.
138. Mostly positive, allows me to speak with my clinical supervisor in real time while still at work.
139. Mostly positive, increased accessibility
140. Mostly positive, increased flexibility for many of my colleagues.
141. Mostly positive, it allowed for more group supervision and flexibility in scheduling time.
142. Mostly positive, it has ensured that my supervisor was more available and could easily fit supervision into both schedules, in addition it did not hinder the learning process
143. Mostly Positive, it has helped with accessing supervisors. I was able to interview for supervisors across state lines so my "pool" for potential supervisors was bigger. And it helps with my work schedule in that I don't have to take time out to travel to meet with my supervisor, I get to do it online and then get back to work.
144. Mostly positive, it has significantly helped me be able to reach my clinical license sooner.
145. Mostly positive, made seeking supervision more accessible
146. Mostly positive, more access to shared resources, and handouts in real time.
147. Mostly positive, my supervisor lived an hour away so being able to meet by televideo enabled us to continue to meet regularly even when weather was bad, or we had other scheduling conflicts.
148. Mostly positive, no concerns. Has helped tremendously with competing schedules.
149. "Mostly positive, no noticeable difference in format, really.
150. Yes, the ability to receive supervision remotely HAS helped with accessing supervisors!"
151. Mostly positive, same quality as in person.
152. Mostly positive, the level of supervision is equal to in person and allows for accessibility
153. Mostly positive, tremendously helped access regular consistent supervision
154. Mostly positive. Allowed some flexibility to meet needs.
155. Mostly positive. I think it has been much more convenient and probably allowed me to participate at a higher level than I might have otherwise. I probably would have missed more sessions and it would have taken longer.
156. Mostly positive. It has definitely helped with accessing supervisors.
157. Mostly positive. It was much more accessible and relevant.

158. mostly positive. Quality is dependent on the people not the format. Saves money and time in travel weekly. Time saved allows me to provide another hour seeing clients.
159. Mostly positive. Supervisors are not always available locally, however their insight, guidance, and knowledge do not require them to be in person to share.
160. Mostly positive. Without remote access to supervision, it would have been unavailable or significantly more expensive for me to receive. Without the remote option I am not sure it would have been an option. I would have either not pursued my license or chosen to practice in a more urban setting rather than the rural setting that I'm providing services in.
161. Mostly positive. Accessibility has been so helpful in managing two people's schedules.
162. Mostly positive. Allowed me to maintain more of a work life balance and my supervisor was more easily accessible given both of our schedules.
163. Mostly positive. I am able to access my supervisor more easily and group supervisions are made possible that would otherwise not be.
164. Mostly positive. I am the spouse of a military member; moving every couple of years is a given. Being able to access my supervisor remotely has taken a huge burden off my shoulders. Additionally, receiving supervision remotely has allowed me to maintain continuity while attaining the required supervision hours.
165. Mostly positive. I can still see my supervisor on the video and I feel my supervision both in person and virtually greatly impact my clinical skills for the better. There is not a difference in my opinion. I also would not always be available to leave my work building to get to supervision so the virtual option has made attaining my hours much more accessible.
166. Mostly positive. I have been receiving supervision in my current state of Arizona and attending online has helped me access services as I do not currently have an LMSW at my work site.
167. Mostly Positive. I prefer in-person engagement, but it allowed me to get my needed supervision times in in spite of both my supervisor and mines often hectic schedules.
168. Mostly positive. I recently relocated from Alaska to Kansas. There were no clinical supervisors where I lived due to the lack of resources in this remote village. If not for remote access, I would not have been able to have a clinical supervisor.
169. Mostly positive. I think meeting in person would have been much more difficult to accomplish.
170. Mostly positive. It allows flexibility and accommodates bad weather.
171. Mostly positive. It allows great flexibility for a profession that can be unpredictable and hard to get away to commute for supervision.
172. Mostly positive. It definitely made it easier to access my supervisor.
173. Mostly positive. It has allowed flexibility for both myself and my supervisor that would otherwise be impossible due to single mother status.
174. Mostly positive. It has allowed me more access to my clinical supervisor without sacrificing quality.
175. Mostly positive. It has allowed me to schedule clinical supervision more easily in my work schedule. I am unsure I would be able to schedule supervision at this time due to travel time/ scheduling conflicts otherwise without it.

176. Mostly positive. It has enhanced my ability to seek supervision from people outside of my organization and it has been more convenient.
177. Mostly positive. It has helped significantly.
178. Mostly positive. It helps to access supervision on a more flexible schedule.
179. Mostly positive. It made supervision more accessible.
180. Mostly positive. It makes supervision more assessable. Traveling to and from supervision takes 30 minutes in itself.
181. Mostly positive. It offers improved accessibility for travel and scheduling logistics, with more minimal interference to regular work / client hours before and after supervision. No notable drawbacks in communication or quality of supervision when done remotely. Allows for easy visual sharing of resources / information.
182. Mostly positive. It was more convenient. I feel it was just as effective as in-person.
183. Mostly positive. It was only done a couple of times, but it was a way to ensure supervision was completed. Televideo didn't take away from what was being discussed.
184. Mostly positive. It's really helped me access it with limited childcare support.
185. Mostly positive. It's been very helpful for me to stay in track and receive excellent supervision even through bad weather busy schedules.
186. Mostly positive. My supervisor has made extra effort to understand my practice, visiting my office and scheduling in-person time but it is primarily online. Remote supervision would be the only way I could received supervision. I live in a rural community and would have to travel at least 1 hour (round trip) to receive supervision. That would take 2 hours out of my work day every week and is far less reasonable for me to manage.
187. Mostly positive. Rarely but occasionally my supervisor is traveling for work, but we are still able to do supervision during the week due to the availability of televideo.
188. Mostly positive. Remotely helped tremendously with a busy lifestyle!
189. Mostly positive. Stays on-subject, more organized, better overall experience.
190. Mostly positive. Televideo has allowed me and my supervisor flexibility in our schedules to see one another. The commute to each other is lengthy so we can have supervision with greater ease.
191. Mostly positive. Television did not affect supervision access for me.
192. Mostly positive. The quality of the supervision does not seem to change when it's in person vs when it's by televideo. It has helped access supervision when one of us is ill/not in the office.
193. Mostly positive. There is a shortage in QUALITY supervisors and televideo is the only way to meet with my clinical supervisor.
194. Mostly positive. There is no change to the quality of supervision via video versus in person. The ability to receive supervision remotely helps immensely.
195. Mostly positive. This method has allowed for greater ease in meeting times and fitting clinical supervision sessions into a busy schedule.
196. Mostly positive. We were easily able to share education materials via the platform, and were able to avoid cancelling due to childcare issues, transportation concerns etc.
197. Mostly positive. With the pandemic I would have had to pause on obtaining my clinical hours for my LSCSW.
198. Mostly positive. Yes, has helped with access.

199. Mostly positive. Yes, having the ability to receive supervision remotely has helped with accessing supervisors.
200. Mostly positive. Yes, it's helped with the flexibility.
201. Mostly positive. Yes, because it is more convenient and there is no travel involved.
202. Mostly positive. Yes, it has allowed continuity of supervision.
203. Mostly positive. Yes, remote access helped provide me with access to a supervisor without having to spend additional time outside of work commuting to receive in-person supervision.
204. Mostly positive. Yes, the ability to receive supervision remotely has helped with accessing supervisors. When I initially started seeking supervision, finding one locally was challenging, however I was able to obtain a supervisor clinically licensed here in Kansas but residing in another. In that we are able to do our supervision remotely. Which is greatly appreciated!
205. Mostly positive. Yes. I live in Lenexa Ks and my supervisor is in Independence MO.
206. Mostly positive. Yes. Remote supervision allowed me to do my job more efficiently by only requiring one hour for supervision rather than requiring me to drive both ways to access it. Remote supervision also allowed me access to a broader skill set than only what was available through employment.
207. Mostly Positive. Yes, has helped with access, and was able to find clinical supervisor with similar professional interest outside of current working relationships, which helps with professional growth.
208. Mostly positive; increase accessibility to supervision has helped rural populations receive adequate and quality supervision
209. Mostly positive; it has made supervision more accessible and easier with a busier schedule
210. mostly positive; more accessible, more flexible, better for expenses/mental health
211. Mostly positive; remote availability of clinical supervision has been helpful (only use this media when unavoidable)
212. Mostly Positive; yes. There are times when my clinical supervisor is not able to be at my worksite or meet face to face, and it helps us to be able to meet and discuss things just as we would in person.
213. Mostly positive; Yes, this has helped in maximizing the amount of time for a supervision session (allowing the supervisor and supervisee to jump in right away, versus get situated when meeting at a secure location).
214. Mostly positive-it made supervision convenient and easy to fit in during my work day.
215. Mostly supportive
216. Much easier to access supervisors!
217. My clinical supervision conducted remotely has been immensely helpful and extremely convenient, given that we are able to connect remotely. If we had to meet in person, this would become a barrier to receiving clinical supervision and furthering my career.
218. "My clinical supervision has been a combination of televideo and in-person. The quality of my tele-supervision has been very positive. Having televideo as an available option improved both accessibility and flexibility (ex. weather)."
219. My experience has been mostly positive. And because of the lack of supervisors in my city of residence, it has definitely made accessing a supervisor much more attainable.

220. My experience has been positive with both in-person and the few televideo supervision sessions.
221. My experience has been very positive. It has allowed us more flexibility which allows my supervisor to be more available.
222. My experience with receiving supervision by televideo has been mostly positive. I ability to receive supervision remotely has helped immensely with accessing supervisors. I had a bigger pool of supervisors to choose from than I would have had if only in-person supervision was allowed.
223. My experience with televideo clinical-level supervision has been mostly positive. The ability to receive this service remotely has allowed me to serve more clients throughout multiple counties. I have been able to receive supervision from multiple people within my specific practice of clinical work, which I would not be able to attain in person.
224. My experience with televideo supervision has been a good one. My supervisor holds licenses in 3 states and lives primarily in another state. There are few LCSW's available in my area. Without the ability to complete televideo supervision I don't know that I would have been able to work toward my clinical license.
225. My supervision quality has not been impacted by virtual sessions. The most significant impact for me has been that my supervision time frame would be extended by 6 months to a year if I did not have that option. So I highly favor the virtual option.
226. My supervisor has been wonderful through remote
227. N/A (not currently under supervision, but I do feel like it would have been helpful during my supervision)
228. N/A I have become used to telehealth/televideo as an educator, trainer, therapist, manager working with staff 100% remote.
229. negatively effected
230. Neutral
231. No I don't believe it has been negatively impacted as we do not always rely on televideo, only hybrid.
232. No it worked well for me
233. No negative impact from remote supervision and yes, it's a huge help with accessing supervisors.
234. Not at all positive, I felt like my clinical supervision failed to provide any content of value. No oversight over the televideo option allows clinical supervisors to do little to no preparation for supervision.
235. Not provided
236. Oh yes, very much so! It makes it easier accessible to supervisees! It's an added bonus when hiring staff.
237. Personally, televideo was more favorable for me given my hectic schedule. I could jump on a Teams call rather than having to drive somewhere else. Also, depending on the day, there were immediate needs that I couldn't avoid, and it made moving supervision to a later time or different date a lot easier. It wouldn't have worked sometimes if my supervision was in-person because the person would have already been at the meeting site. My supervisor works within the same company as me, but we work at two different locations so televideo was more beneficial for us.

238. Positive (21 Responses)
239. Positive - and yes, it has helped with access as it requires less time away from patient care for both supervisor and supervisee.
240. Positive yes it has helped to access supervisors
241. positive (I am referring to ongoing supervision not for the level of obtaining licensure); it still feels effective despite some challenges like for sharing handouts.
242. Positive. Helps with supervision in a rural area.
243. Positive and accessible
244. Positive and has been a great asset! I was able to find a great supervisor who via telehealth
245. Positive and has helped with access
246. Positive and helped with accessing my supervisor. She was unable to leave her home due to a fall but it did not prevent us from meeting and the quality of supervision felt the same.
247. Positive and increased availability of both myself and the supervisor to receive adequate supervision time.
248. Positive and very helpful in accommodating my unusual schedule.
249. Positive and very helpful!
250. Positive and yes it has helped to access my supervisor
251. Positive and yes, helped with accessibility especially during the pandemic
252. Positive because having an option for more supervisors in rural areas is great.
253. Positive due to the amount of time and accessibility for both me and my supervisor. I appreciate the flexibility.
254. Positive experience and was helpful to have the flexibility during work schedules.
255. Positive experience w/ televideo, and yes, it is helpful to access my supervisor much more easily.
256. Positive experience with additional in-person training
257. Positive experience. As someone who lived in MO during my clinical supervision, the televideo option made it possible to have supervision with a well-known and highly regarded supervisor who was over an hour from my home.
258. positive experience. helps with time management and was able to stay with someone i trusted when i moved cities for work.
259. Positive if there is an agenda and talking points
260. Positive in being able to access supervisors.
261. Positive--- in person is preferable
262. Positive it has helped me get the correct amount and not have to have travel time
263. Positive. Yes, I wouldn’t be able to receive clinical supervision with my agency without the remote option.
264. Positive, and yes the convenience and flexibility was important
265. Positive, and yes the time spent I feel is focused and can be convenient
266. Positive, as a school social worker sometimes I am unable to leave the building. This has made it possible to still access my supervision.
267. Positive, definitely helps with locating a supervisor.
268. Positive, has increased access to supervisor, especially during inclement weather

269. Positive, it has allowed for increased flexibility and more consistent supervision meetings. It also facilitates real time review of tools, resources and information to better inform our discussion.
270. Positive, it helped to meet the needs of both of our schedules and I still got quality supervision.
271. Positive, saves drive time and allows me more flexibility
272. Positive, when combined also with in-person supervision also provided on a regular basis.
273. Positive, yes in terms of access
274. Positive (2 Responses)
275. Positive. I live in a rural area and access to meet for clinical supervision would be challenging for in person. We do a combination of remote and in person and I don't feel any negative impact of the remote access.
276. positive. No challenges whatsoever.
277. Positive. Accessible and convenient
278. Positive. All of my clinical supervision was in person, however I have been working on EMDR certification and that has been remote and has been amazing.
279. Positive. Having access to televideo has improved access to my supervisor!
280. Positive. Helped with limiting travel and reducing time conflicts.
281. Positive. Helps access supervisors, more flexibility in scheduling with high caseloads, etc.
282. Positive. I believe access to televideo supervision is beneficial in helping with access to supervisors.
283. Positive. I believe this allows for both supervisor and supervised to reduce travel time and have more time in their day.
284. Positive. I was able to both in person and televideo. It does offer access for areas limited
285. Positive. It allowed me to continue supervision when complicated circumstances arose such as childcare, illness and highly urgent issues.
286. Positive. It depends on quality of the supervisor, as well as level of commitment by both parties.
287. Positive. It gives me better availability to meet with my supervisor
288. Positive. It has had no impact on the supervision I have received.
289. Positive. It has made it more accessible due to scheduling and conflicts or illness.
290. Positive. It provides much more flexibility, coordination of schedules, and helps to connect supervisors with supervisees who are not local to one another or within the same agency.
291. Positive. It was more conducive to my schedule.
292. Positive. It was only one time while my supervisor was sick.
293. Positive. It's the primary thing that made it possible
294. Positive. Televideo makes connections possible with far less barriers.
295. Positive. This has helped my ability to access clinical supervision.
296. Positive. We were able to screen share and review documents with ease. It was very professional and productive.
297. Positive. Yes I was able to have a supervisor across the state the offered great advise and help and wouldn't of got that if I wasn't able to get if I wasn't allowed telehealth
298. Positive. Yes, it helps.

299. Positive; Allowed for flexibility in adhering to supervision requirements during periods of unpredictability.
300. Positive; helped
301. Positive; yes
302. Positively
303. Positively influenced by removing barriers to in-person attendance and coordination
304. Positives it's not my preference but has been nice to have an alternative when needed for things like scheduling changes or inclement weather.
305. Primarily positive. It certainly helps accessing supervisors, even within my own organization due to how spread out the organization is.
306. Quality has been positive. Ability to receive supervision via televideo has been beneficial and increases time available to provide direct services to individuals (reduction in drive time = more time with clients)
307. Receiving clinical supervision via televideo has been very helpful, it provides with me flexibility to meet with my clinical supervisor as often as needed and allows for concerns to be addressed more promptly as I do not have to drive to meet with her.
308. Remote access to my clinical supervisor has been paramount, as we live three hours away from one another. I believe that my clinical supervision with this individual has been extremely positive. I have had other supervisors in the past (in person) that have not worked out as well for me. So, allowing remote/televideo clinical supervision has helped me access the RIGHT supervisor.
309. Remote clinical supervision was extremely positive. It allowed flexibility and less costly overall.
310. Remote is sufficient for supervision. More time and access to meet with supervisors due to everyone's busy schedules.
311. Remote supervision as a back up to in person has been a great option and mostly positive
312. Remote supervision has been 100% a positive experience. It provides me more access to my supervisor when needed and more times available to meet because I don't have to go to an actual building/location to meet/commute times.
313. Remote supervision has been very positive and an important way to help get weekly supervision in
314. Remote supervision was no different than in person; in regard to quality. The accessibility of a remote option was very helpful in certain situations (ex. Supervisor or myself was sick).
315. Remote, I believe is a great option for various reasons rather transportation, Weather, accessibility. I personally am able to obtain positive experiences through this form and believe it is helpful overall.
316. Supervision is typically conducted in-person and was only moved to be virtual on 2 occasions when one of us was sick. It didn't impact the quality of supervision and did help with accessibility.
317. Supervision provided via televideo was a completely positive experience. I was able to get supervision from someone who specialized in the area of expertise I am most interested in. It allowed me to spend less time commuting and more time on focusing what was important.

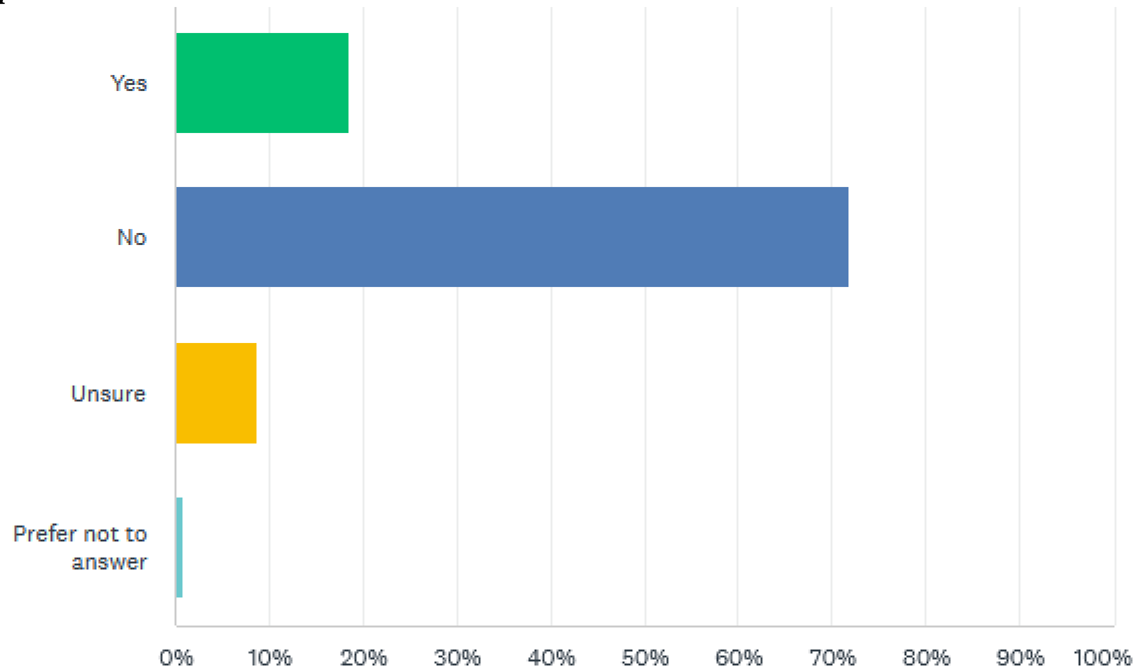
318. Supervision via telehealth has been positive. I prefer in person supervision, but it has been really great to have the option in inclement weather, if not feeling well, etc.
319. Televideo and virtual modalities are not the same quality as in-person. It is almost absurd to dispute that point.
320. Televideo has been very helpful. I encourage we continue to all for this option. It opens the door to qualified supervision by opening the door to supervision options.
321. Televideo has made supervision more accessible because my supervisor is in a different county, however I would say the quality of supervision over televideo is mostly negative because I can see my supervisor scrolling Facebook in her glasses.
322. Televideo supervision allowed me and my clinical supervisor to review the clinical record at the same time while remaining face to face on video. For social workers in a rural area, allowing televideo increases the quality of supervision, as it would be more difficult to have a supervisor without a dual relationship or other conflict of interest in a small community.
323. Televideo supervision has allowed for group supervision. With this, I have been able to learn from other supervisees and guidance from our supervisor that I would not obtain due to schedule conflicts for in person supervision. Televideo supervision has been highly beneficial.
324. Televideo supervision has been positive. It increases access to supervisors as we work in multiple locations and have different schedules.
325. Televideo supervision is a positive change that helps people access needed supervision. It does not have any negative impact on supervision quality.
326. Televideo supervision was efficient and positive. It allowed for more efficient use of my time by not having to travel to my supervisor’s office. I was able to find a supervisor that was in my interest area with greater ease because of televideo.
327. The ability to do televideo supervision has been helpful if weather or other factors deter me from attending in person. The quality of the televideo supervision is hit and miss but that is more so on the supervisor than on any other factors.
328. The ability to have supervision over televideo was a positive experience. My supervisor was not always in my local area, so the ability to do supervision remotely was important. Also, the ability to have remote supervision allows the opportunity for those in rural areas to have the opportunity to have supervision.
329. The ability to move supervision in person to televideo as need arises has given me to opportunity to continue gaining supervision and see as many clients as possible.
330. The ability to use remote options for supervision was very important to me for accessing clinical supervision during and after the pandemic. I feel the quality was similar to in person supervision and at times better. It was easier to share materials and discuss using screen share and this allowed for me to gather more resources and tools.
331. The quality of my supervision has been positive.
332. "The quality of televideo supervision is overall positive.
333. Televideo supervision is not of as high quality as is in-person supervision.
334. Receiving supervision remotely does help in accessing supervision (self-explanatory, such as in context of physical illness sxs or transportation or other logistical challenges)."
335. The remote option has been positive. It has allowed me to pick supervisors that are in alignment with my population and therapeutic approaches.

336. There have been no supervisors available to me, in person or not.
337. There were only a couple of times that we had to do supervision remotely. It did not affect the quality of supervision. Mainly my supervision is in person.
338. This allowed more options for supervisors.
339. This has allowed me to meet with supervisors who are not only LSCWS, but also RPTS and helped me in both learning more about my clinical skills, as well as my play therapy skills at the same time.
340. This has been a mostly positive experience. I have been able to meet with my supervisor more regularly and it has helped in scheduling around their and my other meetings/appointments.
341. This has been a positive change to increase accessibility, ensure clinical oversight, and improve client care.
342. This has been a positive experience
343. This has been all positive. It helps with scheduling.
344. This has been essential!!
345. This has only been positive. I was living in a rural area and could receive supervision from my supervisor who lived in an urban setting. It also allowed for greater time flexibility. Lastly, I was able to have more options for supervisors.
346. This is not about this question per se, but there was nowhere to put additional comments…but I wanted to bring up the LSCSW exam. I took it and missed by 1 point. It was so stressful, and my mental health suffered from the anxiety. I have been a sw for over 23 years and have passed both the LBSW and LMSW exams. Would BSRB be willing to consider taking a second look at sw's that missed by such a small margin on the exam? It's 1 point, but I cannot take it again due to the stress.
347. This type of supervision allows the Social Worker to be matched with specialists and people who match their clinical need. I believe this is highly beneficial.
348. Though I prefer in-person because I would always rather meet with someone in person vs online in any situation, I did find tele-supervision to be as effective as in-person supervision.
349. Very positive (3 Responses)
350. Very positive and allowed for some flexibility considering how much I have to work to afford paying for my own clinical supervision.
351. Very positive and beneficial
352. Very positive and realistic as traveling to and from takes away from my daily duties.
353. Very positive and very thankful for the opportunity to be able to do that!
354. Very positive because of my strong bond with the individual. The tele aspect did not diminish.
355. Very positive, it's easier to fit into my schedule when completed over televideo.
356. Very positive. It allowed more freedom and time for my supervisor and I when arranging our appointment times.
357. Very positive. Virtual supervision has allowed us to meet when weather is bad, children are sick, etc. I find value in both in person and virtual supervision. I tend to be more open on virtual sessions.
358. Yes (11 Responses)
359. Yes especially with scheduling conflicts

360. Yes- I feel with technology televideo supervision is no different than in person supervision
361. Yes, I felt my supervisor and meetings were high quality and fine
362. Yes, I have never felt like there was an issue with televideo supervision. My supervisor handled it very effectively.
363. Yes, I have received positive results. It has allowed me to save gas going out of town as well as remain available for my clients. I've also had some car trouble which would have otherwise made traveling for supervision very difficult as well as more expensive due to gas reasons.
364. Yes it has all been positive no downside at all.
365. Yes it has helped when my supervisor was busy and it would have resulted in a cancelled session otherwise.
366. Yes, it is helpful to have multiple options
367. Yes it was a positive experience and helped to make supervision more accessible.
368. Yes it was mostly positive, being able to meet for supervision by televideo was very helpful for access, it increased the times available for us to schedule and meet, cut down on travel time and expense, and seemed very beneficial to have as an option for both supervisor and supervisee!
369. Yes, it's been mostly positive. It's allowed for ability to keep supervision appointments when other weather, scheduling, or transportation issues they have gotten in the way otherwise.
370. Yes more convenient and just as helpful
371. Yes more flexibility
372. Yes most of my supervision was remote and good quality and It significantly reduced what would have been barriers for in person supervision.
373. Yes mostly positive
374. Yes remote is conducive to work schedule
375. Yes this has helped immensely in accessing quality supervision.
376. Yes! It removes barriers and allows the supervision to continue when life brings challenges.
377. Yes! It was easily accessible & I could see resources quickly. I was providing a lot of Telehealth & supervision in the way was helpful to be able to model & transfer skills practiced.
378. Yes! My clinical supervisor was always available and supportive.
379. Yes! Perfect all the way around for flexibility with schedules.
380. Yes! This has been so helpful, as when someone is sick or traveling, meeting can still occur.
381. Yes, all positive. Accessibility has been positively affected as well.
382. Yes, definitely positive. Remote supervision allowed me to continue my clinical supervision during the pandemic when it was necessary if I was sick, my children were sick, or my supervisor was sick. Without it, I'm not sure if I would've been able to complete the clinical licensing process.
383. Yes, I loved my video supervision. It was great to add it into my workday instead of taking off time to drive and meet someone. It was very high quality.
384. Yes, I'm blessed with the best without this it would Not be possible
385. yes, it has been positive and necessary in my circumstances given some life events with family health issues making office visits difficult.
386. Yes, it has been very positive.
387. Yes, it has made supervision attainable and should remain an option.

388. Yes, it was quality supervision that was received.
389. Yes, there are times my clinical supervisor is working at a different location than me so it is very convenient to do televideo instead.
390. Yes, when I was working in a rural area, access via televideo saved me multiple hours of drive time and helped me to maximize my patient/client contact.
391. Yes. Makes it much easier to receive supervision when both are busy professionals who sometimes don't have time to be in the same space.
392. Yes. I believe being remote added so much flexibility and removed a lot of barriers. My supervisor experience was mostly positive.
393. Yes. It was a positive experience and helps with access.
394. Yes. My supervisor would not be able to meet every week in person only.
395. Yes. Super helpful to have the option of virtual. Saves time.

Question 14**. Kansas currently requires 40 hours of continuing education every two-year license period for each level of permanent social work license.* ***Do you believe lowering the required number of hours from 40 hours to 30 hours would negatively affect professionalism and safe practice?



ANSWER CHOICES	RESPONSES	
Yes	18.62%	483
No	71.78%	1,862
Unsure	8.71%	226
Prefer not to answer	0.89%	23
TOTAL		**2,594**

Additional Comments

The Behavioral Sciences Regulatory Board thanks all social works who completed the 2024 Survey of Social Workers. In addition to the feedback that was provided through the survey, a handful of individuals sent messages to the BSRB with additional comments, so those comments have been summarized below:

- One individual stated they loved this approach;
- One individual noted they had been licensed as a bachelor's level social worker for several decades and expressed discouragement with the lack of jobs available for social workers at the bachelors and master's levels of licensure. This individual expressed a request for a way be able to advance to a higher level of license based on years of practice, noting that it would not be feasible to return to school and incur student loans;
- One individual asked if it would be permitted to share information for the survey on a social media group site (*note*: the BSRB informed this individual that it would be appropriate to share news about the survey, but not to share the individual message, as that was sent to his personal e-mail with a specific link for him to take the survey.);
- Two individuals noted being unable to receive the survey (*note*: the BSRB followed up with both individuals and offered to work with these individuals to obtain their responses. One individual agreed and the results from this individual were entered manually into the survey results and are reflected in the combined report. Several other e-mail "bounce-back" notices were received by the agency, so the BSRB followed up to update contact information and to send the survey to individuals who did not receive it originally.)
- One individual noted difficulty answering the demographic question on the survey, as he holds two different employment positions, and one job involves work in an urban setting while another job involves work throughout the entire state;
- One individual expressed concern that the survey questions may be written in a misleading way and noted that they might have answered some questions differently if they did not read the questions closely. This individual also expressed concerns with being asked to provide feedback on topics, such as a proposed multi-state compact, without more details being made clear, such as whether a person would need to pay a fee for a multi-state license if someone is already licensed in Kansas;
- One individual stated interest in learning the outcomes from the survey, specifically concerning the question on a potential decrease in continuing education hours. This individual expressed support for decreasing the required hours from 40 hours to 30 hours and noted that workshops can be costly, given social worker salaries. (*Note*: the BSRB informed this individual that the survey responses would be included in a report and a link to the report would be sent to all social workers when the report was available.); and
- One individual expressed concern regarding a possible decrease in professional standards, such as discontinuing a national examination and lowering continuing education hours from 40 hours to 30 hours. This individual noted the social work community should be working to strengthen professional standards to better serve clients, given the need for ethics, advanced critical thinking, and communication skills.