

# **Behavioral Sciences Regulatory Board**

## **Survey of Social Workers**

**July 2025**

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## ***Introduction***

This report is part of a series of reports studying survey results in the spring and summer of 2025 from individuals holding a permanent license under the Kansas Behavioral Sciences Regulatory Board (BSRB). In Kansas, the BSRB is the state agency charged to license and regulate most of the state's mental health professionals, including addiction counseling. As of February 2025, Kansas offers four levels of permanent licensure for the social work profession: (1) an associate level of license called the Licensed Associate Social Work (LASW) license; (2) a level of license for bachelor's educated professionals called Licensed Bachelor's Social Work (LBSW) license; (2) a level of license for master's educated professionals called a Licensed Master's Social Worker (LMSW) license; and (3) a level of license for individuals able to practice independently called the Licensed Specialist Clinical Social Work (LSCSW) license. LASWs, LBSWs, and LMSWs and LACs must practice under supervision. To assist the work of the Board, the BSRB utilizes seven subcommittees, called "Advisory Committees," which are comprised of the Board member for the profession (serving as Chair), a public Board member, and between three and ten other individuals, usually licensees in that profession.

In 2025, members of the Social Work Advisory Committee for the BSRB requested the creation of a survey of licensees in their profession. The purpose of the survey was to collect information relevant to the public protection mission of the Board, seek feedback on topics relevant to the work of the Advisory Committee, and to better understand the social work workforce in Kansas. The members of the Advisory Committee worked with the Executive Director of the BSRB to draft potential questions for a survey, while BSRB Advisory Committees for other professions developed similar questions for surveys for licensees in their professions. While the final survey included a few unique questions per profession, efforts were made to create uniformity for most topics between the professions, so both a profession-specific report and an overall summary report comparing professions could be created.

As of July 2025, the total number of licensees in the social work profession in Kansas totaled 8,624, including practitioners with a LASW license (4); LBSW license (1,126); LMSW license (4,151), and LSCSW license (3,343). From June 17, 2025, to July 21, 2025, all LBSWs, LMSWs, and LSCSWs under the BSRB received an e-mail from the agency informing them about the optional survey and notifying them to expect an invitation sent directly from SurveyMonkey with a link to complete an optional survey from the BSRB. While the survey was optional, licensees were encouraged to complete the survey. Adjustments were made to the SurveyMonkey system to ensure responses remained anonymous; however a series of targeted reminders (about one per week) were sent to licensees who had not yet completed the survey. (*Note: as there were 4 LASWs at the time of this survey, there were concern that there may not be a way to preserve confidentiality in the analysis of the responses for this small group, so they were not sent the survey invitation.*)

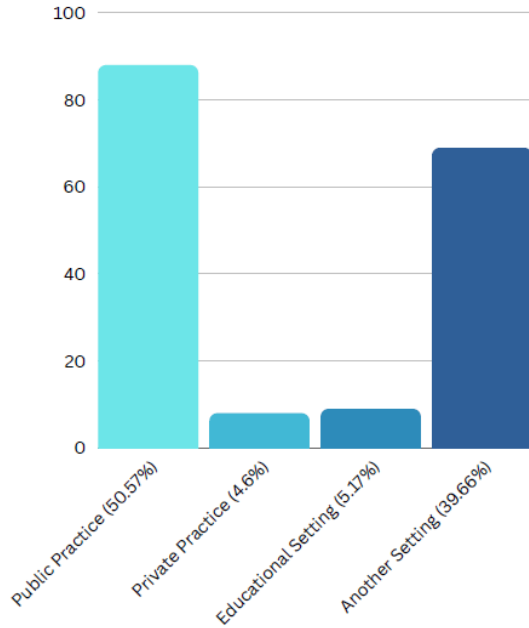
Over the 31 days that the survey was open for responses, 2,000 social workers completed the survey, for an overall response rate of 23.2 percent. For the LBSW level of license, 174 individuals completed the survey, for a response rate of 15.5 percent; for the LMSW level of license, 862 individuals completed the survey, for a response rate of 20.1 percent; and for the LSCSW level of license, 964 individuals completed the survey, for a response rate of 28.8 percent.

*Note:* While summary information on the results of the 2025 survey is included on the following pages, specific language from open-answer responses is found in the appendices that follow the summary information. Identical responses were grouped, edits were made for spelling and grammar, and slight edits were made to preserve confidentiality, but otherwise language in this report reflects responses as they were provided in the survey.

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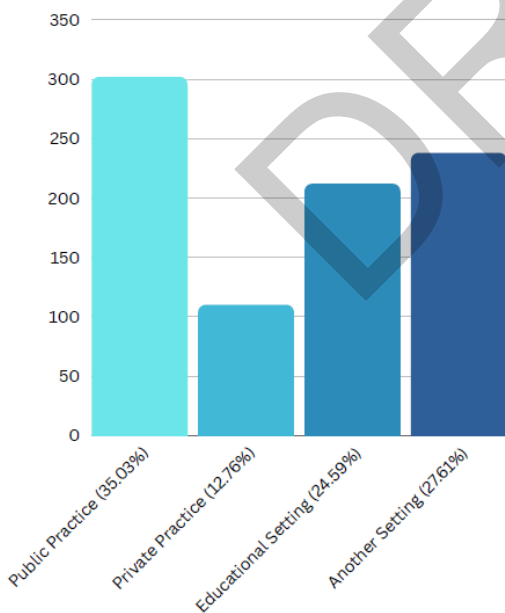
**Question 1 (LBSWs, LMSWs, and LSCSWs). Do you primarily work in public practice, private practice, an educational setting, or another setting?**

**LBSW Responses**



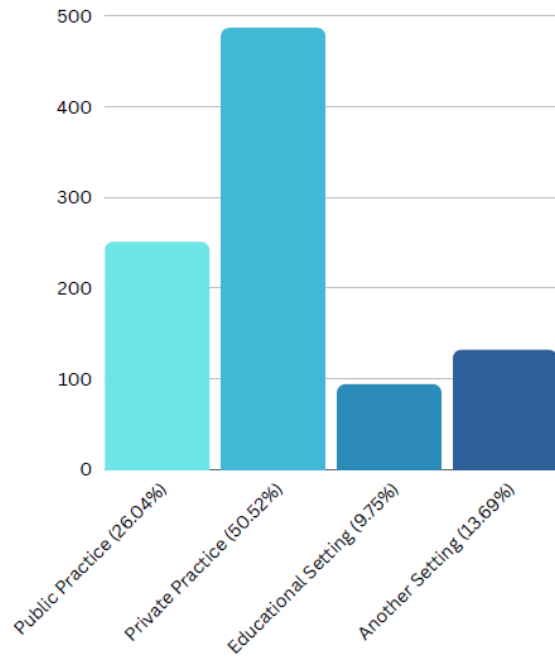
Of the 174 LBSWs that answered question 1, 88 reported working in public practice (50.7%) 69 reported working in “another setting” (39.7%). All other responses were less than 6%.

**LMSW Responses**



Of the 862 LMSWs that answered question 1, 302 reported working in public practice (35.0%); followed by 238 individuals working in “another setting” (27.6%); then 212 individuals working in an educational setting (24.6%); and 110 individuals working in private practice (12.8%).

### LSCSW Responses

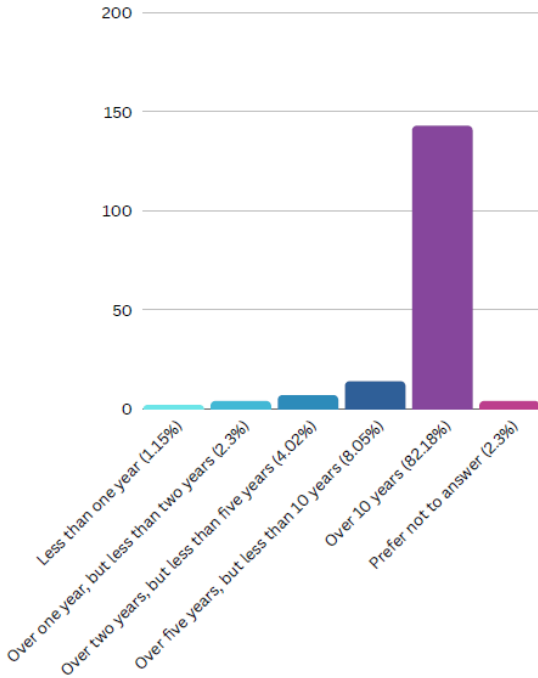


Of the 964 LSCSWs that answered question 1, the largest number of respondents, 487, reported working in private practice (50.5%); followed by 251 individuals working in public practice (26.0%); then 132 individuals reported working in “another setting” (13.7%); followed by 94 individuals working in an education setting (9.8%).

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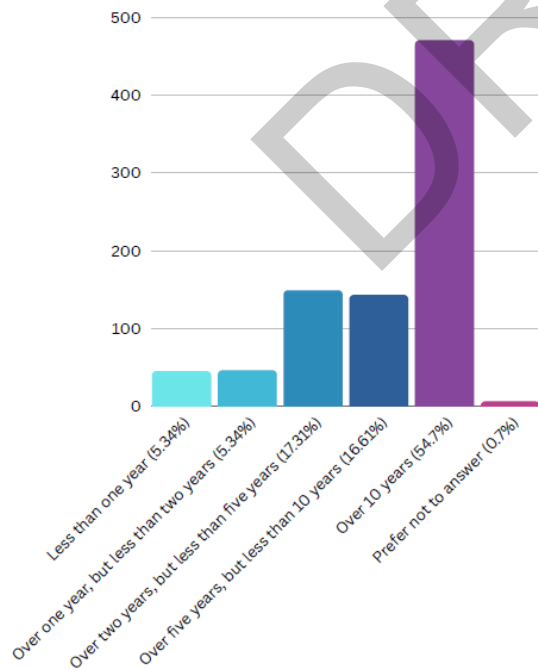
**Question 2 (LBSWs, LMSWs, and LSCSWs). How many years have you practiced as a social worker (between Kansas and other states)?**

**LBSW Responses**



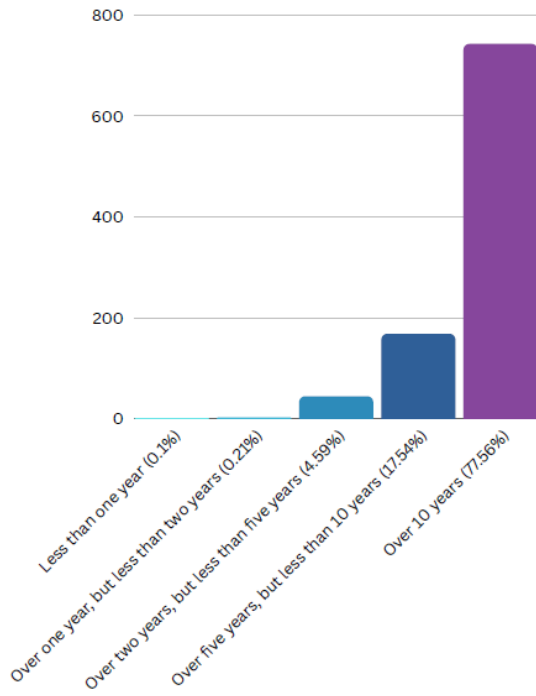
Of the 174 LBSWs that answered question 2, 143 individuals reported practicing over 10 years (82.2%); and 14 individuals reported practicing over five years, but less than 10 years (8.1%). All other responses were less than 5%.

**LMSW Responses**



Of the 861 LMSWs that answered question 2, 471 individuals reported practicing over 10 years (54.7%); followed by 149 individuals practicing over two years, but less than five years (17.3%); then 143 individuals practicing over five years, but less than 10 years (16.6%). All other responses were less than 6%.

### LSCSW Responses



Of the 958 LSCSWs that answered question 2, the largest number of respondents, 743, reported practicing over 10 years (77.6%); followed by 168 individuals practicing over five years, but less than 10 years (17.5%). All other responses were less than 5%.

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***Question 3 (LBSWs, LMSWs, and LCSWs). Do you maintain an active license, but no longer work as a social worker? If so, please explain why you are not providing services currently.***

### **LBSW Responses**

One hundred and seven LBSWs answered this question, identifying reasons why individuals might maintain an active license but not provide services. (Responses for all licensees can be found in Appendix #1 on page #).

65 respondents indicated that this did not apply to them. Of those who it did apply to, the most frequently reported reason why was because it is not required for their current job (27 responses). While less frequently reported, other reasons included licensees:

- Being retired (seven responses)
- Liking to stay up to date on continuing education (four responses)
- Have a different license that they practice under (three responses)
- Moved out of state (two responses)
- Believing that the pay in the social work field is too low (two responses)

### **LMSW Responses**

Five hundred and fifty-four LMSWs answered this question, providing insight into why individuals might maintain an active license without providing services. (Responses for all licensees can be found in Appendix #2 on page #).

This question did not apply to 424 respondents. Of those who it did apply to, the most frequently reported reason why was because it was not required for their current job (56 responses). Commonly reported jobs included education (14 responses), administration (seven responses), Director of an organization (four responses), school counseling (three responses), CEO of a company (two responses), federal government employee (two responses), and working with policy (two responses).

The second most frequently reported reason for maintaining an active license but no longer working as a social worker was due to individuals being retired (21 responses). While less commonly reported, other reasons included:

- Family responsibilities (seven responses)
- Pay in the social work field is too low (seven responses)
- Medical/health reasons (six responses)
- Burnout (three responses)
- The job became too stressful (three responses)
- Live out of state (two responses)
- Provide training to social workers (two responses)
- Provide supervision (two responses)

## **LSCSW Responses**

Five hundred and ten LSCSWs answered this question, providing insight into reasons why licensees might maintain an active license but not provide services. (Responses for all licensees can be found in Appendix #3 on **page #**).

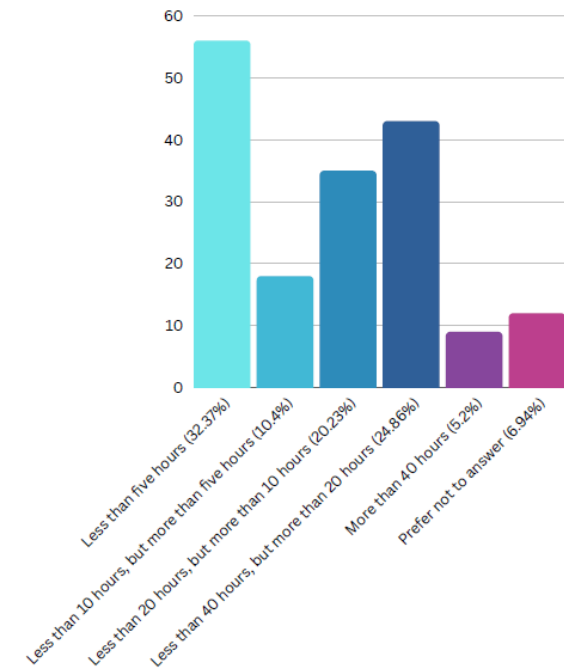
One hundred and forty-one respondents indicated that this situation did not apply to them. The most frequently reported reason (twenty-four responses) is due to providing services not being required for one's current job or that they only offer supervision. One of these respondents did, however, note that they plan to start providing services again soon

While less frequently identified as the reason above, other licensees noted that they maintain an but are considering retiring soon. Other respondents indicated that they are currently retired or a stay-at-home parent.

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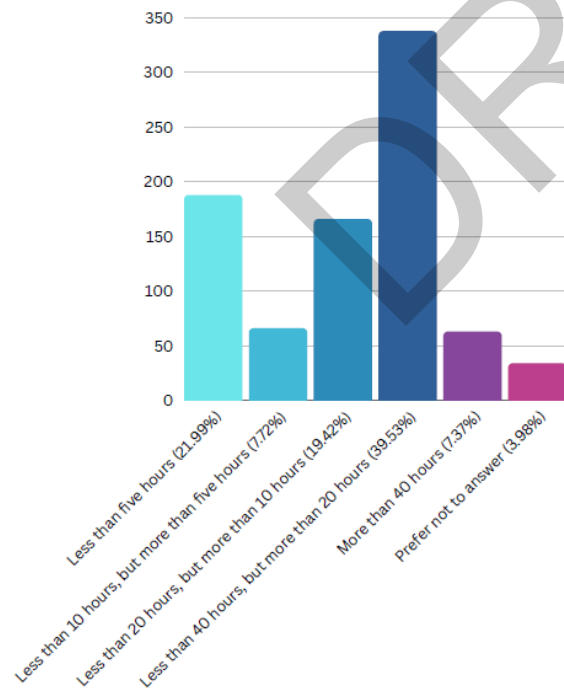
**Question 4 (LBSWs, LMSWs, and LCSWs). In a typical week, how many hours do you provide in-person services to clients?**

**LBSW Responses**



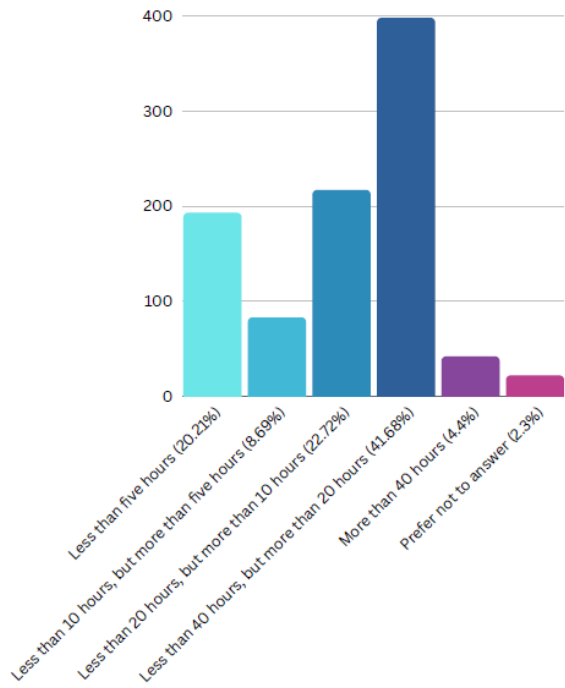
Of the 173 LBSWs who answered question 4, the most common response was from 56 individuals who provided less than five hours per week (32.4%); followed by 43 individuals providing less than 40 hours, but more than 20 hours (24.9%); then 35 individuals providing less than 20 hours, but more than 10 hours (20.2%); and 18 individuals providing less than 10 hours, but more than five hours (10.4%). All other responses were less than 7% each.

**LMSW Responses**



Of the 855 LMSWs who answered question 4, the most common response was from 338 individuals who provided less than 40 hours, but more than 20 hours per week (39.5%); followed by 188 individuals providing fewer than five hours per week (22.0%); then 166 individuals providing less than 20 hours, but more than 10 hours (19.4%). All other responses were less than 8% each.

## LSCSW Responses

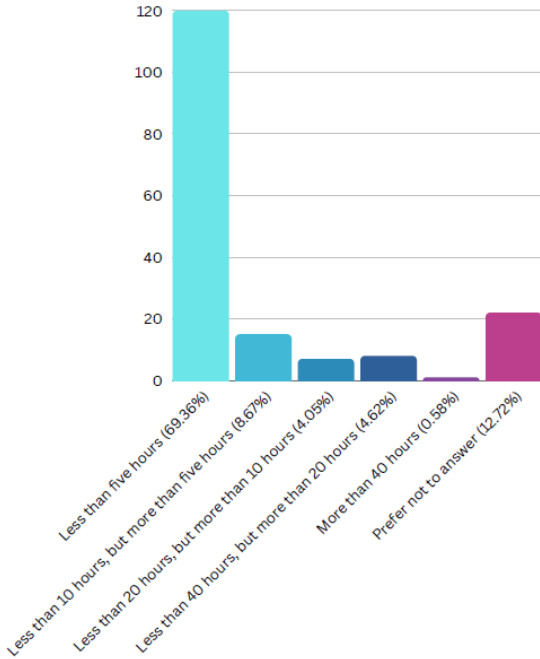


Of the 955 LSCSWs who answered question 4, the most common response was from 398 individuals providing less than 40 hours, but more than 20 hours per week (41.7%); followed by 217 respondents providing fewer than twenty hours, but more than 10 hours (22.7%); then 193 individuals providing less than five hours per week (20.2%). All other responses were less than 9%.

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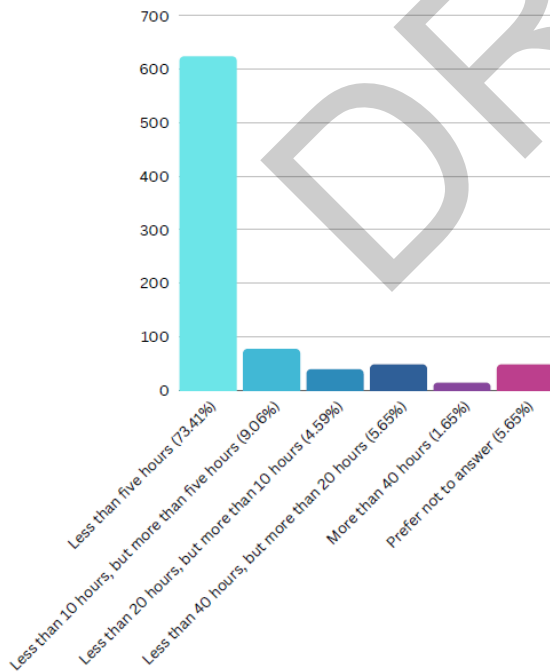
**Question 5. In a typical week, how many hours do you provide telehealth/remote services to clients?**

**LBSW Responses**



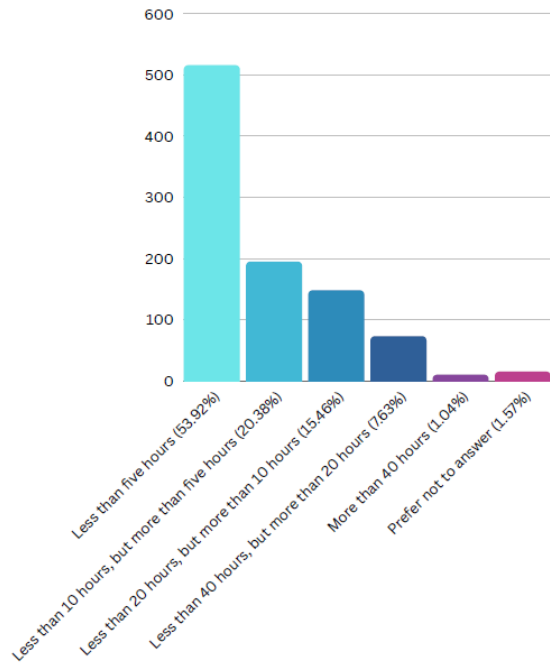
Of the 173 LBSWs who answered question 5, the most frequent response, 120, was from individuals providing less than five hours of remote services per week (69.4%); then 22 individuals preferred not to answer (12.7%). All other responses were under 9%.

**LMSW Responses**



Of the 850 LMSWs who answered question, the most popular response was 624 individuals providing fewer than five hours of remote services per week (73.4%); followed by 77 individuals providing between five to 10 hours of remote services per week (9.1%). All other responses were less than 6%.

## LSCSW Responses



Of the 957 LSCSWs who answered question 5, the most popular response was 516 individuals providing less than five hours of remote services per week (53.9%); then 195 individuals providing between five to 10 hours of remote services per week (20.4%); and 148 individuals providing less than 20 hours, but more than 10 hours per week (15.5%). All other responses were less than 8%.

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***Question 6 (LBSW). Are you currently working towards attaining a Licensed Master’s Social Work (LMSW) license in Kansas? / (LMSW) Are you currently working towards attaining a Licensed Specialist Clinical Social Work (LSCSW) license in Kansas? If you are not taking steps to receive such license, please explain why you made that decision.***

### **LBSW Responses**

One hundred and fifty-five LBSWs answered this question. (Responses for all licensees can be found in Appendix #4 on page #).

11 respondents indicated that they are actively working towards attaining an LMSW license. Four of those 11 noted that failing to pass the licensing examination is keeping them from getting the license. Six individuals indicated that they may be open to pursuing LMSW licensure in the future but are not currently.

The most frequently reported reason for not pursuing LMSW licensure concerned schooling. Specifically, it was reported that the required education and other associated licensure fees are too expensive (34 responses), licensees do not have time to go back to school (eight responses), and licensees not wanting to go back to school (seven responses). The second most commonly reported reason for not attaining an LMSW license was due to age/retirement (24 responses). 21 licensees also reported that their current job does not require a master’s degree or master’s level license. While less frequently reported, other reasons reported included the fact that licensees would not receive a higher salary (11 responses) and that they hold a master’s degree in another field (two responses).

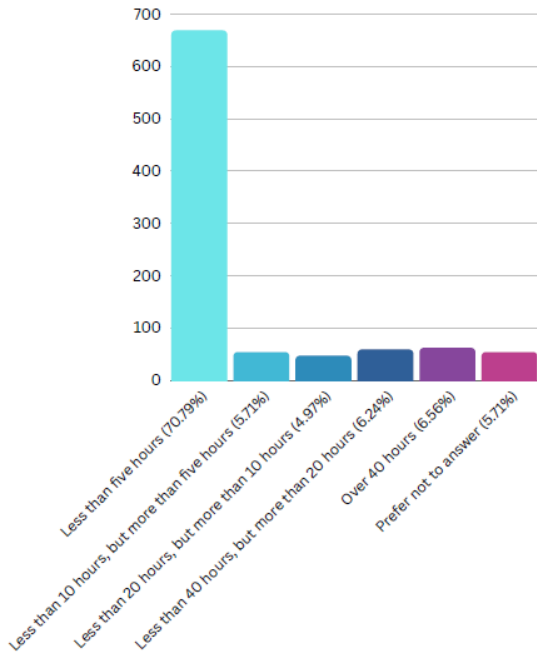
### **LMSW Responses**

Eight hundred and one LMSWs answered this question. (Responses for all licensees can be found in Appendix #5 on page #).

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**Question 6 (LSCSWs). In a typical week, how many hours are you responsible for supervising, managing, overseeing the work of others?**

**LSCSW Responses**

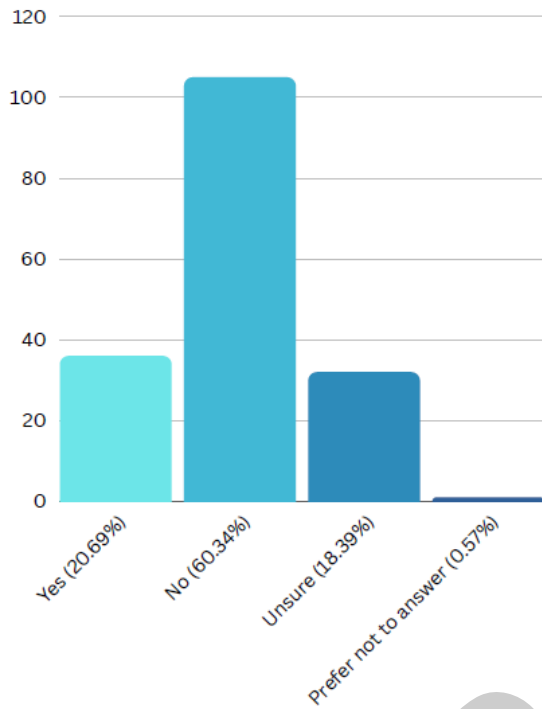


Of the 945 LCACs who answered question 6, the most common response was from 669 individuals who reported less than five hours per week (70.8%). All other responses were less than 7.0%.

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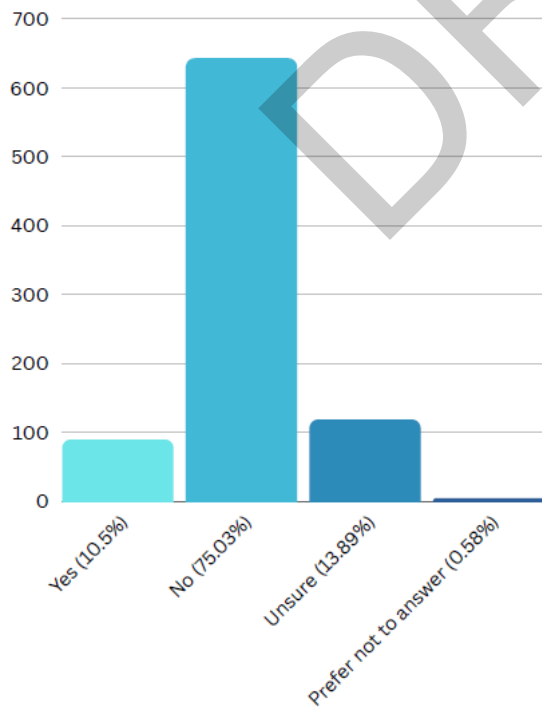
**Question 7 (LBSWs, LMSWs, and LSCSWs). Do you anticipate retiring from the social work profession in the next five years?**

**LBSW Responses**



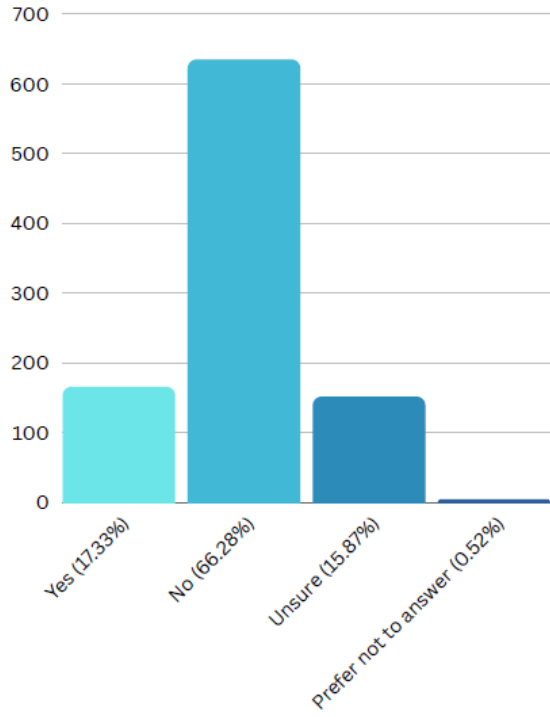
Of the 174 LBSWs who answered question 7, the most common response was from 105 individuals answering “no” (60.3%); followed by 36 individuals selecting “yes” (20.7%); then 32 individuals responding “unsure” (18.4%). Other responses were less than 1.0%

**LMSW Responses**



Of the 857 LMSWs who answered question 7, the most common response was 643 individuals responding “no” (75.0%), followed by 119 individuals selecting “unsure” (14.0%); then 90 individuals selected “yes” (10.5%). Other responses were less than 1%.

### LSCSW Responses

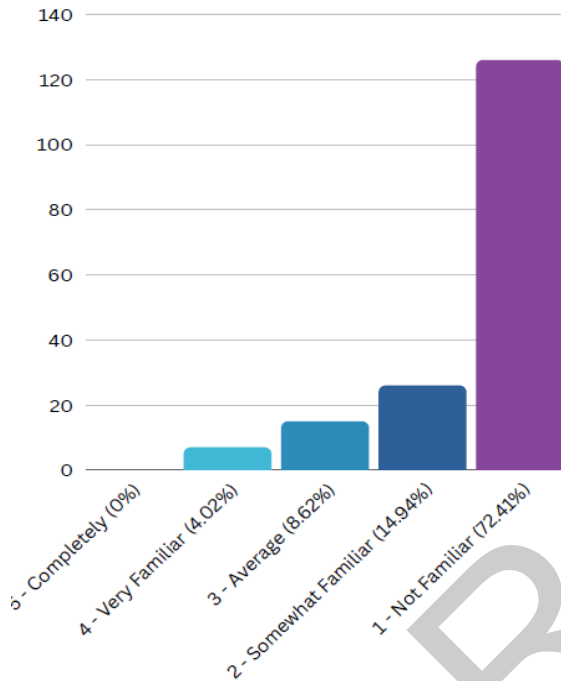


Of the 958 LSCSWs who answered question 7, the most common response was 635 individuals responding “no” (66.3%); followed by 166 individuals responding “yes” (17.3%); then 152 individuals selected “unsure” (15.9%). Other answers were less than 1.0%.

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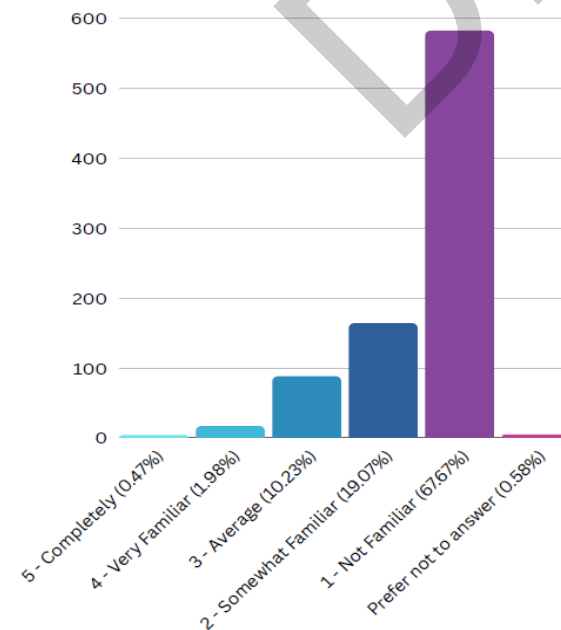
**Question 8 (LBSW, LMSW, and LSCSW).** To assist the work of the Board, the BSRB has seven standing Advisory Committees (one for each profession regulated by the Board), which are primarily composed of licensees in each of the seven professions. Advisory Committees discuss topics relevant to the work of the Board and make recommendations back to the Board on potential changes to statutes and regulations governing the profession. These meetings are broadcast on the BSRB YouTube channel every-other-month. On a scale of 1 to 5, how familiar are you with the work of the Addiction Counseling Advisory Committee?

**LBSW Responses**



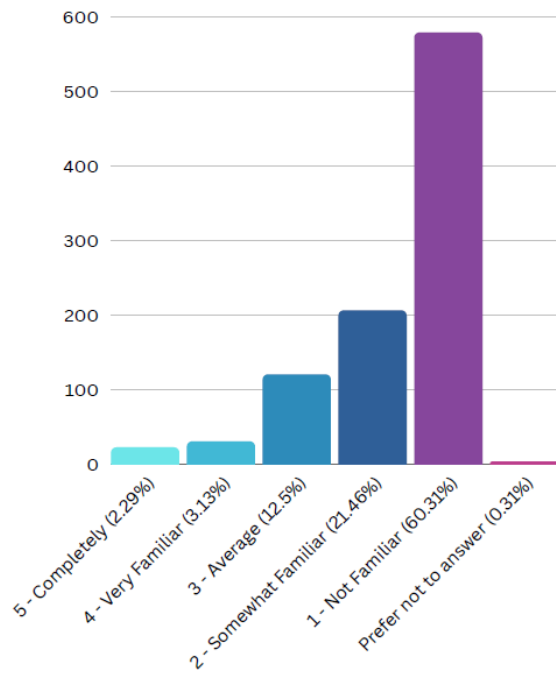
Out of the 174 LBSWs that answered question 8, the most common response was 126 individuals selected “not familiar” (72.4%); and 26 individuals noted they were somewhat familiar with the work of the Advisory Committee (14.9%). All other responses were less than 9.0%

**LMSW Responses**



Out of the 860 LMSWs that answered question 8, the most common response was 582 individuals reported no familiarity with the Advisory Committee (67.7%); followed by 164 individuals noting they were somewhat familiar with the work of the Advisory Committee (19.1%); then 88 individuals reported average familiarity (10.2%). All other answers were less than 2.0%

## LSCSW Responses



Out of the 960 LSCSWs that answered question 8, the most common response was 579 individuals who noted no familiarity with the work of the Advisory Committee (60.3%); followed by 206 individuals noting they were somewhat familiar with the work of the Advisory Committee (21.5%); then 120 respondents who noted an average level of familiarity (12.5%). All other answers were less than 4.0%.

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***Question 9 (LBSWs, LMSWs, and LCSWs). Over the past two years, based on your observations and experience practicing the social work profession, could you share information on any practice-related issues you have seen, such as areas where practitioners appeared to need more continuing education or training in a certain area? Please explain.***

### **LBSW Responses**

One hundred and thirty-one LBSWs answered this question, identifying practice-related negative issues that they have seen. (Responses for all licensees can be found in Appendix #6 on page #).

43 respondents indicated having experienced no practice-related negative issues or training needs to report on.

The most frequently reported practice-related negative issue involved unlicensed case managers having no oversight or Board to report to (seven responses). Other reported negative issues included:

- Politics in the workplace (five responses)
- Burnout (four responses)
- Heavy caseloads (three responses)
- Understaffing (three responses)
- The belief that the CEU requirement is too high and/or a financial burden (two responses)
- There being a general lack of resources (two responses)
- Pay in the profession is too low (two responses)

Shifting focus to areas appearing to need more education or training, the most frequently reported was in the area of ethics (10 responses). These answers related to general ethics, as well as on developing ethical guidelines for artificial intelligence and telehealth. Other frequently reported areas needing more education or training included:

- Interpersonal/people/customer service skills (i.e., good communication, emotional intelligence, and ability to provide feedback and engage well) (eight responses)
- Safety (i.e., knowing how to appropriately navigate emergency/crisis care, knowing techniques on handling hostility, and being educated on prevention strategies) (eight responses)
- Boundaries (seven responses)
- Professionalism (i.e., being respectful, taking accountability, and having professional writing and grammar skills) (six responses)
- Trauma (five responses)
- Cultural Competence (four responses)
- Child Welfare (three responses)
- Bias (three responses)
- Appropriate supervision (two responses)
- Compassion (two responses)
- Empathy (two responses)

- Intellectual disabilities (two responses)
- Interview skills (two responses)
- Self-care (two responses)
- Self-determination (two responses)
- Substance abuse (two responses)
- Technology and digital literacy (two responses)

## **LMSW Responses**

Six hundred and seventy LMSWs answered this question, providing insight into practice-related negative issues experienced and/or observed. (Responses for all licensees can be found in Appendix #7 on page #).

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## **LSCSW Responses**

Seven hundred and twenty-three LSCSWs answered this question, providing insight into practice-related negative issues that they have seen. (Responses for all licensees can be found in Appendix #8 on page #).

One hundred and forty-four respondents indicated having seen no practice-related negative issues.

Frequently reported practice-related negative issues can be broken into four main areas: ethical issues, documentation, insurance, areas needing more education or training, and other issues. Licensees reported the following ethical issues:

- Navigating boundaries with coworkers and supervisors
- Dual relationships in rural communities
- Professionalism
- Burnout
- Personal bias
- Quality of care from new graduates
- Social Media
- Trauma care over telehealth
- Cultural competency
- Continuity of care
- Practicing outside of one's scope of practice
- How AI/Mental Health Applications are protecting PHI
- Political Climate
- LMSW's working in Private Practice
- Two-year temporary licenses
- Reduction of clinical hours

Documentation issues reported centered around the need for more education and/or training in the documentation used by courts and in private practice. Responders also highlighted that new graduates lack documentation skills.

Insurance issues highlighted the difficulty in navigating insurance and the reimbursement requirements, along with poor reimbursement rates and problems with Medicare and Medicaid.

Many responses focused on areas that need more education and training. Frequently reported areas included:

- Billing and Coding
- Suicide Prevention
- Business skills
- Clinical supervisor training
- Trauma-based care
- Addictions
- Autism
- ADD/ADHD
- Telehealth
- Diagnosis
- Documentation
- D.E.I
- Domestic and Sexual Violence
- Eating Disorders
- Minorities

Other respondents highlighted communication issues between agencies, a lack of self-awareness among therapists, and an increase in burnout.

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***Question 10 (LBSWs, LMSWs, and LCSWs). Over the past two years, have you experienced any issues concerning tele-health, either through professional practice or observations of other practitioners? Please explain.***

### **LBSW Responses**

One hundred and thirty-three LBSWs answered this question, identifying a range of issues concerning telehealth. (Responses for all licensees can be found in Appendix #9 on page #).

115 respondents indicated having experienced no issues concerning telehealth. Of the 115, six respondents stated that they do not provide telehealth, four stated that telehealth makes services more accessible, and three stated that telehealth is useful under certain circumstances.

The most commonly reported issue concerning telehealth was issues with technology and the internet (four responses). Other reported issues included:

- HIPPA and confidentiality cannot be verified
- Unlicensed individuals are providing social work services
- Telehealth is not fit for children; children do not stay engaged
- Some providers are digitally illiterate

There were also issues specifically relating to clients and/or sessions. Such issues included telehealth making it more difficult to connect and build rapport with clients, to engage clients and keep their attention, and in observing body language and nonverbal cues.

### **LMSW Responses**

Seven hundred and six LMSWs answered this question, identifying issues concerning telehealth. (Responses for all licensees can be found in Appendix #10 on page #).

578 respondents reported having experienced no issues concerning telehealth. After providing this answer, many licensees followed up with additional information. These licensees noted that:

- They do not provide telehealth (20 responses)
- Telehealth has reduced barriers and increased access to services (11 responses)
- Telehealth is a great/beneficial resource (seven responses)
- Telehealth is beneficial for rural areas (five responses)
- They love telehealth (five responses)
- Telehealth is great for those without transportation (four responses)
- Clients love telehealth (two responses)
- They only provide telehealth (two responses)
- Telehealth allows for more expedient services (two responses)

There were many issues concerning telehealth frequently identified, with the most frequently reported being Wi-Fi/connectivity/technical issues (20 responses). The second most commonly

reported issue was with clients and/or providers not being in private settings for telehealth sessions (13 responses). Other reported issues included:

- Telehealth is harmful/ineffective/unethical with children (10 responses)
- Confidentiality challenges/concerns (seven responses)
- Telehealth cannot be provided if the client or provider temporarily goes out of state (seven responses)
- Telehealth is beneficial/useful in crisis situations and when it is the only available option (seven responses)
- Lack of access to technology (six responses)
- There needs to be more training around telehealth (four responses)
- Telehealth is not covered by all insurances (four responses)
- Not everyone can connect/relate through a screen (three responses)
- Older populations struggle with telehealth (three responses)
- Organizations need to have telehealth policies if utilizing it, but many do not (three responses)
- Audio-only telehealth (three responses)
- The use of AI in telehealth sessions (three responses)
- Questionable platforms being used to conduct telehealth (two responses)

Four respondents also reported having observed telehealth being used inappropriately.

Furthermore, it was reported that, compared to in-person services, telehealth:

- Makes it more difficult to observe body language and nonverbal cues (six responses)
- Is impersonal (six responses)
- Makes it more difficult to keep clients engaged (four responses)
- Is ineffective (four responses)
- Increases distractions (three responses)
- Produces less accurate assessments (three responses)
- Produces less client participation (three responses)
- Can lead to less effective communication (two responses)

It was also noted that providers need to be more aware of when it may be best to shift a client to in-person services.

## **LSCSW Responses**

Seven hundred and thirty-nine LSCSWs answered this question, providing insight into issues concerning telehealth. (Responses for all licensees can be found in Appendix #11 **on page #**).

Five hundred and thirteen respondents indicated having experienced no issues with telehealth. After providing this response, some respondents added more information. The following information was gathered from these respondents who indicated having no issues with telehealth:

- Telehealth is an excellent resource for inclement weather
- Works well when there are clear rules for telehealth sessions
- Removes the barriers of transportation
- Concerns with not connecting with the clients, as well as in-person
- Make therapy more accessible
- Clients can miss less work and school

While the feedback following reports of no telehealth issues is mostly positive, some report not supporting telehealth and believe that in-person services are more effective. Thirty-three respondents indicated that they do not provide telehealth.

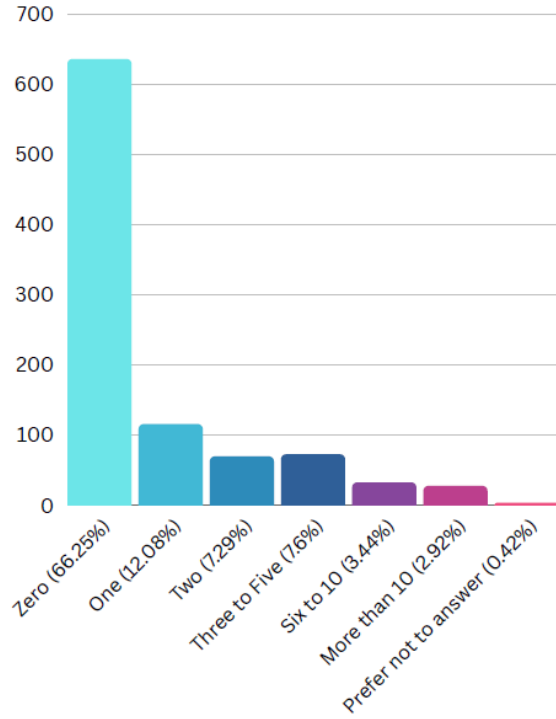
The following were frequently reported issues experienced concerning telehealth:

- Internet connection
- HIPAA compliance for sites
- Confidentiality and client data concerns
- Telehealth in different states and the requirements on the location of clients
- Distractions while in sessions
- Clients having sessions in areas that are not confidential
- Doesn't work well for children
- Not suited for all clientele.
- Having a safe space for clients doing deep trauma work.
- Needing to have clear regulations on telehealth
- Low insurance payouts
- Feels impersonal

Some respondents noted that they have had a hard time determining the legitimacy of sites and are concerned about smart home devices listening to or recording client information.

**Question 11 (LSCSW). How many individuals do you currently provide supervision to?**

**LSCSW Responses**



Out of the 960 LSCSWs that answered question 11, the most common response was from 636 individuals who answered “zero” (66.3%), followed by 116 individuals reporting supervising one person (12.1%). All other responses were less than 8%.

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***Question 11 (LBSW and LMSW)/Question 12 (LSCSW). Over the past two years, have you experienced any negative issues involving supervision? If so, please explain.***

### **LBSW Responses**

One hundred and thirty-one LBSWs answered this question, identifying negative issues involving supervision. (Responses for all licensees can be found in Appendix #12 on **page #**).

103 respondents reported having experienced no negative issues involving supervision. After providing this answer, two respondents followed up by complimenting their supervisors.

Of those who did report on negative issues involving supervision, the following were frequently reported:

- Licensees had supervisors who were unavailable, unethical, and/or unsupportive
- Supervisors failing to empower supervisees
- It is difficult to find supervisors
- Licensees had supervisors who were not licensed social workers
- Overwhelming caseloads placed either on supervisors or onto supervisees by supervisors

### **LMSW Responses**

Seven hundred and two LMSWs answered this question, identifying negative issues involving supervision. (Responses for all licensees can be found in Appendix #13 on **page #**).

540 respondents expressed having experienced no negative issues involving supervision. After providing this answer, 20 respondents expressed having great supervisors and/or supervision experiences, five stated that they did not have supervisors, and two expressed wanting a list of available supervisors.

The most frequently reported negative issues involving supervision included there being a lack of availability of supervisors (supervisors are hard to find) (26 responses), supervision is a financial burden and/or unaffordable (18 responses), and that licensees' supervisors were not social workers (18 responses). While less commonly reported, other reported negative issues and/or comments involving supervision included:

- Supervision is too unstructured (10 responses)
- School settings have no supervisors who are social workers (seven responses)
- There is a lack of time to complete all supervision requirements (six responses)
- Supervisors are not actually supervising (five responses)
- A lack of communication (three responses)
- A lack of guidance (three responses)
- Supervisors need more training (three responses)
- There are too many demands placed on supervisors (three responses)

- Documentation is time consuming (two responses)
- There is little oversight (two responses)
- Supervisors using artificial intelligence inappropriately (two responses)
- There are few opportunities to receive free supervision (two responses)
- There is too much politics at play (two responses)
- There needs to be higher standards for supervisors (two responses)

## **LSCSW Responses**

Seven hundred and one LSCSWs answered this question, identifying negative issues involving supervision. (Responses for all licensees can be found in Appendix #14 on [page #](#)).

Four hundred and fifty-four respondents indicated that they do not experience negative issues with supervision. Of these respondents, only one reported interest in providing supervision in the future.

The most frequently reported negative issues involving supervision focused on the need for training for clinical supervisors, specifically concerns regarding new graduates and supervisee-supervisor relationships.

The following were frequently reported issues experienced concerning Supervision:

- Social media
- Supervision as an admin
- Find quality supervisors
- Boundaries with coworkers
- Supervision isn't one size fit all
- Too many changes in clinical requirements
- New grads in private practice
- Supervisor abandonment

Some responders noted not liking that requirements were lowered and confusion about tracking hours.

***Question 12 (LBSWs and LMSWs)/Question 13 (LSCSWs). Do you currently use artificial intelligence (AI) in your practice? If you do, in what areas do you use AI?***

**LBSW Responses**

One hundred and forty-two LBSWs answered this question, identifying uses of AI in practice. (Responses for all licensees can be found in Appendix #15 on page #).

120 respondents reported that they do not use AI in their practice. Of the reported uses, the most commonly reported was using AI for note-writing (seven responses). Other areas of AI use included:

- Summarization purposes (four responses)
- Wording/grammar purposes (four responses)
- Developing lessons and/or trainings (three responses)
- Policy purposes (two responses)
- Proof reading (two responses)
- Research purposes (two responses)

**LMSW Responses**

Seven hundred and fifty-five LMSWs answered this question, providing insight into the uses of AI in practice. (Responses for all licensees can be found in Appendix #16 on page #).

571 respondents indicated that they do not use AI in their practice. After providing this answer, licensees provided more context, both positive and negative. Positive remarks included licensees being interested in using and/or learning more about AI use (six responses). Five licensees indicated that they will begin using AI in their practice soon. Shifting to negative remarks, 10 licensees expressed that they are opposed to using AI, three had ethical concerns about AI use, two expressed their distrust with AI, and two had concerns about the use of AI with notetaking. Two licensees noted wanting more guidance on the ethical use of AI before they would be comfortable with using it.

The following areas of AI use were reported by respondents:

- Progress Notes/Notetaking (48 responses)
- Documentation (21 responses)
- Email Purposes (18 responses)
- Brainstorming/Generating Ideas (15 responses)
- Developing IEP and/or Treatment Goals (15 responses)
- Letter Composition (11 responses)
- Lesson Plan Purposes (seven responses)
- Asking/Generating Questions (five responses)
- Research Purposes (five responses)

- Exploring Resources (five responses)
- Summarizing (five responses)
- Word Choice Purposes (five responses)
- Report Writing (four responses)
- Social Story Creation (four responses)
- Treatment Plan Purposes (four responses)
- Writing Purposes (four responses)
- Generating Activities (three responses)
- Planning Purposes (three responses)
- Training Purposes (three responses)

AI platforms used that were specifically mentioned by name included Eleos (12 responses), ChatGPT (six responses), and Grammarly (two responses).

### **LSCSW Responses**

Eight hundred and forty-one LSCSWs answered this question, providing insight into the uses of AI in practice. (Responses for all licensees can be found in Appendix #17 on page #).

Five hundred and sixty-three respondents reported that they do not use AI in their practice. while others stated that they are considering implementing AI in their practice. One hundred and two noted they are currently using AI.

The most frequently reported use of AI in practice (sixty-nine responses) was for note-taking purposes. The following is a list of other reported AI uses:

- Research
- Writing/Grammar
- Marketing
- Handouts/Presentations
- Treatment planning

Some respondents expressed concerns about the privacy surrounding AI and client PHI.

***Question 13 (LBSW and LMSW)/Question 14 (LCSW). Based on your experience as a licensee in Kansas, do you have any recommendations on additional ways the BSRB could protect and serve and consumers of services offered by BSRB licensees?***

### **LBSW Responses**

One hundred and seventeen LBSWs answered this question, providing recommendations on additional ways the BSRB could protect and serve consumers of services offered by BSRB licensees. (Responses for all licensees can be found in Appendix #18 on page #).

81 respondents reported having no recommendations to provide. The most frequently reported recommendations were specific to CEUs (eight responses). More specifically, it was recommended that:

- The BSRB offer free or low-cost CEU opportunities
- The number of CEUs required for renewals should be lowered
- A database or list of high quality CEUs be made available to licensees
- The BSRB should accept Medicare-/Medicaid-specific CEUs

Additionally, five respondents recommended additional training in the areas of autonomy, confidentiality, cultural competence, addressing burnout, and HIPPA. It was also recommended that the BSRB ensure title protection for social workers; social work positions should only be held by licensed social workers (three responses), as well as to make the BSRB website, resources, and services more user-friendly (three responses).

Complaint-/Investigation-Specific Recommendations included:

- Strengthening oversight for boundary violations
- Allowing anonymous complaints
- Providing consumers with information regarding how to file complaints
- Providing more clarity around self-reporting

### **LMSW Responses**

Five hundred and ninety-six LMSWs answered this question, providing recommendations on additional ways the BSRB could protect and serve consumers of services offered by BSRB licensees. (Responses for all licensees can be found in Appendix #19 on page #).

375 respondents indicated that they had no recommendations to provide.

The following are frequently reported recommendations made by licensees:

- There is a need for lower cost and/or free CEUs (10 responses)
- Keep high licensing standards; stop reducing licensure requirements (nine responses)
- Continue to support and move towards implementing the multi-state compact (nine responses)
- Make it cheaper to keep and maintain licensure (eight responses)
- Enhance public education on licensed services (seven responses)
- Advocate for higher pay for social workers (six responses)

- Allow grandfathering (five responses)
- Expand insurance coverage (five responses)
- Hold universities accountable and/or audit them (five responses)
- Make AI guidelines (five responses)
- Bring back the six-hour diagnosis and treatment CEU requirement (four responses)
- Continue to support and allow telehealth (four responses)
- Use a different licensing examination (four responses)
- Provide study materials for the licensing examination (four responses)
- Protect the social work title (four responses)
- The BSRB and licensees could benefit from better communication (three responses)

It was also recommended that there be more training in the areas of ethics (six responses), co-occurring disorders (three responses), HIPPA (three responses), suicide risk (three responses), supervision (three responses), digital literacy (three responses), and AI (three responses).

### **LSCSW Responses**

Six hundred forty-three LSCSWs answered this question, providing recommendations on additional ways the BSRB could protect and serve consumers of services offered by BSRB licensees. (Responses for all licensees can be found in Appendix #20 on page #).

Three hundred twenty-seven respondents indicated having no recommendations to provide.

The following is a list of frequently reported recommendations from licensees:

- Keeping standards and not lessening the standards for licensure
- Insurance and reimbursements
- Having online forms, especially for disciplinary
- More affordable/fee ceus
- Multi-state compacts
- More notifications from the BSRB
- Updates to unprofessional conduct
- Background checks
- AI trainings
- Social work name protection
- Telehealth ceus
- Community networking opportunities
- Advertisement for Board participation

Some respondents focused on new graduates in private practices, expressing that they require more oversight. Some respondents wanted more transparency on licensure and discipline from the Board.

***Question 14 (LBSW and LMSW)/Question 15 (LSCSW). Do you have any other comments or feedback you think would be helpful for the members of the Social Work Advisory Committee of the BSRB to receive when evaluating possible changes to the statutes and regulations for the addiction counseling profession? Please explain.***

### **LBSW Responses**

One hundred and six LBSWs answered this question, providing comments and feedback that they think would be helpful for the members of the Advisory Committee. (Responses for all licensees can be found in Appendix #21 on page #).

72 respondents reported having no comments or feedback to provide.

The most frequently reported comment made was that untrained/unqualified individuals providing social work services need to be regulated (six responses). Additionally, three respondents expressed the importance of keeping “social worker” a protected title. Other comments made included the belief that getting and maintaining licensure should be more affordable, and that the BSRB should advocate for better insurance coverage and reimbursement.

### **LMSW Responses**

Five hundred thirty-one LMSWs answered this question, providing comments and feedback that they found helpful for the members of the Advisory Committee. (Responses for all licensees can be found in Appendix #22 on page #).

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### **LSCSW Responses**

Five hundred and seventy-eight LSCSWs answered this question, providing comments and feedback that might be helpful for members of the Advisory Committee to receive when evaluating possible recommendations for changes to the statutes and regulations for the addiction counseling profession. (Responses for all licensees can be found in Appendix #23 on page #).

Three hundred and thirty-one respondents indicated having no other comments or feedback to provide. The following is a list of the most commonly reported comments and feedback:

- Moving forward with an Interstate Compact for social work
- More training for suicide prevention
- Maintaining standards for the profession by not lowering standards.
- Training for supervisors

- More transparency for licensing and disciplinary processes
- More affordable or free CEUS

Other comments and feedback highlighted the need for more education in self- self-care, insurance and private practices. Additionally, the following comments and feedback were made reflecting potential issues in the field:

- Newly licensed applicants in private practice
- Lack of community in the profession
- Having sessions with clients while they are in another state for crisis services.
- Reduced clinical hours and the effects on newly licensed clinicians
- Need for case load limits

DRAFT

**LBSW Q3. Do you maintain an active license, but no longer work as social worker? If so, please explain why you are not providing services currently. (107 responses)**

Active and using

Active license

After I became a social worker, I worked for a few years, then became a mother of 4 ( in 4 years) and chose to stay home. My husband practices law and we also farm, in which I help. Our kids are graduating college and starting families in which I also help. I choose to keep my license to keep educated and have felt many times throughout the years of applying for various social worker positions. I feel this may continue to be an opportunity for my future.

As a Senior Director at a nonprofit organization, I no longer work directly with clients.

Available as a licensed SWer

Continue to work as a licensed social worker

Currently working as an RN, love social work but couldn't live on the wages

I am a trainer and train staff.

I am an active social worker

I am currently active with my license and also work as a social worker.

I am currently the CEO of a social service agency that does provide direct services to individuals.

I am working in child welfare on the Development team. I'm able to utilize my knowledge to assist.

I have an active license

I have an active license and currently practice

I have an active license and I work as a case manager.

I have been a police officer for the last 12 years but keep my license and am currently assigned as a School Resource Officer. I also serve on our departments Peer Support Team and am a Crisis Negotiator.

I maintain a license and I'm in the role as an administrator. I practice direct Social Work less than 40 hours a year.

I maintain license because CEU's inform my practice, however; licensure is not required for my role as a Probation Officer.

I maintain my license and currently work as a social worker.

I maintain my license but only work periodically in PRN positions

I maintain my license, but I'm also a registered nurse. So my current positions are based around my RN license.

I now have a LNHA license, but keep my LBSW if I need to jump in and help with social work

I retired in 2020 and just now went back to work.

I run a nonprofit with residential aspect

I still maintain my license.

I work as case manager for an Independent Living Center

I work in an administrative setting in another field.

I work in education but not a school social worker as a home visitor and maintain my license e

I'm Retired

**Maintain an active license (2 responses)**

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| Maintain an active license and work as a social worker.   |
| Maintain an active license. The position I hold requires education but not specifically a social work license.  |
| My job does not require a Social Worker degree, but keep it in case have to switch jobs and still learn from the Continue education.  |
| My position doesn't require my license but, it is important to keep my license because I may need it later or decide to work part-time.   |
| <b>N/A (23 responses)</b>   |
| N/A actively working  |
| NA-I continue to work as an active Social Worker for approximately 42 yrs.  |
| <b>No (24 responses)</b>  |
| No, I'm a licensed social worker and work as one.   |
| Poor work environment for social workers. Employers are not really sure what a social worker is and we are often seen as the dumping ground for tasks nobody else wants to do. We are expected to work in high risk environments with little safety support in the community.   |
| Pretty much a stay at home mom now, but I keep my license active because you never know what will happen in life and I would need to go to work again.  |
| <b>Retired (3 responses)</b>  |
| Social Work pay is very low and so I am working as a director on home health  |
| Still practicing.   |
| Still work as LBSW  |
| The politics of the job, the stress of the job, and the feeling that I have to "tow the line" politically speaking.   |
| The position I currently have does not require a license but I don't want to lose it. I wish that the licenses could be put on hold when this happens.  |
| This question is hard to answer as I consider myself a social worker first and foremost no matter the position I'm in. I don't provide direct client services anymore by I supervise a program that does. So I guess? I am a program manager for a federal grant, but I would take offense to someone saying I "no longer work as a social worker". |
| <b>Yes (3 responses)</b>  |
| Yes maintain an active license in Kansas but work in Missouri but keep it active incase I decide to get a job on Kansas side since I reside close to state line.  |
| Yes, currently in an admin/agency leadership role.  |
| Yes, I currently work for an agency that does not require a social work license. I run a group home facility but I continue to keep my license so I do not have to retest when I chose to change directions in my career.   |
| Yes, I had to move to Georgia. My license did not switch. I have one in Kansas though.  |
| Yes, I keep my license but I work outside of social work. So none of the questions are relevant to me   |
| Yes, I maintain an active license, but am retired working part-time temporary closing cases for state agency.   |
| Yes, I maintain my license. I have worked as a childcare provider since my 24 year old son was 4. Though it is not social work, I do use a number of the same skills, daily with the children as well as their parents.   |

Yes. I was ED of an affordable housing org and now retired but work PT for NP to decrease barriers to mental health services

DRAFT

**LMSW Q3. Do you maintain an active license, but no longer work as social worker? If so, please explain why you are not providing services currently. (553 responses)**

Out of work due to medical reasons, maintaining my license

**Active (2 responses)**

Active and still work

Active license

Active license and continue to work as a social worker

Active license and practice.

Active. Still providing.

Actively working with license

After retiring in 2018 as the Executive Director of a nonprofit, I ran for elected office. I am not serving in my seventh year as a member of the Johnson County Board of County Commissioners where I use my social work education, skills, and experience to help shape county policy and priorities regarding housing, mental health, human services, and transit. I am proud of being a licensed social worker, and I worked too hard to become one to allow my license to lapse.

Burnout. Working in a system that is designed to respond to issues rather than prevent them is exhausting and numbing.

CEO of not for profit

Current license and practice

Current license and still working as SW

Current LMSW

Currently practicing/providing services

Currently still working

**Currently working (2 responses)**

Currently working and licensed

Certain job does not require a license.

Doing Mediation and training

Employed as a Career Counselor in present job

Employed in an Administrative position.

Executive orders have eliminated my job. Finding a job which pays comparable has been difficult.

Have a active license.

Have license, work as SW

Health issues

I actively work for the past 10 years full time. Right after I received my license, I let it 'expire' to stay at home for my family but easily reinstated when I returned to work full time.

I am a SW educator

I am age 69 and just retired. However, I want to maintain my education and licensure for future possibilities. I want to volunteer at the upcoming Mt. Carmel Hospice House!

I am CEO of a community foundation past 17 years. Macro level alignment with funding charities, addressing vulnerable populations and using skills with staffs and board of directors. I do occasionally supervise social work students.

|  |
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| I am currently caregiving my aging parents and I am maintaining my license so I can eventually return to work.   |
| I am currently working as a social worker with a license   |
| I am employed as an early interventionist.   |
| I am hoping to no longer do SW soon. Just due to the licensure requirements  |
| I am in an administrative/supervisor role that does not require direct service hours.  |
| I am licensed but work with data supervision as it pays more. Occasional clients   |
| I am not providing services but I keep my license active because I will use it for publications of articles and/or books in the future. And there is always the chance that I might pick up a social work job and need my license for that.  |
| I am practicing social work.   |
| I am semi-retired due to my age and desiring to focus on around 20 hours of work and with less responsibility  |
| I currently work as a social worker  |
| I did not go back to work after having my second child because the cost of child care didn't make sense for the salary I was making working part time as a hospital social worker. I maintain an active license even though I do not work.   |
| I did work as an administrator in a non-profit for 14 years and then returned to school social work. During that time I kept my license active. Now, of course, I need licensure for employment.   |
| I do maintain an active license. I am currently practicing as a therapist.   |
| I have 2 active licenses and practicing social work  |
| I have a current LMSW license in Kansas. It is required for my job.  |
| I have a license and I provide services for military members   |
| I have a license and work as a social worker.  |
| I have a LMSW in Kansas but currently live in Washington. I have a LICSWA in Washington and will be taking clinical exam to be fully licensed LICSW by end of 2025. I'm keeping Kansas license active because why start over and let it lapse? I may see Kansas clients again, I could do Kansas telehealth and one day I could end up in Kansas again. I do work full time as a licensed social worker in Washington. |
| I have an active license and am an active social worker  |
| I have an active license and practice as school social worker, along with working at a private practice part time.   |
| I have an active license and still practice as a social worker.  |
| I have an active license but do not currently work in providing services. I retired from academic work when I reached age 70 but have maintained an active license.  |
| I have an active license.  |
| I have an active license.  |
| I have an LMSW, and I'm an administrative SWer, and I practice daily!  |
| I have taken a position as a school counselor. This still allows me to utilize SW skills and I am required to maintain my professional license.  |
| I hold an active license and work as a social worker.  |
| I knew I always wanted to work in policy, but the ethical standards of a social worker are important to me, as are staying true to who I am, which is a social worker, and an active license helps me do that.   |

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| I let my license lapse many years ago since it was not needed in my academic position. I recently decided to reinstate my license so that I could call myself a social worker and use that credential.  |
| I maintain a license and while I am an educator, I still consider the work social work as well.   |
| <b>I maintain a license and work as a social worker (3 responses)</b>   |
| I maintain an active license and I work as a social worker part time.   |
| I maintain an active license and I work as a social worker.   |
| I maintain an active license and still work in social work.   |
| I maintain an active license and work as a social worker.   |
| I maintain an active license as best practice though my position does not require it as I work in social welfare research.  |
| I maintain an active license, but my current position does not require an LMSW. However, the work I do in supervising Care Managers directly involves working with the Medicaid population in addressing their safety, health and well-being.   |
| I maintain an active license.   |
| I maintain and do work  |
| I maintain my LMSW license but work in a healthcare consulting role doing process improvement for medical centers. I wanted to pursue my clinical license but the low financial compensation, paperwork/supervision hoops to get approved for supervision and differing hours among states for LCSW/LSCSW have made it difficult. Most jobs won't hire unless you're registered for supervision, but you can't register for supervision without a qualified supervisor. |
| I maintain an active license, but do not provide direct services currently due to being a full-time caregiver to child with special needs. An educational setting fits the needs of my family during this time.   |
| I practice as a social worker   |
| I renewed my license last year, but did have a hiatus for 4 years.  |
| I retired from my social work job 2 years ago but have maintained my license.   |
| I still work as a social worker.  |
| I transitioned full-time to tech. The short answer as to why I am no longer providing service is money. Social workers just aren't paid enough. I keep my license active though because I still love social work and know I will return to it full time in the future.  |
| I work and maintain an active license   |
| I work as a social worker   |
| I work as a social worker with an active license  |
| I work as an LMSW   |
| I work as the executive director of a CASA program. I use social work skills and knowledge but CASA programs are part of the legal system, rather than social services.   |
| I work for a managed care organization as a fraud investigator for behavioral health services   |
| I work in an educational setting. I keep my license current in case I decide to seek other work.  |
| I work in healthcare, and maintaining my license is required by my job.   |
| I work in higher education. I maintain my license as I'm the current consultant for our ASWB ACE programming.   |

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| I work in social work education not direct service provision.  |
| I work in the an administrative environment.   |
| I work on the macro side as a program officer for a major local funder. I enjoy systems work and also the pay is better!   |
| I work on the Missouri side with a LCSW but keep my LMSW in Kansas as I live in Kansas and could work here again.  |
| I'm an administrator   |
| I'm not sure I need my license, I do community coalition work related to homelessness. I keep my license active because I keep thinking I'll host CEUs at some point but I know it's somewhat expensive to do that.  |
| I'm technically working as a school counselor, but maintain my license as I still use my social work training / skills in my daily practice.   |
| In leadership as Executive Director  |
| Licensed in Kansas and Missouri  |
| Limited paternal leave benefits and childcare access required that I resign from my job.   |
| LMSW & ACHP- SW  |
| maintain license but work in management  |
| Mo   |
| My current employment is not specifically social work related, although it has social work components.   |
| My current position does not require a licensure but I already was an LMSW, so kept the licensure.   |
| My current work does not require a license.  |
| My license is active and I still work as a social worker.  |
| My position is not listed as SW, but it really is  |
| My position requires a Master's degree and experience in the education field. While I lean into my training/experience as a SW in my role, I am providing "social work services".  |
| My work still aligns with social work practice, but on a macro level. I provide support to many social workers and other helping professions by offering free training, consultation, tools and resources to help prevent, treat, and recover from substance use disorders. I'm no longer working directly or indirectly with people who need help because I spent 20 years doing that and got to the point where I just couldn't do it anymore- burnout, compassion fatigue and moral injury had taken its toll on me through so many years where we were not encouraged to take care of ourselves. |
| <b>N/A (135 responses)</b>   |
| N/A (I am licensed and still work as a social worker).   |
| N/A- still work as social worker   |
| N/A Actively active  |
| N/A - I am a manager of a mental health facility   |
| N/A, I am actively working   |
| N/A, maintaining active license and practicing social work   |
| Ni   |
| <b>No (183 responses)</b>  |
| No - have active license and still work as a social worker   |

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| No - I use my license   |
| No - I work as a SW   |
| No - N/A  |
| No - still practice   |
| No- active and practicing   |
| No however I will likely be in this category within the 6-12 months to stay at home with my kids; license will be maintained and when I go back to work after 3-5 years of being a SAHM I'll be getting a job where I can obtain supervision to earn my LSCSW |
| No I am actively licensed and will remain licensed.   |
| No I have LMSW  |
| No I work as a SW   |
| No I'm an active social worker  |
| No, actively working.   |
| No, I am currently licensed and employed as a social worker   |
| No, I am currently working  |
| No, I am still working as a social worker.  |
| No, I currently work as a SW  |
| No, I have an active license and practice social work   |
| No, I maintain a license and work as a SW   |
| No, I still practice as a social worker.  |
| No, I'm licensed and practice as a social worker.   |
| No, my license is active.   |
| No, working as active social worker.  |
| No. I have an active license and still work as a social worker.   |
| No. I still am a Social Worker and providing services   |
| No. I am an active licensed social worker   |
| No. I currently work as a SW.   |
| No. I have an active license and am providing services.   |
| No. I have an active license and work as a social worker.   |
| No. I still work as a social worker   |
| No. My license is active and I am working as a Social Worker  |
| not applicable  |
| Not applicable.   |
| Partially - stay at home parent   |
| Physical health issues  |
| recently retired  |
| Required for my position at work.   |
| <b>Retired (6 responses)</b>  |
| Retired but offer free service  |
| Retired but potentially could resume work if tempted.   |
| Retired. Maintain my license, because ya never know what the future holds.  |
| Sort of. I maintain the license and currently work as a "Social-Emotional Facilitator," completing the duties of a k-12 school counselor.   |
| Still active  |
| Still work as a social worker   |
| Still working   |
| Still working as a licensed social worker   |

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| Still working- Still licensed  |
| Stopped direct client work due to high level of secondary trauma and too much stress. Switched to administrative work in a human service organization.   |
| This question doesn't make sense. Are we supposed to answer yes, and then what if we continue to work full time? n/a? or do we answer no, and no as well? either way, I work full time and keep an active license  |
| While I don't do direct practice with clients, I would say that the work I do is guided by my social work education and the ethics of our profession.  |
| Work as sw   |
| <b>Yes (15 responses)</b>  |
| Yes - I am an Assistant Principal, but I do work as an Adjunct Instructor with a School of Social Work   |
| Yes active license   |
| yes I actively maintain my license   |
| Yes I currently work in research. I keep my license because it's important to my professional identity and the code of ethics guides my work. It also helps me keep my options open in this time of economic crisis.   |
| Yes I maintain an active license   |
| Yes- teaching social skill and life coping skills class at junior college  |
| Yes, I'm currently retired now for health reasons.   |
| Yes, active license  |
| yes, am now a nursing home administrator   |
| Yes, and work as an LMSW and LMAC.   |
| Yes, but am now retired  |
| Yes, I am actively using my license.   |
| Yes, I am currently working as a Sr Director for the elderly and the position does not require a license but I use my social work skills.  |
| yes, I am in an administrative position with a state agency. Therefore, do not provide any direct client services.   |
| Yes, I maintain a license but currently work as a special education teacher. It was easier to go for a masters in special Ed than to get a job as a school social worker at my age.  |
| Yes, I maintain an active license but am not currently practicing. Due to life circumstances, I had to find another job with a steady income. I was in private practice and only have about 500 more hours in order to sit for my clinical exam but I had to put it on hold unfortunately. |
| Yes, I maintain an active license. I currently work in a school setting as a teacher's aide, it's less stress and fits our family's schedule. My husband's job is demanding.   |
| Yes, I maintain my license (LMSW), but I do not currently provide clinical services.   |
| Yes, I retired three years ago.  |
| Yes, I work as a federal employee overseeing behavioral health grants.   |
| Yes, I work as an Associate Executive Director for a nonprofit but still maintain my LMSW license.   |
| Yes, I work for an Association and provide training throughout the state.  |

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| Yes, I work in a national quality department of a health insurance company with the NCQA Health Plan, Utilization Management, and Health Equity Accreditation products. I work with the Medicare, Medicaid, Exchange, and Commercial lines of business. My role is to help insure quality accreditation for health plans ensuring member-centric quality health care. |
| Yes, I work in a private K-8 school where my title is 'school counselor'  |
| yes, I work in creating policy and oversight at a federal level.  |
| Yes, looking for new job  |
| Yes, maintain active license  |
| Yes, maintain active license but do not work as a social worker. Found that the work-life balance was not manageable for myself. Impacted my physically, emotionally, mentally. Working in higher education now and love it!  |
| Yes, my license is current. After retiring in 2021, I conducted private practice for 3 years. I keep my license current in the event I need to return to work, to keep my mind sharp by completing CE, and in the event I act in the capacity of a consultant to area hospice organizations or CMHC.  |
| Yes, the non-profit I work for does not have a technical social work position but I work with kids and families.  |
| Yes, work in higher ed but still keep active license  |
| Yes, working in Addictions.   |
| Yes. I am caring for my brother with Intellectual and other disabilities  |
| Yes. I am retired but working part time outside of the field.   |
| Yes. I no longer provide direct care, my practice focus is now mezzo/macro level.   |
| Yes. I retired at the end of the year.  |
| Yes. LMSW   |
| Yes. Financially it was difficult to do social work positions, so went into other areas for financial reasons. I maintain my license because I hope one day I am in the position to go back and help others in a social work capacity.  |
| Yes. Fully retired  |
| Yes. I am a licensed teacher and currently employed as a teacher.   |
| Yes. I have an active license but no longer practice full time. I work PRN but left due to burn out for low pay.  |
| Yes. I work in an educational setting teaching social work.   |
| Yes. I'm semi retired   |
| Yes. My job does not require a license Social Worker.   |
| Yes. Social work became overwhelming and caused physical problems.  |
| Yes. To have to get your Masters then take an exam for a LMSW then all of the clinical hours, which doesn't pay near what I make now not practicing, then even after that to have to take another exam is ridiculous and very costly.   |

yes; I am permanently disabled and in chronic pain always. I'm trying to find part time work where it doesn't interfere with my disability too much. I need several more surgeries and will continue needing more throughout my life so keeping my Medicare/Medicaid is crucial. I never know what may happen with it being the most severe pelvic separation & trauma in history/existence. It worsens, instantly debilitating me. Left unable to work, walk, function, take care of my son, myself or anyone else without assistance. I'm in bed for days. No warning. I still have a great passion for the work and field I went into and have a degree and license in. My goal is to find a part time job helping people however I can- such as online therapy, working with children, in the school systems, or hospital settings if needed. Just something I can do where it doesn't effect my pain/injury and the ability to perform the job needed. So I have not given up on my profession, I still intend on working as a social work as soon as I can. I just physically am unable at the current moment. But I am trying to find something that can work for my situation.

Yes; it is important to me because I facilitate continuing education for social workers' maintenance of their licensure, and I don't think it's ethical or responsible to do so without being accountable to a licensing body myself.

Yes...field-based stress, case overload, consistent client and agency crises, and lower agency standards by hiring of non-SW degreed people to fill positions that need SW level of understanding.

DRAFT

**LSCSW Q3. Do you maintain an active license, but no longer work as social worker? If so, please explain why you are not providing services currently. (510 responses)**

**Active (4 responses)**

Active and use

**Active license (5 responses)**

Active license and also works as a social worker

Active license and working

Active license in Kansas and Missouri

Active license, still working as a social worker

Active only

Active Social Worker and proud to be that

Actively practicing

Actively work

Actively working

After finishing my PhD in Social Work, I currently work doing qualitative health research. While my license is not required, I still use my social work training with my research projects regularly. I still plan to eventually incorporate clinical work into my job later, depending on how my career progresses.

Almost retired

Cancer dx

Current license specialty clinical social worker

Currently considering retirement.

Currently working under a grant so I don't bill anything but definitely still doing social work things.

Currently, I am not practicing while I care for my son with Down syndrome, but I hope to go back to work, specifically in the special needs community.

Don't do direct clinical care often because I am in an administrative/supervisory role

Faculty in a Social Work program

For family reasons; retired but may someday return to the field

Have an active license and am in practice

have an active license and still practicing

I actively practice

I am a part time clinical social worker, and work part time for another company. I only do part time clinical social work due to my own burnout and taking care of my own mental health. Another factor was the ability to make a higher salary to create more stability for my family at the other job.

I am actively providing services

I am actively working as SW.

I am also a clergy member and work currently for a church.

I am an administrator, do training, and do crisis response work all over the country. Day to day I am a CEO in New Mexico, but I keep my Kansas license for training and crisis response, and in case one day we move back to Kansas.

I am currently practicing

I am licensed & working

I am not longer seeing clients. I supervise therapists

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| I am not working as a social worker.   |
| I am still working   |
| I am working as a Church Pastor currently.   |
| I am working as social worker  |
| I am working in management and providing supervision towards clinical licensure, so I am no longer directly involved with clients in-person.   |
| I continue to practice social work   |
| I continue to practice.  |
| I currently do not use my license but I plan to go back to a practice. I want to keep it current.  |
| I currently maintain a LSCSW license.  |
| I currently work as a social worker/faculty field liaison. I am mostly retired.  |
| I do have an LSCSW   |
| I do maintain active licensure.  |
| I do not see clients, but provide some training and technical assistance to mental health centers. I plan to continue my license as long as possible.  |
| I do not.  |
| I have a license and continue to practice.   |
| I have active license and provide services   |
| I have always maintained my license; but have primarily worked in research and training in a university setting. Additionally, I see a small handful of clients (2-4/week) as an independent contractor with a private practice. |
| I have an active license   |
| I have an active license   |
| I have an active license and am still working.   |
| I have an active license and do a few cases a year for our district domestic court. I no longer work full time.  |
| I have an active license and I am providing services.  |
| I have an active license and provide school social work and contract therapy services.   |
| I have an active license and still practice.   |
| I have an active license and work as a social worker   |
| I have an active license and work as a social worker   |
| I have an active license, and I practice   |
| I have practiced for 29 years and continue and plan to continue practicing Social Work in my community.  |
| I have recently retired but I volunteer with Red Cross and must maintain my clinical license for that volunteer position. I serve incarcerated vets at Lansing State prison.   |
| I keep my license active and I'm still practicing.   |
| I maintain a license and have been a supervisor of a BH team during this time as well as would like to clinically supervise students and/or LMSW's that are pursuing licensure   |
| I maintain a license and still practice.   |
| I maintain an active license and continue to work as a social worker.  |
| I maintain an active license and do work as a social worker.   |
| I maintain an active license and provide services currently  |
| I maintain an active license and work for an MCO   |
| I maintain an active license in Florida and Kansas.  |

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| I maintain an active license in Kansas and Missouri   |
| I maintain an active license in Kansas and Missouri. I used to do Private practice through a contract with an agency. However, the agency closed back in 2016. I think. I'm trying to set up a private practice doing telehealth but it's more complicated than I thought it would be. I'm also considering doing a PRN social work job if I can find one that is available.                      |
| I maintain an active license.   |
| I maintain license and work in private practice.  |
| I maintain my license so I can provide direct services if the opportunity arises.   |
| I no longer work full time in direct service, but I maintain my practice via part- time weekend work at a hospital.   |
| I practice  |
| I provide clinical supervision. I am retired .  |
| I retired in 2024.  |
| I still practice  |
| I still work as a social worker.  |
| I still work as a social worker.  |
| I still work as a SW  |
| I supervise a team of clinicians, mainly social workers, and my primary role is supervision and clinical supervision. I do take on clients occasionally due to staffing changes, case complexity, etc.  |
| I work and maintain my license  |
| I work as a mental health therapist and am still in the profession.   |
| I work for veterans crisis line they say is a non-clinical position. I disagree with the VA on this and consider this to be a highly clinical role and continue to maintain an active license.  |
| I work in a position that does not require a license.   |
| I work in higher education as a resource. Over the years, I found I liked educating individuals, assisting them with financial aid questions, and providing financial literacy workshops more than one-on-one clinical counseling. I use my listening and communication skills all the time. I just don't see people for ongoing therapy. I do meet with people one-on-one and provide workshops. |
| I'm working   |
| I've been an active social worker with a license since 2006. I will be beginning with my bachelors.   |
| I'm retired but retain my license if I do chose to use it again.  |
| I'm serving as the president of a non-profit organization at the moment but plan to return to seeing clients in the next 12 months.   |
| Just retiring now due to health condition.  |
| Maintain active license and actively practice social work at a federal agency.  |
| maintain an active license but in hospital admin now  |
| Maintain an active license, working in MO.  |
| Maintain and active license and work as a social worker   |
| Maintain license and work as a social worker  |
| Maintaining license in retirement. Not currently seeing clients, supervising staff, or providing training as I did previously.  |

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| My license will expire in September of 2025, and I will not renew as I plan to retire as I am going to be 75. |
| My licenses are current   |
| <b>N/A (139 responses)</b>  |
| N/A - I'm currently practicing with an active license.  |
| N/A I work and use it   |
| <b>No (169 responses)</b>   |
| No - n/a  |
| No - I am active as a social worker   |
| No I am actively working  |
| No- I maintain a practice   |
| No- I work as a social worker.  |
| No I work as psychotherapist  |
| No I work in social work  |
| No I'm an active social worker  |
| No, active and practice   |
| No, but I plan to. I hope to enter into more of an administrative role.                                       |
| No, have active license   |
| No, I actively work as a social worker  |
| No, I am an active social worker working in private practice.   |
| No, I continue to work as a social worker with an active license  |
| No, I continue to work as a social worker.  |
| No, I do both   |
| <b>No, I have an active license (2 responses)</b>   |
| No, I have an active license and am practicing as a social worker.  |
| No, I have an active license and continue to work as a social worker.   |
| No, I have an active license in three states, including KS.   |
| No, I love being a social worker.   |
| no, I maintain a license and work as a social worker  |
| No, I provide services.   |
| No, I still am practicing.  |
| No, I still work.   |
| No, I've always been a social worker  |
| No, still active and still work as a clinical social worker   |
| No. My licenses are active and I am actively working.   |
| No. Social work is where it is at for me!   |
| No. I do maintain my clinical license and have a small caseload of clients.                                   |
| No. I am in practice with active licenses.  |
| No. I have active licenses and am in active practice.   |
| No. I use my license for my career  |
| No. I wish.   |
| No. Still active.   |
| No-I have maintained my licenses and worked as a social worker for all of my career.                          |
| Not applicable  |
| Not until recently. Fighting terminal diagnosis of cancer.  |
| Recently retired  |

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| Recently retired from a BSW academic setting - uncertain about reinstating my private practice.  |
| <b>Retired (4 responses)</b>   |
| Retired. But haven't decided yet if I'm really done working. :)  |
| Retired. I have several volunteer jobs, 2 require LCSW   |
| See clients on a minimal basis because I am a Senior Director, so oversee programs primarily. I do provide clinical supervision still on an ongoing basis.   |
| Semi retired. Need my license for job but not truly doing a practice. Work in a hospital   |
| Still active and working   |
| Still passionate!  |
| <b>Still working (2 responses)</b>   |
| This question is invalidly written. I am working as a social worker. I am providing services currently.  |
| Work as a part-time consultant   |
| <b>Yes (14 responses)</b>  |
| Yes Retired. Occasionally pick up a contract with Dept of Defense.   |
| Yes my job requires a license  |
| Yes, I retired but still give presentations and lectures.  |
| Yes, and working full time.  |
| Yes, but have not used in employment capacity since retirement in 2019.  |
| Yes, but I also practice as a social worker  |
| Yes, I am home with my babies for the time being.  |
| yes, I do maintain an active license   |
| Yes, I have an active license  |
| Yes, I hold an active license in KS and MO   |
| Yes, I maintain an active license. I do practice indirectly working at a managed care organization.  |
| Yes, I work in healthcare but at the national level not in direct patient care   |
| Yes, recently retired. Keeping active license for future options   |
| Yes, renewing license and recently retired   |
| Yes, taking a needed break currently the answers are based on my recent position   |
| Yes. I am a contract monitor/consultant.   |
| Yes. Retired, but want to keep future working options open.  |
| Yes. I keep my license for several reasons. 1) I don't want to retake the test or have to do things over ever again; 2) I want my license available in case I want to work again or do pro-bono work in a crisis situation; and 3) keeping current with my license gives me credibility as a clinical professor. |
| Yes. I maintain a license but have not practiced since becoming a full-time tenure track SW faculty member in 2002.  |
| Yes. Retired from institutional practice. Considering to work virtually but unaware of how to do this.   |
| Yes. Stay at home mom  |
| Yes; I am currently a SAHM to triplets.  |

**LBSW Q9. Over the past two years, based on your observations and experience practicing in the social work profession, could you share information on any practice-related negative issues you have seen, such as areas where practitioners appeared to need more continuing education or training in a certain area? (131 responses)**

Advocating for ourselves for better wages

Agency policies that hinder self-care, ethical boundaries

All social workers in the foster care system need more training. I think new social workers need to have more hands-on work during schooling before they start in the professional world as I have noticed social workers do not stay in the foster care field longer than 1-2 years.

Appropriately handling emergency and/or crisis of someone with anxiety and not a diagnosed mental illness

Boundaries. But this issues was with a non licensed MSW.

Burnout high case loads and little resources

Case managers and support staff working in the foster care system appear to need more education on ethics, cultural competence and non biased practice habits.

Child and family engagement, safety, data, quality assurance

Cultural Competence and Sensitivity - One of the most significant issues I've noticed is a lack of cultural competence and sensitivity among some practitioners. Continued education in cultural competence can help address this gap. Technology and Digital Literacy - The rapid advancement of technology has transformed many aspects of social work practice. However, not all practitioners are equally comfortable or proficient with digital tools and platforms. This can hinder their ability to effectively use telehealth services, manage electronic health records, and engage with clients through digital means. Training in digital literacy and the ethical use of technology in social work can enhance practitioners' effectiveness and ensure they are up-to-date with modern practices. Burnout and Self-Care - Social work is a demanding profession, and burnout is a significant concern. Training in self-care strategies, stress management, and recognizing the signs of burnout can help social workers maintain their well-being and continue to provide high-quality services. Elder Care and Gerontology - With the aging population, elder care and gerontology are becoming increasingly important areas of practice. Training in gerontology can help practitioners better support elderly clients and their families.

DCF CPS services. Can work with about any degree!

Dealing with and helping families deal with people with dementia

Does not apply to me.

Equity

Ethics and accountability for ethics violations. Such as boundaries and HIPPA.

Ethics and customer service

Foster care case managers need more child welfare training

Hard to say

Haven't worked for last two years.

high case load

I am not qualified to answer this question. I have a limited view of my field. I work in specialized areas concerning drugs/alcohol assessments for adults and drug endangerment of children. I do feel there is a vast gap in knowledge social workers display in generalized practice concerning substances and related areas. Unless you're specializing in this area the educational information taught is limited. I feel substance use education should be a part of standard practice and not limited to specialized practice. The knowledge is too important for any social worker who practices in Education/Schools, Hospitals, Nursing Homes, and Human Services. My response is solely based on conversations I've had with other social workers when speaking about our areas of practice.

I believe the training has kept up with the educational needs of social workers.

I don't know

I feel that Ethics in AI new technology will need to be a focus.

I find it more and more difficult to find continuing education trainings that are free or at low cost. Particularly in areas of ethics.

I have not worked under LMSW often. But, learning how to appropriately supervise others seems to be an issue that needs more training or continuing education.

I have observed a few practitioners struggle with maintaining professional boundaries--such as oversharing, blurring the lines of the professional relationship, displaying favoritism toward certain clients, and refusing to assist with completing necessary documentation.

I have seen many licensed people showing their political views with clients. More training is needed for them to understand that is inappropriate.

I have worked in community mental health, DCF, child advocacy center, and now as a victim witness advocate and I can say that social workers are often nervous and unsure about court and court procedures.

I personally haven't had any negative experience.

I regularly see untrained case managers making life changing decisions regarding children in care without any knowledge regarding how their decision may affect the children long-term; at times appearing to show care or concern.

I see the younger generations of new social workers lacking social skills and telephone skills.

I think I would like to see more CEUs on cognitive impairment (dementia, TBI, stroke, etc.) and psychosocial strategies for mental health

I think more education on giving bad news or negative feedback would be helpful. Newer social workers seem to have trouble dealing with the negative response that can be received when giving bad news such as telling a family their child will be removed from their care.

I work for one of the CWCMPs that contracts with DCF to oversee the children in custody. I think we need more licensed case managers. I think they try to maintain a certain percentage of licensed case managers, but I'm not quite sure what that percentage is.

I work in a setting with skilled, veteran social workers and haven't had the opportunity to interact with many others in the profession.

I work in foster care - always looking for ways to educate myself to better serve my clients

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| Ibn this day and time. I believe we are being challenged to find more outlets to assist people. Everyday there seems to be more resources that are not available.  |
| In my opinion, emotional intelligence is a need.   |
| Jo   |
| KanCare services to available  |
| Knowledge of I/DD services is lacking.   |
| Lack of resources across the board, not any certain area of training needed.   |
| LBSW renewal should require advanced ethics. I supervise Child in Need of Care cases, exclusively, and the foster care agency employees regularly harm children with and through poor work product   |
| Less expected hours to secure the license. Instead of 40hrs every two years 30hrs would be best. Again it's the cost factor. In most other states the amount of hours expected are less. Please consider this!!                                  |
| Maintaining boundaries   |
| Mandated reporter training.  |
| Many new workers are not as committed to their profession as in the past   |
| Maybe  |
| Maybe more technology assistance for workers that have been around longer.   |
| More education is needed in LTC behavioral health and interventions  |
| More training in mental health is needed.  |
| More training/education needed on trauma informed care.  |
| More trauma-informed care  |
| Most jobs available to LBSW's are also open to any other 4 year degree. A license as BSW has very little benefit anymore.  |
| Most staff are attempting to balance workload and staff shortages. I think BSRB needs to spend more time explaining to the legislature why these positions are important and salaries need to reflect the training and education.                |
| My coworkers seem to have a lack of knowledge on suicidal ideation and how to approach that. Also, there are many mixed opinions on Housing First.   |
| <b>N/A (10 responses)</b>  |
| Needed services for veterans, state and federal levels especially with current trend of federal budget cuts  |
| New social workers are mostly driven by what the learned in books in college and less by instinct and hands on experience with working with people. I also believe that graduate SW should have field experience before they get an MSW or ASCW. |
| <b>No (14 responses)</b>   |
| No observations  |
| <b>None (3 responses)</b>  |
| None at this time  |
| None come to mind  |
| None identified  |
| None my agency provides what is needed and I have been able to find what is not.   |
| None that I'm aware  |
| Not any that I can think of  |
| Not aware of any.  |

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| Our patients are not prepared to live in the high stress world that we have today. Each decade brings new stressors and I believe that people just do not know how to survive anymore.   |
| People skills, have pure empathy for staff and employees. Burnout they tend to like the money but do not to want to do the job tasks that come with the job.   |
| Person/ strength-based interview skills  |
| Practitioners always need continuing education in personal safety, documentation practices and more recently appropriate use of telehealth services.   |
| Prescribing medications without seeing the patient and/or taking in opinions and observations of others who are involved with the youth/client. Only prescribing medications to a client who is not receiving any other mental health services.  |
| Prevention and engagement. These are issues across organization and service. We are always responding to crisis, which limits options to work with the family.   |
| Professionalism  |
| Professionalism, fighting against burnout, licensing preparation   |
| Psychotropic medication use  |
| reality of rural social work and barriers to expanding the needed care to rural areas. telework changes how social work looks in society. how other careers are taking over to perform the social work because there are not enough social workers in practice.  |
| Respect, dignity, right to determination. This is seen in the healthcare sector. Patients would be observed as being told what they have to do vs. what the patient would want to do.  |
| Rules for supervision, especially across state lines.  |
| safety   |
| Safety. More training on how to interview intellectually disabled adults.  |
| See a decline in the number of individuals seeking a degree in social work and a number who have a degree to not license.  |
| Self determination, boundaries, ethics, more focus on the impact of your decisions as a social worker especially in child welfare  |
| Social work as a profession often leans unapologetically progressive and aligns with more democratic political values. In contrast, Kansas maintains a predominantly conservative and Republican-leaning political culture. I have observed situations where social workers, driven by political ideology, have become confrontational in ways that ultimately alienate individuals from needed services. This tension can create internal conflict for practitioners who strive to remain true to their political convictions while serving a population that largely holds differing views. Unfortunately, in some cases, this has led to open hostility rather than compassion toward those with opposing beliefs. This highlights a critical need for more training in cultural humility and political neutrality in service delivery. Social workers must be equipped to navigate ideological differences without compromising empathy, professionalism, or access to care. |
| Substance Abuse  |
| Supervision, Leadership/management training when moving to admin roles<br>CEU tracking -Easier way to sync multiple licenses that use similar CEUs. Which alcoholic  |
| Telework ethics  |
| Telehealth and texting   |

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| The child welfare system has fewer licensed workers   |
| Therapy modalities and diagnosis  |
| There are plenty of concerns but you do not need to make it harder to get licenses so I do not want to share  |
| There need to be more practitioners for first responders that are culturally competent. There is a lot of misunderstanding about police and first responder culture and it is hard for first responders to find appropriate therapy.  |
| Too political and ideological. There's training to deal with client trauma, but there's no training for political diversity of thought.   |
| trainings on child abuse of all kinds has went down. There are not enough LBSW's  |
| Trauma and how it effects family systems and, especially children   |
| Trauma education is always an ongoing need  |
| Trauma training!  |
| Understaffing, lack of communication between workers.   |
| Unsure  |
| When reviewing written correspondence and documents with many social workers their ability to write with correct and professional grammar and spelling is lacking. I feel the courts see this in court reports and it doesn't give them confidence in the education and training of the case workers. |
| Yes- ethics   |
| Yes- providing services in a genuine compassionate way  |
| Yes, I have been in CPS and the unlicensed CPS are having difficulties with being empathetic with customers.  |
| Yes, training on how not to be bias toward Christians, political opponents, Jews, etc.  |
| Yes. More professional professionals need to have training and education on Naruto behavior model and FASD.(fetal alcohol spectrum disorders.) and all of the struggles that come along with that for an individual.  |

**LMSW Q9. Over the past two years, based on your observations and experience practicing in the social work profession, could you share information on any practice-related negative issues you have seen, such as areas where practitioners appeared to need more continuing education or training in a certain area? (670 responses)**

(1) Mental health and trauma training for school staff (noticed while working social work adjacent positions in schools) and (2) LGBTQ population

#1 Suicide experiences: reducing suicide risk, including with people who are attempt survivors; suicide grief; personal caregiving for friends and family with suicidality; understanding that suicide loss in personal and/or professional life happens to even skilled and compassionate social workers; and including response to discussion of suicide in informed consent. #2 Grief from deaths of pets and people by any cause. #3 Social justice as basis for social work, especially in times when the federal government acts against many groups of people. Note: Those are my areas of extensive training and experience (personal and professional)

1) The business of Private Practice as a Social Worker. 2) What constitutes "scope of practice?"

1. Trauma-Informed Care - Many practitioners demonstrate gaps in applying trauma-informed approaches, particularly when working with clients with complex trauma histories. 2. Culturally Competent Practice - Social workers often face difficulties when serving clients from diverse cultural backgrounds due to insufficient training in cultural humility and responsiveness. 3. Burnout and Self-Care - Social worker burnout remains an area of concern, affecting both client outcomes and practitioner well-being. There is a growing recognition of the need for training on self-care, resilience building, and managing work-related stressors

1 Knowledge of psychotropic medications. 2 Diagnosing

A thorough overview of Ethics would be beneficial.

Actually providing therapy. Even in school, no one sits in a room with me to see what I need to do better in.

Addressing unmanageable caseloads and expected work

Adoption competency

AI, the rapid changing political climate and repercussions on or to the person who is licensed.

All of the Hospice social workers I have worked with have been wonderful. I find that social workers who are working in nursing homes are not lacking education but severely lacking pay and resources, which means they are unable to provide a quality level of care to residents.

Although there is a need for macro-practice social workers, many organizations fail to see the benefit of having social workers trained to do these tasks. So much emphasis is placed on clinicians, and it is disheartening to see the lack of respect for those that want to work on the bigger picture.

Any issues I've come across can be understood when looking at the difference in years and type of experience between myself and others. In the educational setting, SWers are an island in our building. Because of this, I tend to do a lot of extra professional development to maintain connections.

Application of ethical principles

Areas have been ethics especially in regards to AI and other technology systems. (Using AI for notes, recording sessions without clients knowledge or client understanding what consent meant in regards to information, also using technology without incorporating professional insights. Primarily using technology to do all the work and figure things out.

As an African American male in the field of Social Work, I have been a target on several occasions, of hate and discontent from coworkers and upper management. This even occurred in college and continued In The field, because it's common knowledge that black men are no protected and are not advocated for, so we are left to fend for ourselves.

As part of my continuing education I read about mental health apps and the ethical considerations for using them with clients. While I have not seen any social workers be negligent in their use of these, I am not sure if I have seen any webinars, CEU courses advertised discussing these issues. Because I don't work somewhere where CEUs are offered or provided, much of my education is self-study with a post-test.

### **Autism (2 responses)**

Balancing financial crisis in current economy while also providing quality service.

Behaviors/ ODD strategies

Being trauma informed with practitioners working in the foster care system, like not understanding the impacts of decisions on children's long-term outcomes.

Being able to work across state-lines. Esp. here near MO/KS.

Benefits and risks of AI, Addressing political based mental health issues

Better leadership

Boundaries

boundaries & presenting professionally

Boundaries and appropriate interactions with clients. Ethical issues & the need for ongoing consultation and supervision by practicing social workers.

Boundaries and ethics

Boundaries with clients.

Boundaries. Boundaries. Boundaries. It wasn't until I had my first job as a social worker that I learned the important of boundaries. I don't believe it was tough well in school and isn't integrated in continue education. I believe it is briefly discussed during self care continue educations, but I've never receive training for formal acknowledge that social workers need to learn how to set strong boundaries when working. When discussing boundaries I am speaking specifically to social workers who work in systems that are challenging or broken and learning how to say no and understand that you cannot fix a macro problem.

Burn out in social workers

Can't think of anything

CEU'S are expensive, and I don't make much, even though I have a Masters degree - so I usually complete the online ones that are cheap and they aren't great. My school district doesn't pay for any CEUs, they are all out of pocket.

CEUs on note taking, documentation, court reports, etc.

CEUs that actually give thorough information for diagnoses - not just one diagnosis.

Ceus on safety should be required across the board.

Challenges with offerings over the summer and mostly all during work hours, which is limiting for those who are unable to attend during those times.

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| Child and teen services, services in evenings and weekends for families and children  |
| Child related areas: ethical use of AI  |
| Child welfare is horrible and they need to be paid more and they need to go back to license workers handling the cases  |
| child welfare workers are NOT sufficiently trained. Social workers need more training in areas related to AI and remote practice.   |
| Client engagement; however this is more an issue for child welfare and the variety of degrees doing the work as opposed to specifically social workers.   |
| Clinical skills! LPCs in MO are regarded as true clinicians however LCSWs are regarded as basic skill set in clinical.  |
| Clinical supervision, diagnosis and treatment continuing education.   |
| Co occurring therapy  |
| Code of Ethics-responsibility to colleagues   |
| Preamble-Dignity Worth of the Person  |
| Communication in their role is lacking. Appropriateness of relationships with clients is lacking.   |
| Communications. I have reached out and instead of forwarding/redirecting me to the correct person I have been told the person I'm reaching out to is the wrong person.  |
| Community Mental Health Center not having the staff to meet the needs of their clients. Foster care not providing needed Mental Health services for children that discharge from PRTF's that no placement has been found, so they are night to night placement.   |
| Complex PTSD and treatment modalities   |
| Confidentiality with related service providers, scope of practice, standards for professional behavior in disagreements and difficult interactions  |
| Continued suicide prevention, lgbtq+ specific ethic guidelines  |
| Continued work in educating about rural educations.   |
| Continuing education is always a plus due to the rapid and continuous changes in society.   |
| Cooperation and consultation with peers   |
| Cost, lack of a decent national organization. Nasw is a joke. We need a national union. I like the work toward reciprocity  |
| Counseling possibly   |
| Crisis in SPMI populations  |
| Crisis mental health, suicide prevention, leadership soft skills, supervisory skills  |
| Critical thinking/problem-solving skills, ability to help clients get to their self-determination, different opinions on intakes/assessment, leading with assumptions/opinions.   |
| Cultural awareness, Disability resources, AODA/SUD  |
| cultural awareness in a rural setting   |
| Cultural Competency - Kansas-specific child welfare, guardianship, and juvenile justice processes. Advocacy skills at school board, county, and legislative levels. Ethics & Boundaries in a Politicized Environment. Political pressure on topics like gender-affirming care, sex education, or diversity programs. Navigating personal vs. professional beliefs |

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| Cultural diversity, it seems to be targeted, meaning there are certain cultures that are studied and/or given attention.   |
| Cultural humility. Patient centered care   |
| Cultural sensitivity! Understanding policies and how politics impacts as social workers as well as our clients. I cannot believe how out of touch some social workers I have encountered can be. Also, privilege and its effects.  |
| Culturally sensitive interventions and working with people of color.   |
| Culture.   |
| Currently, I would think that a clear ethics driven view of DEI in our political climate that seeks to neither understand or care is critical. Adhering to our ethics in the face of political pressures, pressures from our employers, and from society would be good. Continued cultural competency courses! |
| DCF social workers need a lot more training  |
| Decreasing stigma with diagnoses such as BPD, Bipolar Disorder, available services in the community for clients with autism.   |
| Decreasing the expectation for Dx training to 3 hours vs 6hours.   |
| Definitely do not feel properly trained to be a mental health therapist.   |
| Diagnosing and documentation   |
| <b>Diagnosis (2 responses)</b>   |
| Diagnostic, child therapy, therapy interventions   |
| Diagnostics  |
| Diagnostics. I am constantly seeing people being diagnosed with bipolar disorders who have never met criteria for a manic episode. There should definitely be a higher standard on this, not just in social work, but in mental health in general.   |
| Difficulty in recognizing personal bias  |
| Direct practice. Serving certain populations such as children or families. Understanding the importance of family systems when working with children.  |
| Directing plan of action after initial session/evaluation  |
| Disabilities- physical, intellectual and developmental   |
| Discharge planning, medical practice in general. My masters program was heavily focused on mental health which is great but there are so many of us working in a healthcare role and I don't feel like my masters program talked about that at all.  |
| Diversity foster care and adoption   |
| Documentation and billing, recognizing vicarious trauma  |
| Documentation and clear parameters on HIPAA compliance   |
| Documentation, burn out  |
| Douglas County TRC: comprehensive overhaul of staff training on recognition of escalating crisis symptoms, verbal de-escalation of crisis symptoms, use of holds, and use of restraints.   |
| Dual diagnosis, training in EBP, differentiating between ethics and competency   |
| Dual relationships - specifically boundaries with social media and clients.  |
| Due to the current political climate, understanding legal requirements as a school, social worker in public education  |
| During my 1st year of supervision. My supervisor did not provide me with anything educational or help with case consultations. I could not report the issues out of fear of retaliation.   |

During the past two years, I have noticed two recurring gaps in clinical practice that would benefit from further professional development. First, a growing number of clients present with co-occurring substance-use disorders and mental-health conditions, yet many providers still treat these issues sequentially instead of through an integrated, evidence-based approach. Additional training in dual-diagnosis assessment, medication assisted treatment coordination, and collaborative care models would help clinicians address the compounding impact these combined disorders have on housing stability, employment, and other social determinants of health. Second, there is a marked increase in children and adolescents exhibiting problematic electronic-media use, accompanied by shortened attention spans and ADHD-like symptoms. Clinicians often lack familiarity with validated screening tools for digital overuse and with family-centered or school-based interventions designed to mitigate its developmental and academic consequences. Focused continuing education in both integrated co-morbidity treatment and pediatric digital-media assessment would substantially enhance the quality of care we provide.

Education pertaining to communities that support children with autism within the school system. We need more options and education for this population of students.

Empathy training for increased culturally appropriate care

Employee shortages and turnover

ESL services

Ethical dilemmas, more needed in setting the expectations that we are professionals and that does mean giving up / self sacrifice, and to have firm and clear boundaries and not pass them. I frequently talk with legislators and there is this ethical issues that come up frequently but more so "bleeding-heart" liberal conservations. And I do agree with some of what they say. This also has to do with boundaries and giving people news they don't want to hear and conflictual conversations. I'm also concerned that the child welfare system now has lowered the requirements to be a case worker. There are fewer case managers I would consider a fellow swer, licensed or not. And that is hurting our profession. It's also hurting the CW system!

ethical incorporation of technology into social work practice, work with diverse clients, work with teens

Ethical issues in the school or educational field as it's difficult working with on social workers who don't have ethics to follow so more training in ethics would be helpful for in the educational workplace

Ethical Use of Technology and Telehealth:

The rise of virtual service delivery has exposed some gaps in ethical practices, confidentiality protocols, and client engagement in telehealth environments. More training in best practices for digital communication, documentation, and boundary-setting is needed.

Ethically navigating organizational dynamics and dysfunction

**Ethics (5 responses)**

Ethics and multi-disciplinary collaboration

Ethics and professional boundaries

Ethics is always a good topic to stay on top of.

Ethics on ai usage, ethics on virtual sessions

Ethics regarding politics.

Ethics, appropriate boundaries.

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| Ethics, safety  |
| Ethics, Tx&Dx   |
| Everything administrative- supervision, budgeting/grant writing, strategic planning, change management, etc.  |
| finding continuing education credits in diagnosing is difficult. Every CEU offered seems to be related to macro or ethics.  |
| Foster Care   |
| Free training with CEU's.   |
| Gender affirming care   |
| Given the current political and funding climate, I believe that all social work education should include classes on grant writing and fundraising.  |
| Graduates seem to have difficulty passing the licensing exam.   |
| Grief and loss  |
| Grief support   |
| Grieving the loss of a client.  |
| Handling behaviors of students in an educational setting.   |
| Hard to say..maybe education on Medicare and Medicaid differences. Streamline services.   |
| Rural practice work and access to services  |
| have not observed any practice-related negative issues.   |
| Have observed the need for additional training in behavioral health crisis / suicide assessment.  |
| Health literacy   |
| High burnout, lack of patience, compromised quality of practice.  |
| HIPAA, helping clients learn to advocate for themselves, immigration, social media.   |
| Homelessness. Reduction of real income based housing in section 8 waitlist.   |
| How politics impacts clients.   |
| How to advocate for the profession more in a school setting.  |
| How to be more person centered, to advocate for the client vs trying to appease the system  |
| How to ethically use AI   |
| Human Giver Syndrome. Gender identity (I think most people lack understanding about that so we need to up our game). Insurance.   |
| human relationships   |
| Human rights and how to better advocate in these changing times   |
| I also work at KU as a Liaison. I feel that there is a need for CE on supervision.  |
| I am a nephrology social worker and spend a lot of my time dealing with patients who have Chronic Kidney Disease and require dialysis three times weekly. Many have been in denial for years about the severity of their illness and refused to address it before it descended on them. Denial is an aspect of life that many patients have not considered as an intractable condition, yet it has sentenced so many of them. I spend a lot of my time encouraging them to stay positive and plan to make the most of the life that remains. It all starts with acceptance. More training on this critical aspect of life would be tremendously helpful for anyone dealing with patients in end-of-life situations. |
| I am concerned with the quality of MSW education. Even while I was in school, I feel like all students pass, no matter the quality of their work. Many new MSW require a lot of help with professional writing and diagnostic skills.   |

I appreciate the required ethics training and feel that needs to continue. I think treatment planning is another area that should be addressed i.e. establishing treatment goals with patients, making referrals, acquiring services/resources.  
I think it might also be good to offer something on how to navigate insurance requirements.

I attended a Generalist Master's Program. I was highly frustrated that they did not have a Clinical track that I could at least get some training in. That information would have benefited any are of Social Work but been available to those who were considering clinical work. Also, I would have liked a course or a CEU on the legalities of being a social worker. Not just the ethics. Also having a course or training of some type available on navigating and becoming licensed and credentialed for those who pursue it. The part on becoming licensed could be a short video on the BSRB website. There are just some things better explained in person.

I believe it could be very helpful for there to be required CEUs on the science of the brain...right brain/left brain, limbic system, amygdala, etc.

I believe that there is a general lack of empathy and understanding for those that have differing thoughts, feelings and opinions than one's self, unfortunately this is not an attribute that is easily "trained."

I believe the decrease in msw practicum hours has lead to less prepared new grads in the work force.

I believe there needs to be more training in management and public policy

I can not think of any.

I cannot recall any specific instances within the last two years.

I could

I do think more continuing education in ethics and our code of ethics would be beneficial considering our current political climate. I also believe more training and education in diagnosing and treatment/DSM-5 TR, is necessary for the success of consumers.

I feel it should be more affordable considering we don't make a lot of money!

I feel like the providers I work alongside are seeking out CEU's and webinars to better understand the changes of our field

I feel like there are always ethical issues that I see. Not major but some. Ethics continuing education credits don't seem to help. Maybe including real life scenarios that social workers have been in and questions about how others would handle the situation would help rather than just a presentation of what ethics is.

I feel like there is a shortage in social workers and the requirements needed to get a C is unobtainable in some cases.

I feel most of the areas of concern are surrounding boundaries

I feel that nursing homes should REQUIRE a Licensed Social Woker instead of an SSD (Social Service Designee). Some times the are straight of the nursing home kitchen or activities director. They have no clue how to do their job. These older people deserve better advocates.

I feel that too many practitioners do not have heart for social justice, and only care about what some random man in camo says.

I feel the profession is growing and that is a plus.

I feel we have way too much training by way of CEU's and the number of them .

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| I have almost 20 years of experience in SW and have no interest in getting my clinical license. I worry that I will face the possibility of being told I have to or I'll lose my job.   |
| I have encountered a number of MSW's in KS who report having failed their licensure or don't feel they could pass their licensure exams. They are working at the same level as I, but their lack of knowledge is staggering. I have equated it to either poor educational programs or lack of participation in CEUs. This is evident in not being up-to-date on current treatment methodology, terminology, and standards of practice. They are also not following any code of ethics. These appear to be newer graduates within the last 10 years. Most of which are reporting having gone to smaller or online colleges.  |
| I have encountered many great social workers and a few who need some more support, particularly in trauma work. I think more CEUs and access to free training on trauma therapy modalities would be helpful.  |
| I have not been practicing. Your stupid survey doesn't have a BOX for my position, which is not working as a LMSW in any way shape or form.   |
| I have not experienced this issue.  |
| I have not personally dealt with this concern   |
| I have not run into any issues.   |
| I have not seen anything  |
| I have noticed that students coming into the field are not prepared do engage in practice. I feel like schools don't properly screen students and students with harmful beliefs are being let into the field. I have seen this in my professional practice of working with students as well as when I was a student. Additionally, I feel like there should be more training required for clinical supervisors. I have had two very poor clinical supervisors and with how much time, money, and effort is required to earn a clinical licensure I wish there were more requirements and checks and balances for people to be clinical supervisors.   |
| I have noticed there are less CE opportunities for ethics and diagnostics through our academic institutions.  |
| I have only been an LMSW since May 2025!  |
| I have only done practicums and I got my license a few weeks ago.   |
| I have primarily worked in the corrections field of social work. The supervisory staff that has been in positions of power above me have been inadequately trained in the setting they are coming into. It would be in BSRB's best interest, due to the growing prison population, that corrections supervisory staff be vetted and screened much better so that undue familiarity and unfortunate situations can be avoided. In the years that I worked in corrections I had 2 supervisors get caught up with Offenders. One supervisor actually was stupid enough to marry the guy she was 'counseling' and then got beaten up by him severely. The second supervisor was discovered early enough and terminated. |
| I have seen other social workers needing more training on cultural competency and acknowledging their own biases  |
| I have seen the most issue with unlicensed social workers who are not held to the same standards but doing social work jobs.  |

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| I have seen unethical behavior at an alarming rate. Poor supervision, unsafe environments and a lack of professional education. I have met social workers and supervisors who lack a basic understanding of the law, the ethics of this profession and what a safe work environment looks like. When I expressed safety concerns I have felt as though I am wrong for speaking up.   |
| I have witnessed clinicians that need to take more time in listening to their clients and be more empathetic and understanding in their practice with them. I get clients that complain that they feel they have not been listen to , heard , respected, or that their wants and needs were taken in to consideration. Clinicians need more training on meeting the client from where they are at and providing empathy, understanding, and respect.   |
| I have worked the majority of my career in hospital settings. I observe that many current social workers in that setting perform only what is necessary for checklists, requirements, and minimal target outcomes. I have had at least 30+ practicum students in my career, and I fostered and mentored patient/client focused interventions for best possible outcomes. There is an absence of critical thinking then planning the best intervention and outcome. Doing as little as possible seems ok now! |
| I haven't really thought about it.   |
| I just returned to the field last summer and typically only work 2 days away week so can't really speak to that.   |
| I just think there could be more free CEU opportunities as well as affordable CEUs directed at interventions using typical modalities: CBT, ACT etc.   |
| I know it is part of continue education however, most LMSW and LSCSW are not as comfortable with providing a diagnosis.  |
| I personally did not have much training working with suicidal clients in grad school. It wasn't until I started working with Johnson county mental health that I recorded this type of training. I think a lot of practitioners need more training in this area in learning how to be comfortable/calm talking with suicidal clients   |
| I personally feel social workers should have more comprehensive education on Medicaid insurance - eligibility, coverage, spend down, etc. It would be amazing to see CEUs centered around Medicaid.  |
| I received very little instruction in my MSW on modalities.  |
| I recently saw a great presenting how to teach people how to break up. That is very helpful  |
| I see often that we can improve our understanding and practices of confidentiality.  |
| I tend to have a lot of policy and reporting questions, especially as someone with a license who doesn't currently work using that license.  |
| I think a lot of social workers who are not working directly in mental health struggle in the area of having knowledge of services and understanding diagnosis of patients/clients.  |
| I think all are trying their best in the world we live in and wish we all could better connect and work together   |
| I think as a whole we need to prepare for the loss of SW with AI technology. We need to review requirements for clinical licensure and make it more reciprocal for when we have reciprocity, to maintain or increase LSCSWs practicing in the field.   |
| I think DEI is severely lacking  |

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| I think it is important for people to be clear about if they do or do not have licensure and then to practice within their scope of licensure.   |
| I think it would be helpful to have CEUs offered at reduced/low prices considering the licensing fees and other costs therapists/social workers typically face in their profession.  |
| I think more education is needed on adaptable social skills and how this relates to working with clients, colleagues and other professionals.  |
| I think more training in communication and documentation. Maybe also refreshers about policies and regulations from time to time   |
| I think overall practitioners need consistent and high quality training focused on understanding and affirming LGBTQ+ identities. Additionally, training that focuses on intersectionality, unpacking racial bias, understanding classism, and understanding politics and the implications of politics on their clients' lives and their own practice.   |
| I think pay is remaining stagnant and hard to survive on with increased demands and acuity. It seems the best way to survive is to become clinically licensed and do private practice. I fear mental health will become a privilege. I do see many working towards EMDR and addictions work. I believe it would be beneficial to expand funding streams to recruit more to the field as a graduate degree is expensive.  |
| I think since Covid, a lot of opportunities for training have decreased specifically in person trainings, which are so important and networking. I see more things offered online, which is convenient, but not always as effective. Specifically, I have not seen trainings that include updated research regarding best practices.   |
| I think some of the basics like confidentiality as well as being purposeful with clients. I have been shocked about how some people talk about clients and information given as well as how some cases are handled. For example a therapist meeting with a teen for years and not really working on any goals and spending that time playing uno and not having any in depth conversations from how it's been explained to me. I think sometimes people lose their purpose and why and the basics are lost because they get more focused on the busy work of making sure they are billing or the paperwork side of things. |
| I think that AI and technology and it's role in SW profession is something we should all be learning more about.   |
| I think that the diagnosis CEU change will be helpful because they are hard and expensive to obtain. It's hard to know what CEU's count or are approved for licensure. I think we will need continuing education in AI in all aspects of social work. I also think suicide issues and LGBTQ issues need constant knowledge upkeep  |
| I think the increased professionalization does not match salary and benefits in most social work employment opportunities.   |
| I think the practicum and continuing education credits being cut has done a great disservice.  |
| I think the supervision hours is a bit steep in contrast to Missouri regulations.  |
| I think we all need my continuing education towards social media and technology. But unfortunately it is a continuing evolving and going faster than at times we can keep up. A lot of my students issues stem from social media or some form of technology.   |
| I thought that fellow social workers would providing support and guidance. Most do not.  |

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| I went to Washburn for one year for my MSW- the instruction was so poor and the leadership was also very low quality. I personally have been to social workers who graduated from Washburn for my own therapy and they were awful. This university need more guidance and regulation on their program, it's awful.   |
| I work as a SPED SW for KCK school district. It would be helpful for us to get more training on behavior issues in children such as Autism, ADHD, ODD, drugs/alcohol and gangs in the school setting.  |
| I work in a hospital setting and have worked with very skilled social workers all around!  |
| I work in a prison setting and a few of my coworkers have terrible communication skills. They allow themselves to demean the inmates to feel power. One is a social worker. The other isn't. Just basic empathy is missing so often.   |
| I work in a school setting, where upper level personnel, such as the superintendent and principals, do not fully understand the social worker role in a school. I have been discredited, undermined, often forgotten about until they need something for me. I would like to have more training based on how to support my role as a school social worker with administration.                             |
| I work in child welfare and there needs to be a child welfare track.   |
| I work in corrections (State Penn) and it presents many more challenges than you might experience in the civilian sector and more training in this area for those considering corrections  |
| I work in education and it has been hard to find training specific to school social workers.   |
| I work in the field of domestic and sexual violence advocacy. Practitioners often lack training in these areas.  |
| I work with hospice social workers and listen to their stories from across the country. A general theme is that they are run by medical professionals and the social workers do not receive respect as a profession. They are just looked at as the do everything person other than medical. I do a lot of coaching on trying to get them to set boundaries with their coworkers as well as their clients. |
| I work with practicum students and there is a huge lack of consistency of what is being taught in social work programs. I work with 3 different universities and some students I have to teach theory to, some advocacy and others social work ethics all dependent on which program they have attended  |
| I would like to see ethics training about working with diverse populations in the current political climate.   |
| I would like to see the LSCSW licensure be more specialized and provide Options for folks To take an exam focused on child mental health, adult mental health or both and receive specialty licensure. I believe more requirements for writing treatment plans and progress notes to satisfy insurance while maintaining HIPPA should be required for renewals   |
| I would say insurance knowledge, billing, when to add community support services to billing  |
| I would say more training in the area of confidentiality. So many share in office client stories that aren't intended for drama/gossip amongst staff.  |
| I would say one of the biggest areas is the types of assessments that are out there that can be used in mental health. Also better understanding mental health crisis in children as well as gender identity issues.   |

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| I would say that I've worked under too many Social Work managers that I feel could use more training on how to manage and provide supervision. And I feel there's too much gray area when it comes to confidentiality and continuum of care in the healthcare setting. |
| I would say that the area that most practitioners need to remain current with would be diagnosis and assessment areas, reducing CEUs in this area I feel would do more harm than good to patients.   |
| I would say, we need more exposure to the special requirements for recertification.  |
| I would like to see more continuing education  |
| I'm not familiar with any  |
| I'm pretty new to the field so I don't have any information to share.  |
| I've noticed that new social workers entering into the field, tend to bring a lot of political ideologies into practice. I feel like no matter who we serve, they should never know our political affiliation.   |
| I've observed "untreated treaters" during my career. The value of Boundaries separates the professional SW from the novice. CE about Boundaries and Compassion Fatigue would be helpful in my opinion.   |
| I've seen many mental health professionals in general becoming therapists who claim to be trauma informed but show they are not with very little knowledge of their own trauma, how trauma is often a family cycle and stemmed from childhood. It is concerning.       |
| I'm concerned that LBSWs are allowed to work in hospice  |
| Impact of social media personal accounts on professional presence  |
| Implicit bias, immigration,  |
| In Kansas I think the largest area needing education is within foster care. This area has been abused by profit makers, even if they state they are nonprofit. Unrealistic outcomes and too many cases for one case manager. I will no longer work in foster care.     |
| In my experience, there are social workers that work with DCF that are not well trained in working with children who have been through trauma.   |
| In my opinion and experience I have worked with professionals that could use additional training in confidentiality  |
| In my opinion, social workers and other professions under the BSRB umbrella need additional training on post-separation abuse and how this affects children and survivors living in this difficult situation.  |
| In my particular area of social work, homelessness and poverty and scarcity of resources have made my job much more difficult. I would love to see more training about how to better serve my people.  |
| In the area of cultural awareness and gender non conformity  |
| In the past few years I have observed several social workers that are concerned about Mandated reporting, or not understanding their roles.  |
| Infant and toddler health  |
| Insurance  |
| Insurance for private practice psychotherapy.  |
| Insurance issues   |
| insurances, elderly  |

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| Intellectual and developmental disabilities, how the effects of prenatal substance use/intimate partner violence present in children  |
| Interdisciplinary collaboration,  |
| It appears that many social workers graduate and are ill equipped to manage the issues that are present within the community.   |
| It appears to be difficult and sometimes costly to obtain clinical supervision.<br>On a personal level it has been very difficult for me to get consistent therapy for my daughter over the last three years.   |
| It feels like the newest set of social workers struggle with adhering to the code of ethics!  |
| It is unfortunate in child welfare a license or degree is not required. This is degraded the system. "Back in the day" there were true social workers working with families and supporting broken families. Now, it is often individuals with no training, resources, and broken ideas trying to be in the helping profession and over their heads. |
| It makes sense as CEUs and training are obviously geared towards those who are practicing and seeing clients, but I think that macro training and educational opportunities are lacking.  |
| It seems the younger social workers I have been around are not willing to put in extra time, if needed, and then others have to pick up the slack. I don't think this can be taught in a CE.  |
| it takes too long to get your clinical hours and you start losing hope and your spirit gets broken and you finally just say forget it it's not worth it   |
| It's difficult to find relevant training/CEUs in diagnosis and treatment category   |
| It's the other staff that I work with who are social workers that need some additional training   |
| I've noticed a growing need for practitioners to grow in their ability to address each other, directly, when they suspect incompetence or want to question practice-related decision making.  |
| I've run into a number of social workers who have a concerning lack of curiosity and empathy. This is not the case with most, but some people really struggle to see the people we serve as human beings with complex realities instead of just clients that they only serve for a salary.  |
| Knowing specific statutes related to social work practice. Specific suicide intervention skills. Navigating ethical concerns and boundaries   |
| Lack of awareness regarding boundaries among some social workers and other mental health professionals  |
| Lack of funding   |
| Lack of funding and poor pay, for example in child welfare  |
| Lcsw's appropriate supervision  |
| Learning boundaries with clients, professionalism, understanding code of ethics and applying it, transference.  |
| learning how to advocate for ourselves in settings social workers to not take on additional tasks outside of our expertise.   |
| Legal issues, co-morbid diagnoses, esp medical & neurological, Autism & perceptual disorders, including Expressive Receptive Language Disorders   |
| Legal issues, use of the DSM  |

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| Lessening the requirements for licensed social workers. We shouldn't lower our standards just to get more workers.  |
| LGBTQ community, interacting with clients on social media and discussing their opinions about current presidential administration   |
| Licensure prep.   |
| Long Term Care setting: disease processes and the accompanying dementias, behaviors and social needs. I.E: Parkinsons' disease has specific behaviors and needs with its dementia which effects parts of the brain differently than Multiple Sclerosis dementia.  |
| Macro level work, advocacy and policy practice  |
| Maintaining boundaries in the social media world. Respecting/understanding religious beliefs and practices and the impacts on client-worker relationship and within the workplace.  |
| Maintaining professional ethics while utilizing AI and other new technologies.  |
| Mandated reporting  |
| mandated reporting expectations   |
| Many seem unfamiliar with the Grand Challenges.   |
| Maybe more training to be in the educational setting  |
| Medical case management turn over seems to be an issue in my field.   |
| Mental health   |
| Mental health across the board social workers need more education about   |
| Mental health for all ages/populations  |
| Mental health therapist are being pushed to do more SUD related therapy instead of the SUD team members.  |
| mental health with children, dual diagnosis, self-care  |
| More CEU focus outside of children and families   |
| More CEU needed on use of AI from a practical but ethical approach. Recently had a great session put on by the practical center for bioethics and I would love to see more of that offered, and at an affordable rate.  |
| More continuing education is special education, coping skills, different disabilities such as IED, data collect for SSW.  |
| More continuing education on financial hardships  |
| More continuing education.  |
| More diagnosing and treatment CEU's. Those are difficult to come by and can be costly.  |
| More education regarding suicidal ideation, LGBTQ+, anger management and conflict management. There seems to also be an increased need for couples therapists.  |
| More resources need to be allocated in teaching social workers how to advocate for social/client issues with elected officials on all levels (local, state, and national). More emphasis needs to be placed on mezzo and macro practice - provide visible examples of what this could look like in an everyday practitioner's work would be helpful. I would love to see 1-3 hours of required mezzo/macro training per period for license renewal. |
| More therapeutic strategies and interventions would be helpful.   |
| More training around grief and loss, anxiety and eating disorder identification.  |

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| More training in crisis. I worked in the emergency room for years. So many social workers think it's time to do crisis therapy in the ED no appropriate.   |
| More training in providing clinical diagnoses  |
| More training on adolescent behavior interventions   |
| More training on use of technology especially in settings when the agency/ school setting does not provide you a work related phone.   |
| More trainings are needed around ethics. Some social workers honestly need an ethics refresher and it's scary.   |
| More trauma informed approaches taught in the schools (including teachers too)   |
| Most nursing facilities hire SSDs but not people who are actual social workers. The lack of education is usually very apartment.   |
| Most social workers have to paid for CEU's/training out of their own pocket and need 40 every two years. We need to have less CEU's or affordable training to meet the 40 hours CEU's  |
| Mostly cultural competence, but sometimes that is something that needs to be learned as you grow.  |
| MSWs calling themselves social workers   |
| Multiple supervisors would focus more on company policy rather than ethics which led to counselors burning out and leaving   |
| My previous practice site conducted unethical terminations. I think clinical social workers would benefit from additional education on how to navigate, improve, and support systems when their practice sites are experiencing systemic challenges. |
| <b>N/A (55 responses)</b>  |
| Need computer training and job finding assistance  |
| Need more free CEU opportunities. I appreciate the fee ones through KU   |
| Need more Spanish speaking Licensed professionals. At my employment, learn how to document.  |
| Need more training about fentanyl  |
| Need way more Mental health specific training and definitely need licensed Social workers back in child welfare investigations and case management positions. Level of service has declined.   |
| Needing to see more trainings for staff regarding basic family engagement and topics related to do no harm.  |
| Neurodevelopmental conditions and thought processes related to those who suffer with personality disorders. Thought processes are only taught in the lens of depression/anxiety.   |
| Neuroscience-related information to help teach/explain to clients how their nervous system works and how different interventions can support regulating their brain-body.  |
| <b>No (81 responses)</b>   |
| No comment   |
| No gaps that I have noticed.   |
| No I personally feel the social workers I know have the training they need.  |
| No one seems to know about attorney-client privilege   |
| No only with other disciplines of counseling   |
| No specific observation, would suggest crisis response; i.e. natural disaster - death, car accidents - death, work related injury - death, etc..   |

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| No, I am pretty isolated where I work.   |
| No, though always more MI, SBIRT, and other brief interventions for substance use concerns are always helpful!   |
| No. My educational needs are provided for me at my setting. Most social workers in my setting are extremely knowledgeable and seasoned professionals, I have learned more by doing (on the job) verses class setting.  |
| No. My observation is that there are not enough licensed Social Workers in the field   |
| <b>None (19 responses)</b>   |
| None I can think of  |
| None observed  |
| None that I can see by working remotely  |
| Non-profits, but think the lack of training is often due to lack of ceu funds  |
| Nope   |
| Not aware of any. Prior to 2 years ago - am aware of a licensed lmsw who was disciplined but has maintained employment as an lmsw but falsely maintains she works out of another state now. She and her employer together falsely state this.  |
| Not enough clinicians, not enough specialty providers, evidence-based practices not used consistently, need to train in measurement-based care   |
| Not enough LSCSW to accept certain insurance although many LMSW have more experience.  |
| Not in my practice   |
| Not particularly- it seems they are just overworked and underpaid (story of a social worker) and it's difficult for them to complete quality and timely work/documenting.  |
| Not really   |
| Not really - the social workers I typically encounter are competent and caring   |
| Not seen any negative practices due mainly to my isolation.  |
| Not specifically   |
| <b>Not sure (3 responses)</b>  |
| Not that I can recall  |
| Not that I can think of.   |
| Not the last two years but when I was actively working, I felt like I was being baptized by fire. Although I was trained I never shadowed anyone doing each type of therapy for the first time, to feel more prepared. Whether it was Functional Family Therapy (FFT), individual, play therapy, marriage/coparenting, etc...all of which were mandated by the courts, it was either sink or swim. I think it would have helped tremendously to have observed & shadowed an experienced therapist during their sessions with various clients, situations, and types of therapy/techniques used. But they had so many referrals the focus was on serving them not on making sure they were served in the best way possible. And it was definitely not focused on the therapist learning, feeling prepared, or any self care. The more sessions you completed and the better outcomes you could create (having positive reviews at the end of therapy with our surveys) the better. The surveys were the most important. If you got good feedback, the more clients that would get stacked on your caseload. |
| Not those with MSW, but there are many issues with training and skills in social service settings.   |
| Not to my experience   |
| Nothing at this time   |

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| Nothing I noticed  |
| Obtaining an LCSW is nearly impossible with a supervisory role or someone who provides intake or crisis work on a prn basis. I had to leave a supervisory role and take a pay cut to increase my availability to clients.  |
| Of concern to me is Social Workers being fired due to conversations they've had with adolescents around disclosures they have made about issues they are facing. I do not feel employment should be vulnerable to being terminated based on using words like erection (or really anything that pertains to body parts and body functions) if they are disclosing and SWer is discussing with them for clarification about what to include in a report to DCF. In addition, I believe we should be treated like any other whistle blower that discloses FERPA and HIPAA violations and advocates for students right to privacy. Someone who is upholding the ethics of their profession in advocating for their clients, using trauma-responsive approaches and promoting confidentiality should not be fired for it. |
| Ongoing I hear social workers using spirit breaking language and practices. There seems to be a lot of burnout and bitterness among some social workers and it effects client care.  |
| Opening their own private practices and having the proper training in grad programs to feel confident to be a therapist upon graduation.   |
| Organization that have been unable to employ licensed social workers have moved to hiring others without licenses. This is creating barriers for families as they are not getting the services they deserve and desperately need.  |
| Over diagnosis in adolescents and teens.   |
| overall I feel that many of the other social workers I encounter in my current practice are incompetent and do not share values of social justice nor do they remain impartial or objective.   |
| Palliative Care; Social Work with today's technology (Social Media and how that impacts patients)  |
| People are very confused about ethics.   |
| Please stop trying to water down social work standards to fit LPC/LMFT standards. Our ethics and holistic approach make our role unique and losing sight of that is a disservice to our clients and profession.  |
| POINT BLANK - I really am not sure I care to continue updating my license because I am no longer proud to be a social worker. As a profession, social work continues to assume everyone has the same faith and political values, they tend to be bullies, they shout about ethics yet hate true advocates (and they definitely won't speak up about abuses in a work environment because they care more about protecting the status quo).  |
| Policy and funding steams. All social services have a cost and many are just realizing that the programs they work on are in jeopardy due to the proposed FFY 26 funding cuts.   |
| <b>Possibly (2 responses)</b>  |
| Post Partum; Trauma and Psychedelic assisted therapy   |
| Practices such as ACT and the ability to recognize the difference between anxiety responses and ODD. Often I have seen kids labeled as having ODD when their responses are more in line with anxiety or trauma.  |

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| Practicum supervisors needing background checks and more training in ethics. Likely, an interview process for pairing supervisors with student interns.   |
| Practitioners could benefit from additional training in Documentation.  |
| Practitioners could use more education on Workplace Violence Prevention and how to manage patients with complex medical and co-occurring diagnoses from a strengths based approach during incidents of violence. While it may be difficult in the moment and we must meet people where they are at, we should not dismiss patients away for the behaviors they seek care for. I have also noticed hospitals using social workers for case management rather than at the top of their licensure scope or including them in wrap around care & therapy services. I would also say practitioners need guidance on changes with gender affirming care and risk/legal guidance |
| Practitioners definitely need more information about ethical use of AI in social work. I am extremely concerned about people using it to take notes during therapy sessions. Not all social workers are reading the privacy policies for the AI scribes they use, and I am concerned that people see "HIPAA-compliant" and don't do any further digging into the small print. BetterHelp claimed they would not disclose HPI too, and that didn't turn out to be the case in the end.   |
| Practitioners in child welfare and mental health  |
| Practitioners need more continuing education in mental health. As providers who typically work directly with the general public, it was shocking to see the requirements were lowered as being mental health informed is so important. I think that having more training in burnout would be a good idea along with having additional trainings available for trauma-informed care.   |
| Practitioners need more training and continuing education before starting clinical work. There also needs to be more regulation/training before practicing with certain populations, such as with the perinatal population, or with couples.  |
| Practitioners seem to need more continuing education on trauma informed care especially regarding sexual violence, anti-fat bias, how to support transgender clients, and polyamorous clients.  |
| Prenatal alcohol exposure and its impacts, research and its impact on the profession  |
| Probably not  |
| Probably Telehealth.  |
| Professional ethics   |
| Professionalism and understanding...working by the code of ethics.<br>Also...dealing with their own personal mental health issues.  |
| Projection, lack of self-care emotionally and physically, Transference  |
| Providing and receiving supervision   |
| Providing involuntary services unethically in order to charge fees/generate income. This includes the content/curriculum being beyond the comprehension and literacy levels of clients, offering a sliding scale but charging full price to clients whose fees were covered by a grant. Misrepresenting content as research but has not been validated, peer reviewed or data gathered to continue to test the theory. Poor documentation. Poor follow thru with referral sources. Slow to return email and phone calls.  |

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| Psychiatric treatment: I worked with a team of child psychiatrists for 4 years through the KU school of medicine and graduate school did not prepare me at all. SWs could benefit from the expertise of child psychiatry and not midlevel APRNs who treat with psychiatry medications. They do not know what they are doing. Diagnostic training is also important again from a expert PhD level psychologists or psychiatrists. We do not do these two things very well and misdiagnose and misrepresent psychiatric treatment modalities. We need to be recommending what the AACAP recommends. Also, gene site testing is not recommended by the AACAP for children but yet, I hear it recommended all the time. It only treats what the liver can metabolize not conditions of the brain. |
| Recommendations related to virtual work, protecting electronic files containing PPI, ethics of AI use   |
| Religious trauma, autism  |
| Safety planning for DV victims.   |
| Safety planning vs sending clients to emergency rooms for inpatient psychiatric hospitalization assessments and their availability of resources in the county to do these assessments through a cmhc  |
| School social work  |
| School social workers could always use additional guidance with ethics and communicating with foster care agencies and families   |
| Social justice and diversity and inclusion.   |
| Social workers need more education around substance use disorders, including but not limited to appropriate language: understanding SUD as a chronic disease; harm reduction as vital prevention services; Social workers need to stop stigmatizing SUDS.   |
| Social workers need more exposure to suicide care, understanding of the system in which we operate, how to best serve those with I/DD   |
| Social workers need more special education laws training to assist with advocating for the student parents, and school to ensure they are receiving support for academic or behavioral needs required to be successful.   |
| Social workers need more training in the healthcare field.  |
| Social workers need support navigating evolving policies related to mental health, including changes in gender affirming care mental health policies  |
| Social workers need to keep up on current culture / sensitivity such as transgender, immigration issues   |
| Social workers no longer are happy doing case management and advocacy work. All new social workers just want to open a private practice.  |
| Software  |
| Special education   |
| Special Education and IEP's   |
| Specifically needing more trauma related trainings  |
| spirituality used in practice   |
| Statutory/regulatory changes and a booming market for services over the past 2-5 years have created a profession that has less oversight, less emphasis on ethical practice, and less emphasis on social work versus billable hours.  |
| Student mental health   |
| SUD   |

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| Suicide intervention and implicit bias  |
| suicide intervention- still treated as taboo subject. I know of one clinician that filed a DFS report because their client (a mother) reported that their kid attempted suicide even though it was clear client was not being negligent   |
| Suicide risk assessment and abuse/neglect   |
| Suicide screens, especially with adults who need extra services but don't want to voluntarily admit themselves  |
| Supervision   |
| Supervision and collaboration during supervision  |
| Supervisors of staff could benefit from training on improved communication skills. I recently left a position because everyone in a position above me, including my direct supervisor, used inappropriate language, including name calling. Those new to the field could benefit from further education on inappropriate relationships with clients.  |
| Sure  |
| Systems training is greatly needed in foster care, accessing mental health services, understanding MCO, Kancare role, KDHE and KS waiver services.  |
| Telehealth. Knowing when to shift Clint's to in person services.  |
| Termination, crisis, diagnosis/assessment, testing tools, treatment modalities  |
| testing...adhd, complex diagnosis, using a SCID V   |
| The amount of hours required to obtain the LSCSW and trying to do it in the school setting is really difficult. You have to pay for supervision on your own and try and get enough hours. Unless you are doing therapy for your hours it is really difficult getting a lot.   |
| The area I might see is the political landscape being too divisive. I have worked hard professionally to take a neutral stance kn politics and political parties. I've seen younger sw professionals getting more vocal and taking positions. This confuses clients. Splits coworkers, amd more. Training in this area would be welcomed. Gender is a huge area of controversy. As a Christian I come with bias for 2 genders. This area of work is hard for our field with focus on dei and where I appreciate adult choices in area, pushing agenda on youth and public concerning. I don't have the answers yet concerned for our societal fabric. Drugs and immigration also huge issues that must adhere to law for law and order. Again opposing values are challenged. |
| The balance in maintaining professionals who have worked in specific areas has been off set negatively because of licensure changes. Needs to be more respect for those who have worked in their specified areas for long periods of time.  |
| The BSRB needs to shop lowering training requirement and supervision hours.   |
| The child welfare workforce could use help  |
| The clinical test is terrible. I have test anxiety so taking it the 5th time does not excite me.  |

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| The CMHCs and other mental health facilities that are on call for any type of crisis doing telehealth for a crisis call that a client is in the hospital which is right down the road is unethical and very dangerous to the clients we serve. An example of this is the mental health center in Manhattan, Kansas. It's one thing if you were a rural community and you need crisis help to be able to offer telehealth services but if you are right down the road, not more than 5 miles away even it's insane to me that they do telehealth during the day, even versus having a therapist go to the hospital to help that person in crisis.  |
| The code of ethics  |
| The decrease of hours needed to complete a practicum has made it hard to really show a student all that needs to be shown and taught.   |
| The difference between poverty and neglect. Mandated reporting requirements and implications of over reporting. Risk vs. safety threats.  |
| The explosion of "coaching" versus psychotherapy is probably confusing to clients.  |
| The increasing use of AI and questionable ethics surrounding it   |
| The main issue I have seen is certain insurance companies not covering LMSW licenses for mental health therapy in an economically impoverished area with limited individuals practicing with "acceptable" licenses  |
| The mental health/behavior need in our schools. The connection between districts and the BSRB would be phenomenal so there's more of a connection and understanding for our need and more support on a state level. Also, more parent connection.   |
| the one issue that I see as a social worker is the up and coming social workers they are not being prepared I've worked in the mental health field and the school based field probably 16 years now and I've had my lmsw 9 years. some of the things that I've seen is the being prepared when you take on a practicum student they really don't know what the social work field is about not saying all students that I've had but I've had a few really taking this seriously preparing for the lmsw test I've been fortunate of all the people that I've supervised they pass the test on the first goal but I've seen a lot of other people students come in that worked under other people that did not prepare I think the field in general not only social work just in general the whole educational field social work field or working with people field the preparation for the up and coming career people the preparation should be a lot better so that's what I see is the issue is is quality of people taking over when we retire <u>our retire they retire</u> |
| The overall education quality for the degree has gone down. I am seeing so many LMSWs essentially do private practice and the do not have the skill set or education. I am seeing <u>more harm than good.</u>   |
| The role is often misunderstood in the educational setting  |
| The role of a CHW (Community Health Worker) is replacing SWer positions throughout healthcare. These roles are not clearly defined nor have the education, training or experience of SW but I have observed will take on work out of their job descriptions, roles or they are put in the position by higher level staff such as the doctors, nurses or leadership sometimes with assumption they carry same level and even misleadingly called SWers <u>without the credentials.</u>   |
| The school system does provide continuing education but most of the time, I have to pay privately for CEU's for them to be BSRB approved.   |
| The social workers from KU seem to lack basic social work knowledge.  |
| the use of AI   |

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| Therapeutic support and services to black clients / addressing obstacles to client reluctance to access services.  |
| Therapists in private practice with next to no experience is typically not a good thing in regards to their lack of knowledge and/or appropriate training  |
| There appears to be a push by clinicians directing clients to disengage from family members and love ones if they disagree politically as opposed to working with clients to implement appropriate communication and coping skills.  |
| There are not enough practitioners in the area and definitely not enough with lived experience and non-white   |
| There have been areas where I've noticed provider could use more education on microaggressions and maintaining positive regard about clients. Knowledge about critical theories on race and intersectionality were also lacking in a provider I worked with at one point.  |
| There is a shortage of providers in the southern part of the state, particularly in the most rural areas.  |
| There is a wealth of in-service options for people who work with children however there are very few opportunities for in-service or continuing education for those working in hospital, palliative, hospice care. These in continuing education options are desperately needed.   |
| There needs to be more training about actually providing personal service. So many Social Workers are an embarrassment to me, because they feel that filling out the papers and being a broker is the only role that they have developed. The service of acting as an advocate and mediator takes getting to know that client and what they fear and what they want. This is rarely addressed in my experience with social workers in the field.   |
| They need to have more trainings for substance abuse professionals that are in depth   |
| Too many brand new social workers going straight into private practice with limited clinical experience to avoid getting that experience in an overworked and under appreciated community mental health facility. Group practice owners are then taking advantage of these inexperienced social workers and coercing them into predatory percentage W2 positions. Andover Family Counseling in Andover, KS is a specific example of a practice taking advantage of new social workers. Lindsay Sanner, owner, requires a therapist to sign a 2 year contract as a W2 employee, and then charges the therapist \$2500-\$6000 to break the contract even though they're an employee and not an independent contractor. She also takes 55% of everything the therapist brings in, and does not decrease that percentage until the therapist is seeing 20 clients consistently. She will then withhold new clients from the therapist to prevent them from earning 55-% of their pay versus 45% for seeing anything under 40 clients every 2 weeks. This is just one example of a predatory practice taking advantage of new social workers who don't know any better. |
| Training in AI in our world and the impacts it has on our clients.   |
| Training in how to do the safest, most effective practice possible in an extremely broken system.  |
| Training in medication side effects<br>Suicide and self harm awareness<br>Competent advocacy/leading clients toward success  |

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| Training on the business side would be helpful. Social Workers who go into private practice could run their own offices instead of needing to hire someone to do something simple. Billing doesn't require much time and cost too much.  |
| Training regarding state specific legislation/changes  |
| Transportation and housing resources   |
| Working with undocumented immigrants in healthcare   |
| Trauma informed care for more BSW professionals.   |
| Trauma informed care needed  |
| Trauma Informed Care.  |
| Trauma informed practices, telehealth and technology, social media, AI   |
| Trauma related disorders   |
| Trauma-informed care   |
| Trauma-informed care, holistic care and care coordination, and training in various types of modalities are the most relevant needs for SW  |
| Treating sexual abusers or those with thoughts of s.a.   |
| Understaffed and under supported in hospital settings.   |
| unlicensed professionals need more training to perform and maintain high-stress roles in the most difficult fields - substance abuse, child welfare, etc.  |
| <b>Unsure (6 responses)</b>  |
| Unsure at this time. Still learning.   |
| Unsure. I have not worked with many social workers - I was one of two in my last district.   |
| Use of AI for treatment planning, documentation, especially without understanding the ramifications.   |
| Using evidence based practices in therapy sessions, being unsure what the different options are  |
| Using work time more for personal issues   |
| We are always lacking enough pay, benefits, and support from agencies. Burn out is high and actual support around burn out isn't provided (more PTO/pay).  |
| We are seeing more co-occurring diagnoses of anxiety and depression with ADD and autism, and how this affects other mental health conditions and family dynamics. We need more clinical training on neurodivergence and intersections of mental health.  |
| we are so focused on evidence-based practice that many therapists, case managers and or generalist social workers do not know how to engage, how to read the room, the client and or the setting. We have been so focused on being politically correct that we have missed many areas related to abortion (past history, the hidden traumas, the connection between unwanted abortions and anxiety, depression, substance use etc. And is the zeal of political correctness we have missed the feelings and beliefs of the population we serve. We have lumped people into categories if you are black, you think this way and you never ask how do you feel about this. |

We definitely as a country need to make social worker more uniform. We need Masters and Clinical. Need to stop making it so hard for social workers to move to other states and get license transferred. When I moved to Washington despite years of experience in Kansas, I felt like I had to start over like a new college graduate in Washington and that hurt. However, I have been told many states and many social workers have had this issues. I think in general social workers needs to stop obsessing about theories and approaching clients as they are. meet them where they are at.

We just had a conversation about how to balance the hours needed to graduate and a more comprehensive education that prepared us a little better for practice.

Well I believe all people should gain more knowledge about vocational rehabilitation services and Pre-ETS because many people are not provided this information that may qualify them for employment or educational support free of charge.

What the state legislature (and previous state administrations) do repeatedly to social services in Kansas makes it very difficult to practice here. There is a desperate need across social services and professions for more support, more funding for programs, better wages and working conditions, more professional training, etc. It often feels like practicing in a desert while climbing a hill while pushing a boulder... I am thinking of leaving social work after 20 years in the profession for that reason. The burnout is real. Also, I am paid barely above a living wage, and have minimal savings. Social work/ social services wages have not kept up with inflation, and I am struggling, even with my LMSW and 25 years of experience in the field. I love my job and the work, but conditions are HARD.

When it comes to make sure that I keep up with transgender topics and correct verbiage it does sometimes require more training

Wide difference in pay for lmsw in school settings.

With telehealth so readily available I believe it's a negative impact to the client if /when they move out of state (ie: at attend college, new job) that the therapeutic work cannot continue to serve the clients mental health due SW inability to practice/cross state lines without licensure in the other state.

With the political environment more and more at odds with social work values, it would be helpful to have trainings about how to navigate it.

Witnessed clinical social workers being unprofessional regarding people in their supervision. As well as one work places not reporting when people are fired for unethical reasons. She was fired for sleeping with an inmate and bringing drugs into the prison. The second situation was not first hand knowledge so I didn't report, the information did come from management that knew.

Work ethic in some practices.

Work ethic is a big concern for me. I see new, right out of school MSWs (some LMSW, some not) who aren't willing to do the "hard" stuff. . .

Working in administration at a community mental health center, I've heard and seen a theme of new MSW graduates having difficulty understanding macro level decision making, how to effectively be included in decision making, effective leadership when working with ethical dilemmas.

Working with practicum agencies the staff shortages and high caseloads are causing burnout. This is being amplified by the current funding chaos.

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| Working with transgender and LGBTQ questioning youth, especially considering new federal EOs and state bans.   |
| <b>Yes (11 responses)</b>  |
| Yes biases towards people with LD and people with wheelchairs that are peers.  |
| Yes, I believe there needs to be more continuing education hours made available and required.  |
| Yes, I worked in a predominately white school. I was the only African American staff member in my building and social worker in our school district. The district had a racial issue between students that went viral. My colleges insisted this didn't happen often and that staff doesn't have the same experiences. I had to advocate for protections of staff myself included. |
| Yes, practitioners need to understand the how cultural should be included in all assessments and considered in planning.   |
| Yes, safety  |
| Yes, school districts are unaware of social work practice, experience or salary  |
| Yes, state laws such as outlawing gender confirming care directly conflicting with the social work ethics. How are social workers able to follow our ethics without going against the law?? I would like to know if BSRB is lobbying against these type of laws?   |
| Yes. I think that the most pressing concern is the unrealistic and unethical expectation from public agencies for their therapeutic providers. In my opinion, supervisors should be required to take continuing education on secondary and/or vicarious trauma, compassion fatigue, and/or burnout to attempt to protect and preserve the wellbeing of their practitioners.        |
| Yes. The biggest issue I have seen is that of confidentiality. Continuing education on the laws of confidentiality and HIPAA every two or three years would not hurt, especially with the younger social workers.  |

**LSCSW Q9. Over the past two years, based on your observations and experience practicing in the social work profession, could you share information on any practice-related negative issues you have seen, such as areas where practitioners appeared to need more continuing education or training in a certain area? (723 responses)**

Child welfare and understanding what really qualifies for being a play therapist. Very concerned with lack of training for community mental health training and what their provider services are being offered yet staff not actually trained to help clients. Also continuity of care between providers and agencies.

Clients tell me an unfortunate amount of unethical therapist behavior they have experienced. Diagnosis and treatment. Would have preferred the required CEU hours stay at 6.

Insurance/Medicare/Medicaid, opting in, appropriate documentation, etc., eating disorders/substance use education

"Practice-related negative issues..." A bit confusing question.

1. Clinicians in private practice lacking experience/knowledge about a wide range of clinical issues including documentation, insurance requirements, and ethical issues. 2. Social workers providing supervision without adequate training, knowledge and skills.

1. The expansion of temporary licenses for two years. This is allowing individuals to practice that can not pass the test, impacting quality of care and interpersonal relations in the workplace. 2. Clinical decision making and diagnostic skills are lacking.

A common negative practice related issue is providers (not just therapists, doctors included) telling guardians their child needs a 504 or IEP without understanding the different processes and regulations involved in each.

Acceptance of no one right way to practice. They are the most critical group of people in online platforms.

Accountability for students and ethics.

ACT

Active practice with children displaying problematic sexual behavior is no longer in like with current research.

Acute trauma care following a significant loss incident (i.e.: supporting a school or large system through a catastrophic incident)

Addiction, providing counseling to BIPOC people, immigration, how to challenge managers in a productive way (ethics)

ADHD

ADHD Evaluations

AI

AI and should we be using it in practice.

Always ethics

Antisemitism

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| Anything extra on assessment and diagnosis would be extremely helpful. I have seen a large variation in conflicting diagnoses given to individuals when they have seen multiple providers. I also think it would be a good idea for there to be a requirement for basic suicide prevention/crisis training, as many clinicians do not seem to know much about this unless they did part of their practicum in a CMHC. |
| Appropriate boundaries among colleagues and patients alike; no oversight for BSRB; and Nuances in mandated reporting I and what is assigned to investigation and what isn't   |
| As a private practitioner, I received no education on how to run a business. Since so many social workers do eventually own their own businesses, a class on how to do this would be helpful  |
| As a social work educator, I continue to be concerned about levels of professionalism especially in areas of communication, confidentiality, and critical thinking.   |
| Assessment. The basics. New social workers need more OJT then ever in my over 20 years of practice.   |
| Assistance in accurately keeping up with changing terminology and jargon. Assistance with Meta, Chat GTP and the benefits and warnings with Mental Health Apps.   |
| Autism support in the community, diagnosing and treatment specifically of youth and older adults.   |
| Autism-more education needed  |
| Axis II Cluster B education, Development of a working relationship with this client, Psychiatric Hospitals and CMOs have the most variety of these clients. Great experience!   |
| Basic rapport building & writing.   |
| Basic social work professionalism. Obligations to report other social work to protect the profession.   |

Behind the scenes, therapists are often harshly judgmental of their peers. Especially in consultation groups or Facebook communities, you'll see elitism, ableism, classism, and racial bias cloaked in "clinical concern." There is a culture of passive-aggressive scrutiny rather than collaborative curiosity. Therapists who are struggling are more likely to be quietly pathologized than genuinely supported. We talk a lot about "holding space," but we don't hold it for each other. We talk about authenticity, but we punish it when it threatens image or authority. We talk about humility, but we enforce hierarchy. Therapy culture, at least in the GKC area, is not trauma-informed. It IS comfort-informed. It exists to protect the emotional safety of the most powerful people in the room, even if that means suppressing truth, grief, and social accountability. Additionally, one of the most pressing and least addressed issues in this profession is that it is far too easy to become a therapist--and the field has no real safeguards against ideological harm masquerading as clinical care. Clinicians are being trained in programs--particularly Christian and evangelical universities--that prioritize moral obedience over ethical reflection, and do not equip students to understand trauma, systemic power, or cultural humility. Many of these graduates enter the field believing they are "called to help," but they do so with unchecked saviorism, theological bias, and a deep lack of relational awareness. The result? They cause harm-- not just to clients, but to colleagues, to communities, and to the profession as a whole. And because they've been socialized to see themselves as morally righteous, they double down when challenged. That's not just an individual failing. It's a systemic crisis. I've experienced this firsthand, especially around grief related to Palestine as the daughter of a Palestinian refugee. I was met with dismissiveness, ignorance, and covert racism by a therapist trained in an evangelical setting. Therapy culture rewards these dynamics. It elevates emotional detachment, punishes authenticity, and confuses professional image with ethical conduct. Those most committed to relational depth, political accountability, and cultural truth-telling are often those most at risk of being pathologized by their peers. We cannot claim to be a trauma-informed field while allowing people to practice without any education on power, whiteness, colonization, or ideological

Best practices for sexual offending treatment, communication to staff members on boundaries

Biggest problem is how to advocate for your clients with insurance companies who refuse to pay for behavioral health treatment.

Billing and coding of services rendered

Blended families, working with victims of incest via siblings

Boundaries and ethics in general.

Boundaries in relation to dual relationships in small communities.

Boundaries or ethics in regards to social media continues to be difficult for some. Also, maybe AI and how it fits in our practice.

Boundaries, dual relationships

Boundaries, dual relationships, mandated reporting, lifestyle changes

Boundaries.

Boundaries. Confidentiality. Overall professionalism.

BSW's need to be encouraged to increase work and life experiences.

Burn out. Lack of resources. Systemic issues and barriers.

Burnout prevention

Can't think of any

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| Care coordination: newer social workers I provide supervision for seem to struggle in understanding how valuable it can be to connect individuals and families with other community resources as well as just taking initiative to gain awareness of other agencies and resources                              |
| CEU's to maintain licensure have gone down over the years—I don't think this is a good thing.  |
| Child welfare practitioners lacking critical thinking skills; not prepared for the complexity of child welfare case management.  |
| Classism   |
| Clinical documentation<br>Billing and insurance  |
| Clinical hours for supervision being cut from 150 to 100. I felt the 150 hours prepared me better for the work I do now.   |
| Clinical supervision of LMSW's should be a required CEU for licensing if providing active supervision.   |
| Clinically speaking, there is a lack of mandated focus on being diagnosticians. It's concerning that a profession that is allowed to diagnose and treatment MH disorders struggles so much in understanding differential diagnosis and has little expectation to continue to hone those skills over the years. |
| Clinicians who provide supervision would be helpful. Ethics is always valuable. Updates on diagnosis.  |
| Collaboration with other providers   |
| Compassionate Leadership when managing/supervising other clinicians to include no tolerance of abuse; ethics including boundaries with other providers and clients; whistle blower options.  |
| Competency in interventions and not promoting expertise in all areas in order to build client caseloads. Also trainings in clinical documentation/therapy notes is lacking.  |
| Concern about no PH at SVAIL WEST  |
| Consistent engagement with clients   |
| Continuing education/training regarding clinical supervision for future LSCSWs is needed.  |
| Continuous mental health diagnosis training regarding adhd, autism, and conduct diagnosis.   |
| Coordination of care seems to be a problem as navigating through the systems and get someone to work with you is difficult due to the unavailability of people.  |
| Court and testifying   |
| Court ordered services - what am I actually legally obligated to provide?  |
| Covid/healthcare burnout, active listening, basic "how to be", confidentiality   |
| Crisis intervention and suicide postvention  |
| Crisis, most think behavioral health and medical professionals think crisis work is determining if acute psychiatric placement is needed and have no skills beyond that to address crisis not requiring hospitalization.   |
| Cross cultural issues, implicit bias   |
| <b>Cultural competence (4 responses)</b>   |

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| Cultural competency and normalizing burnout and low pay.  |
| Cultural competency in the LGBTQIA  |
| Cultural responsiveness, time management in terms of working a hybrid/remote model post covid, the effects of technology on clients mental health   |
| culturally responsive care, and clients with challenging co-morbidities   |
| DEI, cultural sensitivity, implicit bias.   |
| Diagnosing. In my observation, too many newer graduates seem to diagnose using colloquial definitions found on the internet rather than clinical guidelines found in DSM.   |
| <b>Diagnosis (2 responses)</b>  |
| Diagnosis Psychopharmacology and clinical interventions   |
| Diagnosis, different modalities   |
| Diagnosis, documentation, managing rural setting challenges with boundary/relationship crossover  |
| Diagnosis, increased experiences with a varied population and sufficient group and individual supervision before stepping into private practice.  |
| Diagnosis.  |
| Diagnostic formulations, developmental theories (including trauma informed understanding), clinical skills, ethics of billing & coding  |
| Diagnostics are bad. Documentation is bad. 50% pass rate for students. Very concerned about reliance on technology.   |
| Diagnostics and Ethics  |
| Differences between rural and urban practices - just read FB post and criticism on those who work in rural areas - we are not the same. Access to trainings - it is difficult to find relevant trainings at times   |
| Differentiation between case management and therapy. Coding and documentation for higher level services   |
| Difficulty w/ social workers finding positions that are flexible, hybrid.   |
| Disgruntled CC clients, how to protect ourselves. Code protects clients, but not necessarily us in all situations. What /how to seek retribution when we are wronged/injured. How to protect ourselves in social media, reviews, etc. it's not the same anymore |
| Disordered eating   |
| Documentation   |
| Documentation   |
| Documentation lack of understanding and ethical negligence  |
| Documentation standards   |
| domestic violence and sexual assault;   |
| Dual diagnosis  |
| Dual diagnosis mental health and intellectual/developmental delays.   |
| Dual relationships. People who live in the neighborhoods of the students/families they work with on a professional level  |
| Duty to warn, responsibilities to the courts  |

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| -Education on PHI privacy in a digital world. I have seen practitioners putting PHI in unsecured spaces, using it on transcription apps that are not HIPAA compliant, etc.  |
| -Education on practicing within our scope of competence. I am an eating disorder specialist with many years of extra training and supervision and have seen many folks who have been harmed by therapists who "treated" them for eating disorders (and who did not have specialized education/supervision) and gave contraindicated advice (i.e., a therapist recommended intermittent fasting for a bulimic client, therapist told a binge eating client to "just lose weight." etc.)  |
| Effective therapeutic modalities  |
| Effective documentation   |
| Elder care and long term care options/planning.   |
| Electronic communication, use of AI, child in need of care, court subpoenas, ethics   |
| Ethical decision making, complex trauma, and personal aspects that affect professional practice   |
| Ethical supervision   |
| Ethical use of AI, school social work roles and responsibilities, Medicaid billing, LGBTQ+ treatment, dual diagnosis  |
| <b>Ethics (4)</b>   |
| Ethics - 1. particularly in blurring of boundaries - enmeshment, personal interests interfering with obligations. 2. Impact on professional judgement - difficulty setting boundaries, loss of objectivity. 3. Potential for Harm - exploitation & harm (dual relationships), client dependency, ethical breaches. 4. Maintaining ethical practice - setting clear boundaries, prioritizing client well-being. 5. Managing Supervisor - retaliation against LSCSWs for bring up ethical concerns.                               |
| Ethics - including understanding and practicing within the BSRB statutes and regulations, obtaining appropriate supervision, use of social media  |
| Ethics & Boundaries, AI   |
| ethics (dual relationships/boundaries, oversharing on social media, dilemmas between political and ethical and religious principles), use of AI, suicide risk assessment, mental health diagnosis   |
| Ethics and current therapies.   |
| Ethics and de-escalation and crisis work. Should be like a required rotation for someone getting their clinical to work at a crisis unit or CCBHC.  |
| Ethics and dual relationships.  |
| Ethics in response times to managing a situation  |
| Ethics is always an interesting subject that we all could use more training in  |
| Ethics related to AI  |
| ethics related to boundaries with clients   |
| ethics related to professionalism   |
| Ethics surrounding group practice. I ultimately decided to leave private practice due to the unethical, unprofessional, and all-around inappropriate behavior demonstrated by the practice owners. Unfortunately, many LMSWs and other practitioners moving into private practice fall victim to these predatory practices, and I feel like I did not have enough education to advocate for myself until it was too late. There was a lot woven into contracts that I would consider unethical now but had no idea at the time. |
| Ethics, boundaries, use of technology.  |

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| Ethics, Diagnosis, Safety   |
| Ethics, law, safety   |
| Ethics, particularly duty to warn, mandated reporting professional role distinguished from personal life experiences. Dual relationships related to attending personal aspects of clients' lives such as funerals, graduations, birthday parties, etc. Understanding role in court - and court processes - and necessity of regular supervision/case consultation somewhere other than list serves - as well as understanding that various licensures have different codes. Importance of establishing goals and measures of success. What to do when there is no progress. |
| Ethics, suicide assessment, diagnosis and especially more information is needed for treatment planning  |
| Ethics/religious counseling   |
| Evidenced based care. I'm seeing people remain in therapy for decades. This is not appropriate. My concern is some just continue seeing clients for many years for \$.  |
| Faith-based counseling is in high demand and not all clinicians are trained in this or culturally competent to work with certain populations.   |
| Financial management and how to support personal understanding of money management, savings, and future financial planning, including a lens on how this ability will open their eyes to seeing clients' mental health or medical issues are tied to financial literacy as much as to other challenges...   |
| for Caucasian social workers need more cultural awareness   |
| Fraud waste and abuse-not seeing private practice clients while working for a community mental health center. Double dipping.   |
| Free CEUs is a need!  |
| Fresh, out of school social workers, support development of resiliency.   |
| Generally social workers would all benefit from supervisor training that is supportive and individualized.  |
| Generational  |
| Great trainings   |
| Grief   |
| Grief and loss  |
| Gut health  |
| Have not observed   |
| HIPPAA compliancy as it relates to telehealth   |
| How current politics are effecting practitioners and clients.   |
| How to access crisis services in their area.  |
| How to deal with all the political rhetoric   |
| How to deal with insurance.   |
| How to handle/mitigate the difficulties of taking insurance. The basics of running a business since many clinical folks end up in private practice.   |
| How to listen well (and be brief and concise).  |

How to manage ethical dilemmas where their own emotions are entangled, safety in supervision and with employers to admit when this is happening without fear of reprisal. Understanding how trauma affects their clients and themselves. Students receiving adequate supervision instead of being used to provide safety for patients when staffing is inadequate

How to navigate AI in the social work profession ethically

How to respond to political strife, maintain professionalism, and uphold SW values.

How to use AI

I am an older adult and I see the younger generation making decisions without consulting someone who has more experience, causing confusion for the children they are hired to protect.

I am concerned that new clinicians will not need to meet high standards of practicing in a clinical setting. We do not need to water down our profession that we have worked so hard to build respect.

I am happy with what I find.

I am not sure I have seen any thing negative. I think young clinicians from any educational background need more experience before jumping into private practice.

I am observing the impact of external stressors on our clients and social workers leading to increased work demands & higher turnover.

I believe Dual Relationships, Contracts that are predatory from private practice social work agencies, and poor business decisions.

I believe Ethics in telehealth is a much needed educational topic for all practitioners who practice virtually. I have not seen any such wrong doing.

I believe it would be helpful in grad school and in practicums, as well as continuing education to know more about record keeping and writing good progress notes.

I believe students are coming out of school more overly confident in their clinical skills. I have heard from more than one recent graduate (out 1-3 years) treating clinical supervision as a hoop to jump through instead of the needed skill building and reflection in themselves as clinicians. I am also concerned with the number of professionals that treat continuing education as a hoop to jump through.

I believe that more training is needed on how LSCSWs can provide quality supervision to provisionally licensed social workers. I have met many LMSWs in Kansas who are not getting adequate supervision because either the institution they work for does not allow time during the workweek and they have to pay for supervision outside of their job or their supervisor has no training in how to supervise and it doesn't become a helpful relationship or practice.

I believe that there need to be more emphasis on building rapport, as many new providers seem to struggle in that area.

I believe there are a lot of social workers practicing therapy models that are not evidence based. This may be because they don't know how to critically assess academic research. I believe this leads to clients being misled about the treatment and even fraudulent insurance billing. Ethics trainings should include instructing social workers on the difference between empirically supported treatment and experimental/anecdotal treatment.

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| I can't, I have been grateful for the array and depth of Kansas clinical social worker knowledge and expertise especially the field of perinatal mental health.  |
| I consistently push for more training in working with complex behavioral health needs (e.g. individuals who may have autism + mental health needs and receive services from an array of service systems). We need to be more open to working with people with disabilities.  |
| I don't agree with the recent changes to lower the required CEUs for diagnosis/assessment hrs. for LMSW/LSCSW.   |
| I don't have any thoughts on this  |
| I don't know of any  |
| I feel like standards for the profession have been lowered because other professions did not have as high a standard. It's reduced quality overall   |
| I feel that there could be more training on ethics so that SWs could make clear decisions on abuse cases. Maybe it's because my supervisees are timid when it comes to things that give them 'ick'?  |
| I felt ill equipped in treatment. Diagnosis was good but actually knowing how to treat was not so hot. Didn't feel like my clinical supervisor was great at it either. Ended up getting a new supervisor and paying out of pocket to have better supervision   |
| I find it appalling that clinicians under clinical supervision or within the first two years of being clinically licensed believe they are worth 100.00 plus dollars an hour. This is unethical. They do not have that level of training or experience. I see ranges up to 250.00 an hour.   |
| I have been a social worker for almost 19 years. My recent experience is that social workers obtaining a Masters in only one year do not have the clinical skills to be effective on the clinical level. I have always seen problems with this but it seems to have become worse more recently, which isn't helped by the reduced hours of supervision needed to become an LSCSW. It's a disservice to the clinician and the client. |
| I have been asked to supervise for the clinical license but do not feel competent enough to supervise someone else even though I hold the clinical license.  |
| I have been aware of a couple practitioners suggesting medications to clients. I feel as though they're practicing out of the profession. I can see a referral being made or even coordinating this, but not suggesting meds. I believe this is an area where more education should exist.   |
| I have been generally concerned about requiring fewer continuing education hours.  |
| I have been practicing for over 35 years. My observation is that there are many in private practice with limited or marginal skills because they enter private practice without the clinical education and limited experience in institutional settings.   |
| I have concerns about people practicing social work from a faith-based perspective and not being up front with clients about that perspective.   |
| I have concerns that providers are not incentivized to actively participate in therapy for themselves.   |
| I have concerns with recent MSW graduates with none or little clinical hours being self employed therapists. Although they are under supervision to get their clinical hours, they are self employed. They are not working with any agency policies. Because they are self employed, they are under no obligation to take direction from their clinical supervisor.  |

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| I have experienced a colleague (also a LCSW) who needed more supervision, and it bothered me that she did not seem to be aware of this - and was practicing independently.   |
| I have had clients come to my office saying previous therapist don't understand trauma. Do not get to the source of the issue, simply using protocols without understanding childhood development and family systems.  |
| I have had clients say that their partners or friends are experiencing therapists presenting with increased burnout and that it is difficult to find providers that genuinely seem to care.  |
| I have had practicum students who did not pass due to lack of responsibility   |
| I have long thought practitioners needed specific training to provide specialized treatments.  |
| I have not experienced any significant practice-related negative issues over the past two years. I am aware of the stress that the current socio-political situation has on practitioners and clients not unlike what we encountered during the pandemic.  |
| I have not observed anything   |
| I have not seen evidence of any practice-related negative issues in the last 2 years.  |
| I have not.  |
| I have noticed a trend in newer clinicians fresh out of school needing more training on documentation (progress notes), assessing for safety (crisis), diagnosis/assessment, and making reports to DCF. The individuals I supervised, where this occurred, were not Social Work students or with Social Work degrees. They were individuals with counseling degrees.       |
| I have noticed people bringing their own religious biases into their practice.   |
| I have noticed those obtaining their Clinical license working in the medical field struggled with clinical work as they have not had to have the outpatient long term therapy experience.  |
| I have observed a low quality of students coming from our local MSW programs that have been assigned to our federal agency. It appears there is no academic rigor required for the profession.   |
| I have observed clinicians asking other clinicians for books/materials/etc. to work with clients in specialties in which they are not properly/fully trained   |
| I have observed two different type of social workers, the ones who over train and the ones who do not. I can't think of a regulation that would help this. I honestly feel like it is has more to do the persons individual personality traits.  |
| I have rarely observed or experienced practice related negative issues, but have heard other practitioners mention observations in their settings that leave me wondering how some of them ever received a license. I am fortunate, I get to work with and be around very capable, committed professionals. I love what I do, have been at it four decades, still learning |
| I have run into an abundance of need and a shortage of social workers. The negative issues I have seen a related to people that do not have a social work degree of any kind. Yet those same people are working in a field, like child, abuse, and neglect, investigations, for a contractor in the child welfare area and even a bug shortage of providers doing therapy. |
| I have seen a downward spiral in boundaries. Often I think practitioners forget about adhering to our own code of ethics.  |

I have seen a need for an increase in training in understanding that social work is hard work sometimes, but that despite that each person still has dignity and worth as a person. I work in child welfare and I think the increase in telehealth has skewed the understanding that for safety of children, in person contact is essential.

I have seen assessment writing decrease in thoroughness. More training on how to document a thorough assessment would be great!

I have seen numerous instances where individuals in management roles do not appear to support social work values, even in cases where the managers themselves were social workers. There is a distinct lack of understanding of Trauma Informed Care as well as the intersection between TIC and effective human services management practices. Too often I see, or hear of, instances where upper management treat their staff little to no respect. This has an extremely negative impact on the quality of services provided, negatively impacting the lives of service recipients who are often already experiencing very difficult circumstances. I've seen this impact occur through staff having compassion fatigue, as well as staff choosing to leave these areas of difficult work to find higher paying, less stressful work in environments where employees are treated better. I believe organizations that have fidelity to Trauma Informed Care models, and choose to support and empower their employees, have better client outcomes. There is evidence to support this philosophy, yet many organizations either ignore this evidence or support it only on a surface level.

I have seen practitioners advertising treatment methods they aren't certified in

I have seen that many social workers focus less on clinical needs and do more case management. This is a disservice to our profession and emphasis on need for clinical interventions around growing mental health needs is vital.

I have sought my own education and training. I have found providers out of state that can offer further education online as Kansas does not have many providers who can provide extensive training for example in combined play therapy and EMDR modalities to address trauma. I do not believe that I come across many if at all KS practitioners who apply both EMDR and play therapy.

I have witnessed "power trips" of workers particularly in situations involving child welfare cases. I often question whether the understanding I gain from a training is different from my peers due to cultural norms and differences or potential codependency and boundaries issues. Maybe more understanding or training for supervisors and something that encourages continuous self development that goes beyond simple CEUs and includes healing and maintenance of the worker. This is something that would need to be implemented within agencies policies to help protect the public and the profession.

I have worked in community mental health before moving over to hospice. I have seen the changes that allow medical social workers to obtain their clinical license. This is really bad in my opinion. They may have expertise in grief & loss, but definitely are not prepared to move into a mainstream area to provide clinical services. It's a disservice to all involved. I refuse to supervise medical social workers for this reason.

I haven't really witnessed that in the past two years, however, I'm the only LSCSW at my setting. I am a contractor thru Children's Mercy Hospital.

I haven't observed anything specific to the profession related to this.

I know of a recently licensed social worker who was licensed over the objections of both her clinical supervisors.

I love my work overall; it is struggles with billing glitches and insurance companies trying to pay low rates that creates issues for me. I have to turn down potential clients if they carry insurance with problematic companies.

I personally don't think so many new graduates should go directly to private practice without more experience. And, I think they should charge less overall, but also particularly at first.

I personally have not observed any negative issues related to need for more training in practitioners.

I see a lack of real understanding, training and lack of competent care for people with Autism.

I see a lot of (understandable) emphasis on providing modalities that insurance companies like, in the ways that insurance companies like us to provide them. It is important to me for accessibility purposes that I can accept most if not all insurance plans at this point, but I also know there is a reason social work research is often qualitative- personal growth, insight & resilience are not always apparent looking at measures and SMART goals. Separately I notice most of my colleagues have little if no training on neurodivergence. I am an ND clinician and don't advertise myself as a specialist in this area, but ND clients seek me out knowing that I share this ID and experience. When I need to refer clients to another provider or have questions in a training about how to apply the information to my ND clients, I find other clinicians often have no experience with that client population or their issues, other than an abnormal psychology course/"I recommend ABA" level of knowledge. The social work perspective is "person in environment"- ND people interact with their environment in significantly different ways, and social workers need to be educated on those needs.

I see a need for practitioners to have more education regarding assessment and diagnosis, specifically in relation to neurodivergence. I also see a need for many working with neurodivergent individuals to have additional education and training regarding neurodiversity affirming care. In addition, I have encountered quite a few individuals coming to me for therapy who report negative experiences with previous therapists. Common themes that are reported to me include be therapy suddenly ending with a therapist due to the therapist not responding to the client or extreme difficulty with scheduling frequent and/or consistent appointments due to the therapists schedule, poor rapport building skills, lack of trauma informed care. There also seems to be quite a few practitioners who express beliefs that when children need therapy, or are in therapy, that it is always because of the parents. This can really lead to shaming and blaming parents and is not a healthy way to approach mental or behavioral health concerns in the youth population.

I see limited collaboration with other disciplines or clinicians since working in telehealth remotely.

I think ethics needs to continue to be a priority and maybe increase the CEU hours required. I think dx should be a priority and I was discouraged to see the reduction in CEU hours required. I think it should be a requirement for a LSCSW to work in a public agency before being allowed to work in private practice. There needs to be more CEUs focused on general therapy practices and how to effectively run a business for those of us in private practice.

I think it would be beneficial to have AI training incorporated into Ethics training or require a separate training for AI. However, due to the constant changes with AI it would be impossible to stay current at this time. I also feel it would be beneficial to have required training regarding the ethics of telehealth. Even if a social worker does not provide telehealth in any capacity; you never know when a situation may occur that would require it since it is such a prevalent part of how our profession provides services. I feel that all social workers should be familiar with it and at a minimum have a basic understanding of the ethics regarding its use.

I think it would be beneficial to have more information about the ethics and legal ramifications of companies using AI to listen to conversations and generate notes. I significantly edit my notes because my intelligence is not artificial and I do a better job. AI misunderstands a lot and doesn't understand nuances or cultural differences,

I think more training in the realm of medical related PTSD due to post Covid and the continued steady increase in cancer cases.

I think more training on trauma informed care, staying safe, advocacy, and maintaining professional boundaries would improve the profession

I think new social workers are in need of continued, meaningful ethics training. Many social workers are in clinical contract settings which have questionable business plans which place payment above treatment and certainly above social work student learning.

I think new techniques (EMDR, ART, etc.) need to be more accessible to clinicians because it is hard to afford those trainings.

I think ongoing training as to best practices to support our clients who are experiencing stress related to our current federal government. And how to navigate the grave injustices for the vulnerable populations which we serve.

I think practitioners are trying to become "experts" in too many areas and are not becoming mastered in a specific intervention. This makes it difficult when helping clients achieve treatment goals and knowing what is outside your scope of expertise.

I think practitioners could use more education related to acceptable use of AI as it is fairly new and still has a lot of gray areas.

I think practitioners could use more training on self-harming behaviors and suicidal thoughts. I have clients that have come to me reporting negative experiences with other therapists such as not having a safety plan or being overly critical of clients.

I think that providers need more education and support in regards to court practices and working with foster care youth. What records are necessary to bring to court and what is to be kept confidential.

I think that there needs to be more training on documentation skills and running your own business or building a non-profit. I also think we need more training in Legal Issues such as how to handle custody cases or testifying. I would also like more information about the use of alternative medicines and the use of THC, Psychedelic Medicine.

I think the area of insurance billing will always be an area for growth. The managed care organizations make offering services to the most vulnerable people very difficult.

I think those of us that are clinical social workers need more in-class hours in therapeutic modalities and actually providing various forms of therapy. We should all have classes on trauma and its effect on the nervous system, I think, because it is so prevalent.

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| I think training specific to EBT is important.  |
| I think we need more information about running a private practice, marketing, etc. in regards to mental health.   |
| I was disappointed that the number of clinical hours for clinical licensure was reduced and was unsure why that change was made.  |
| I was on the social work advisory board for several years<br>Currently, I supervise social workers for clinical license in Kansas in<br>I see a growing need for understanding the use of technology and providing services, understanding, AI and how to separate Personal from professional   |
| I wish social workers who are working in private practice would be required to do some of their own healing work in therapy or other healing modalities such as breath work etc. I believe others such as LMFT's are required to attend therapy. I could be wrong :)  |
| I work primarily alone in solo practice.  |
| I work with children and parents; lately several families have shared they have not had good experiences with nurse practitioners or other psychiatrists or those administering mental health assessments. I have been hearing the environment was cold and sterile. Just this week: Two different teen clients shared that they were unsure they wanted to take medicine for their symptoms because the practitioner did not seem to care about them. They were asked questions without having a sense of why it was important and little trust in their providers. It sounds like the bedside manner is an area of continuing education need. |
| I worked in an agency that would hire staff just out of school but did not train them in therapy techniques/models which can be dangerous to clients  |
| I would like more education on how to handle suicidal clients in private practice.  |
| I would like to see more training on working with insurances, billing, getting paneled, etc.  |
| I would love more information on working in the clinical setting with elderly. I also feel that social work schools do not prepare clinical social workers to be business owners which most of LSCSWs move in to a private practice role and don't have the necessary information on how to run a practice, bill, manage employees, etc.  |
| I would say I'm in a setting where there are few social workers but a lot of educators so we aren't valued as much. A lot of conflicting ideas because we advocate for the client not always the school district which puts me in a difficult situation at times.   |
| I would say some new social workers seem to lack strong work ethic and strengths based approach   |
| I'm my opinion, it is almost too easy for any MSW to enter into an Independent Practice even though they are receiving supervision from outside their office. Some are not equipped for this setting yet.   |
| I'm old school and attended course in person. Hybrid courses had just become a thing when I was in grad school. Over the years, you can CLEARLY tell who got their degrees completely online. They lack a lot of interpersonal and customer service skills. Convenience has seemed to override Professionalism to the Profession as a priority.   |
| I've had a lot of transgender clients coming to me complaining of being mistreated by other therapists, some of them social workers.  |
| I've never had any issues with finding a variety of CEU's.  |

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| I've witnessed colleagues receive too harsh of consequences and too delayed of consequences from the BSRB for license violations that didn't actually harm clients  |
| I'm sure there have been instances of education being needed but nothing currently comes to mind.   |
| Impact of divisive, negative and fear based political climate on mental health; relativism leading to lack of what to believe as solid truth about self and others; decline in critical thinking.   |
| Impact of how they dress at work, importance of not having their own phones out in sessions and looking at it, addressing their own mental health issues in individual therapy.   |
| In another state, getting CEUs related to supporting suicidal patients is required. I have found it helpful.  |
| In areas of supervision: providing supervision and accepting/receiving supervision. How to make supervision effective. It is THE vital aspect of our training.  |
| in general SW is a very white very female field. More diversity is needed.  |
| In my experience, practioners need more training in higher level diagnoses (schizophrenia, bipolar disorders, personality disorders, etc.) I have interacted with many social workers who are uncomfortable working with individuals with these diagnoses. Being able to recognize symptoms and accurately respond to those symptoms is vital, and many social workers lack basic training skills with these diagnoses.   |
| In my position, I haven't had the opportunity to work with direct practitioners.  |
| In my social work master program at Newman University, I felt like I didn't receive adequate skills on how to actually provide therapy and had to learn techniques on my own. In general, I'd love more ongoing training on diagnosing, ruling out disorders, addiction, personality disorders, ADHD, OCD, ASD, schizophrenia-related disorders, etc.   |
| In person training seems to have a greater impact (or retention) on for continuing education. Recommend considering not allowing all CEUs be completed without some in person training.   |
| In the past few years, particularly following the pandemic, there appears to be a much heavier focus on self-care within the social work field and in social work education. While I believe that self-care is important, there appears to be a need to educate social workers on the balance between self-care and person-centered care. It's important that social workers don't view these two concepts as completely separate. Rather than having tunnel vision about self-care or person-centered care, a well-trained and well-educated social work should be able to balance these two needs simultaneously. I don't see this develop into issues a lot, but I have seen this become problematic for some people who don't know how to balance this. |
| Inappropriate relationships with clients or their family.   |
| Income is dependent on insurance reimbursement that never seems to increase.  |

Insurance companies and managed care pushed me out of therapy practice. I have worked two jobs and provided licensee supervision for a long time. It sad there has been zero support or advocacy from the board or NASW on this issue. People are leaving the field or going to cash pay for therapy. Vulnerable populations are very much negatively impacted as a result.

I also feel that we see license boards - KS and MO care more about CE's than gatekeeping.

Insurance compliance

Insurance sucks

Inter-state licensure mandates

issues of aging and nursing / group home mental, emotional and physical health

It is a common thread of thought that LSCSWs or LMSWs are not qualified to provide clinical services at certain capacities especially out of grad school. I can understand this as other disciplines such as LMFTs have more rigorous therapy education because it is more specialized in therapy. I do think social workers need to have the clinical knowledge if serving a clinical role. I also think you need to be more strict on the clinical test. It is too easy to pass and you allow a lot of questions to be missed.

It is hard to manage people moving, traveling, etc. It will would be great to have a training on the upcoming compact. There are many other therapist professionals that criticize social workers intervention based education and I think we need more intervention based classes to support those deciding to go into their licensure to help feel more prepared.

It may be helpful to take documentation, and safety CE's.

It would benefit the social work field if we had some education on the business/legal side of private practice. If you go that path, you will be running your own business and I believe we did not get the education for that in our program. More readily available training or CE's to assist with that would be beneficial.

Its hard to find CEU

Lack of ethics/boundaries, more; education on being culturally aware/competent

LBSW's making decisions above their knowledge.

LGBQT

LGBTQ community or people of color

LGBTQ+ awareness and sensitivity training

LGBTQ+ psychotherapy as a specialty, people need to not require the client to educate practitioner, you are not culturally competent enough to label yourself LGBTQ+ affirming if you don't even know the differences. I rarely find therapists who know what the ace-aromantic spectrum means. I offer free consultation monthly to support spreading the knowledge because I feel like it's a public safety risk to not offer it.

Licensing regulations.

Licensure across state lines

Licensure boundaries related to making diagnoses.

Limited diagnostic and trauma informed understanding. Limited understanding of theory.

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| Lowering the standards for achieving a clinical license and/or negating the necessity of it has greatly affected the quality of care provided to patients. I often receive calls requesting a therapist with “gray hair” because these kids just aren’t cutting it.   |
| LSCSW and more practicing in substance abuse without being dually licensed  |
| LSCSW are Seen as below PhD Psychologists and not valued as much in my previous employment  |
| Maintaining confidentiality of clients. Not often but periodically a practitioner not understanding the extent of confidentiality. In addition, the retention of records, particularly of children.   |
| Managing risk; use of evidence-based treatment vs solely talk psychotherapy;  |
| managing the demands of commercial insurance companies, but not sure that the solution is to have more continuing education or training   |
| Mandated reporting. Court Participation (our rights as therapists, protecting our client's HIPAA rights to privacy, and legal considerations every SW should know). Trauma-informed treatment.  |
| Many clinical social workers struggle with Fidelity to treatment modalities. Oftentimes they Excel with Rogerian factors, and rapport building. Unfortunately, without also being able to apply evidence-based modalities, I see the outcomes don't tend to come as rapidly if ever, and clients tend to stay stuck in therapy and almost become reliant on their clinical social work therapist. Encouragement of including evidence-based abuse would be beneficial.  |
| Many going to private practice accepting only cash for services. Cuts to fundings for non-profit agency leading to loss of jobs and freezing raises. Seems to be a large focus on becoming certified in every modality which is costly and time consuming taking away autonomy and attunement to client needs.  |
| Many LMSW are not aware of the regulations governing their license unless they have a training plan i.e. that they must practice under direction. An e.g. if a training gap. Informed consent is a neglected topic. Because it's do not have an awareness of the many facets of the processes, including that of new grads treating 5 yo for the first time. They aren't telling the parent their child is their first or and provide the option to see a different staff. Parents don't know this, aren't informed, and because they are those in poverty or otherwise disenfranchised, it gets by them. |
| Many need a focus on trauma   |
| Many new young providers in up to date on all the latest but seem overly confident that they know the answers.  |
| Many social workers do not seem to the use of the DSM-5 in formulating a client's mental health diagnosis. Some do not understand the concept of dual relationships and confidentiality .   |
| Medicaid and providers understanding the benefits to taking it for therapy.   |
| Medicaid guidelines   |
| Medicare placement guidelines   |
| Medicaid  |
| ADHD  |
| Autism  |
| mental health   |
| More certifications and specialties would be nice. The cost of these are substantial.   |

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| More clear direction on documentation, how to access support for navigating best practice (Am I practicing within my scope? Am I documenting correctly and if not where are the guidelines?)   |
| More continuing education in clinical report writing, clinical documentation, and working with individuals in crisis. The influence of AI is quickly working to reduce a valuable skillset. I have experienced licensees utilizing AI to write a solid clinical note; however, when it comes time to explain their documentation or detail out specific symptoms the connection between what is written and what is spoken is absent.  |
| More continuing education on personality disorders, specifically treatment and diagnosis.  |
| More continuing education on providing Clinical Supervision, and more training on interventions and practice for dual diagnosis (IDD/Mental Health)  |
| More dangerous, I find there is just not enough support or respect for the services we provide. I also would prefer 30 hrs. of CEUs rather than 40!  |
| More education and training surrounding 2SLGBTQ+ populations and more training and education surrounding domestic violence   |
| More education in diagnosing mental health conditions and treating personality disorders.  |
| More education is needed regarding dual relationships and boundaries and more consequences need to exist for crossing boundaries. More education on documentation.   |
| More education on the credentialing/billing process. There is little to no education or easily accessible information on these processes other than trial and error, this negatively affects income for most social workers.   |
| more education on trauma modalities.   |
| More funding opportunities for education opportunities. My work is funded through a grant.   |
| More in person conference options  |
| More mental health training, current events and how to support people in the current toxic political climate.  |
| More people going directly into private practice with no agency experience leaving them unaware at times of supervision requirements even if not seeking LSCSW, poor ethical, clinical and billing practices. I am sometimes stunned by what clients and supervisees tell me about their experiences with other clinicians. There needs to be better monitoring of social workers in private practice who are not under clinical supervision. I think the ethics CEU requirement should be increased to include use of AI and/or telehealth. |
| More relational training would be beneficial   |
| More training and BSRB regulation will be needed around AI. It is becoming so prevalent.   |
| More training for the business side of private practice.   |
| More training in a systems view. More person-in-environment foundational thinking  |
| More training in admin and management  |
| More training in clinical diagnosis. I was surprised to see the number of CEU hours reduced to 3 per renewal.  |
| More training in therapeutic modalities , more standards for those supervising   |

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| More training in trauma, diagnosis, ethics, and actual modalities rather than just general theoretical concepts.   |
| More training on documentation in private practice.  |
| More training on working with Geriatric population, Neuroscience   |
| most practitioners need more training on neurodivergence and anti-ablism   |
| motivational interviewing, personal self care  |
| Multidisciplinary team work/role of social work  |
| Standards for Records releasing to court or children's division with and without subpoena  |
| Parental custody and therapy- testifying   |
| My exposure is limited to an online forum, as I do teletherapy. I'm drawn to ethics issues because they are so important. Online some providers struggle with clients demands for anonymity whereas the provider should have basic PII as a responsible part of their practice. Another issue online is kind of "magic eight ball" expectation by clients - like human behavior could ever be analogous to fixing a mechanical device! Providers need to develop ways of tactfully educating clients |
| My issue has been related to schools sending students to intern at a substance abuse treatment facility and never having heard of ASAM criteria.   |
| <b>N/A (36 responses)</b>  |
| Navigating therapy as the clinician is having the same experiences as the client (i.e., previously was COVID; is now the political climate). Also, use of AI   |
| need for training in boundaries  |
| Need more collaborative spirit not about fending for oneself but we are a community of providers.  |
| Need more training in evidenced based treatment modalities, psychopathology and ethics   |
| Need more training in tele-health work and supervision of staff.   |
| Need more training on assisting clients negatively impacted by political issues.   |
| Need more training on how to support Autism  |
| Need more training on the body-based modalities  |
| Need reciprocity between all states.   |
| Needs to be education around providing clinical supervision and practice management in the private sector.   |
| New licensees do not appear to have full awareness of ethics or values of the professions or responsibilities of carrying licensure. There limited, if any, signs of familiarity with psychosis or other diagnostic experiences. There is down play on safety risks and having to fulfill the safety training within the first 2 years is 2 years too long.  |
| New social workers are not ready for private practice. I am hearing horror stories from clients who are looking for experienced clinical social workers who are more seasoned to help them reach goals.  |
| New therapists not supervised / not having skill for services providing  |
| <b>No (99 responses)</b>   |
| No concerns  |

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| No negative issues, but would like to see guidance on the use of artificial intelligence in SW practice  |
| No, I believe we have overall a very competent and well trained profession. I am impressed by the new graduates coming out of school as well.  |
| No, I do not. I have been practicing solo for over 2 years.  |
| No, maybe a broader range of continuing education units being offered to expand our knowledge.   |
| No, though discounted or free CEUs in specialized areas of training is always helpful.   |
| No. Just limited resources for our clients.  |
| No. When I worked at an agency (most of my career) I was very fortunate to work with a very skilled group of providers.  |
| <b>None come to mind (2 responses)</b>   |
| None in particular   |
| None that are standing out   |
| None that I am aware   |
| None that I can think of   |
| None that I can think of at the moment.  |
| None that I have seen.   |
| None to note   |
| None whatsoever  |
| None. The only negative issues I see are social workers being undervalued in medical settings, through no fault of social workers themselves.  |
| Not enough quality CEU's; not enough on psychotropic medications   |
| Not in a position to give relevant information.  |
| Not many opportunities to observe this   |
| Not passing of ASWB exam not being reflective of a candidates true abilities.  |
| Not practicing outside of knowledge - i.e.: not accepting a referral for a concern or diagnosis that they have limited training/knowledge because another professional is looking for a referral       |
| Not really.  |
| Not specific to social work. Overall it seems like new therapists are going into private practice before they have much experience overall. Some seem to not have done their own work on their issues. |
| <b>Not sure (4 responses)</b>  |
| Not that I can think of  |
| Not that I can think of right now.   |
| Not that I can think of.   |
| Not that I have noticed. My colleagues are very good at getting the CEU's related to their areas of practice.  |
| not that I see   |
| Not with KS licensed social workers.   |
| Note writing and documentation.  |
| Nothing comes to mind.   |
| Nothing in particular  |
| nothing specific   |
| Only in the area of foster care and child protection services.   |

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| Only lived in the region for 1 year, unsure if I have enough time to have meaningful information/response.  |
| Our code of ethics includes social justice which many social workers appear to not realize or understand. Understanding how helping minorities and marginalized people is integral to social workers  |
| Over the past two years, I've observed a notable gap in clinical rigor and standards within the social work profession—particularly in the areas of continuing education and applied clinical training. While licensure requirements often mandate a minimum number of CEUs, the content is frequently too broad, overly theoretical, or disconnected from real-world practice, leaving clinicians under-equipped to handle complex cases with the depth and nuance they require. One area of concern is the limited training in evidence-informed modalities beyond the basics. For example, practices like Internal Family Systems (IFS), Somatic Experiencing (SE), or other trauma-informed approaches require significant depth and skill—yet many clinicians utilize them superficially without appropriate certification or supervision. This can result in ethical gray areas or even unintentional harm. Another area in need of more robust education is countertransference and the management of clinician bias, particularly when working with diverse or high-conflict populations. These relational blind spots are often not addressed meaningfully outside of supervision, and ongoing education in this area could elevate the quality of care and professional resilience. In short, I believe our field would benefit from more rigorous clinical training standards, increased accountability for skill-based CEUs, and a culture that encourages depth of practice—not just compliance with minimum requirements. |
| People identifying as offering psychotherapy but only limited to one technique. Clinicians not understanding the broader range and deeper issues needing addressed in psychotherapy. It's a concern that anyone with the advanced license can present themselves as mental health providers when they have only worked in non mental health areas of social work and have no specialized training in mental health.   |
| personal bias tend to impact practice in some areas   |
| Personal boundaries /professionalism and confidentiality.   |
| Personal safety, community advocacy .   |
| Policy changes in LGBTQ+ that effect youth and reproductive rights in the state that affect practice.   |
| Poor coordination between KDADS and barn. KDADS does not hold TLS workers to a qualified standard of supervision.   |
| Practice implications in the digital age; using digital/online resources ethically in the SW practice context   |
| Practitioners and others in the mental health field would benefit from education as to how LSCSWs are different from LMLP/LPC   |
| Practitioners definitely need more trauma training.   |
| Practitioners have needed more education on how to properly document services provided  |
| Practitioners need more education in personality disorders and how to work with those with personality  |
| Practitioners would benefit from further guidance in trans issues.  |
| Presenting professionally whether that be address or communication style. Utilizing supervision for reflection and growth specifically related to transfer and boundaries.  |

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| Private practice clinicians using sessions to process their own challenges !   |
| Private practice ethical business practices, technology use, certifications in specific therapy types  |
| Private Practice: Insurance companies are becoming increasingly more challenging to work with and appear to be trying to provide oversight into shaping treatment where it is not welcomed by the client nor the provider. It is not optional oversight and it cannot be declined by the provider despite the client not wanting the insurance's input. Despite parity laws, there appears to be a clear separation of mental health and physical health according to the insurance companies. |
| Professional boundaries  |
| Professionalism and being timely with clients  |
| Professionalism, boundaries, counter transference  |
| Professionalism, workplace comportment   |
| Professionalism/ professional ethics; Maintaining sw values in advocacy  |
| Provision of clinical supervision, use of AI   |
| Psychopharmacology; multicultural practices  |
| <b>Quality documentation (2 responses)</b>   |
| Race equity. Very limited understanding on intersectionality. Practice behavior are not culturally sensitive.  |
| Racial equality, Spiritual equality are both areas where judgement and biases are seen the highest.  |
| Recognizing and knowing how to treat trauma, especially complex trauma   |
| record retention of case records for minors  |
| Retired, so not seeing anything.   |
| Running a private practice. The taxes associated   |
| Safety   |
| Safety assessing, safety planning  |
| School social workers that have no experience outside of the school seem to be lacking some clinical skills.   |
| Second year social work students should be required to have more hours now that Covid is over.   |
| Self care and prevention of burnout  |
| Self regulation in teen, LGBTQ+ needs  |
| Self-Care. OCD.  |
| Senior abuse by adult children. For every one senior abuse is reported, 23 go unreported.  |
| Senior-related- capacity, advance directives, guardianship, etc.   |
| Serious BH issues. Limited experience of service providers to deal w serious behaviors.  |
| Services to those with idd   |
| Similar and different from your question. People in the community where I practice have completed parts 1 and 2 of EMDR training, but do not list themselves on the EMDR.com website as having done so. What's up with that?   |

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| <p>Social anxiety/fear is increasing rapidly - training about dealing with the current political climate would be useful.</p> <p>The emotional deterioration of children appears to be increasing due to screen time dependency and fewer actual social experiences. Would like insight re: possible treatment ideas.</p>  |
| <p>Social work in the state and county court system. No clarity on roles and responsibilities.</p>   |
| <p>Social work students entering into practice sometimes struggle to maintain boundaries and be aware of personal beliefs and values as they impact practice.</p>  |
| <p>Social workers are coming out of MSW programs very unprepared to be clinicians. The online/hybrid programs are no where near the caliber and rigor that I went through in 2003. I am having to do a TON of training with students and new graduates.</p>  |
| <p>Social workers are graduating with their Masters and wanting to go straight into clinical private practice with little experience in diagnosing and treatment.</p>  |
| <p>Social workers are not given enough time for documentation and for additional duties such as Safety Planning for suicidality or homicidality. I have observed this in community behavioral health settings where production is a priority over self-care and sometimes even over client care. Even with the required suicide prevention training, there are times when social workers need more training in crisis services. Misdiagnosis is also a negative issue I have seen.</p> |
| <p>Social workers are woefully unprepared to be clinicians when they graduate from graduate school but are expected to immediately be clinicians despite receiving the least amount of clinical training compared to all if the other mental health disciplines.</p>   |
| <p>Social workers have been just as hateful to each other as the general population in regard to differences of opinions. SWers need to be able to listen reflectively to then be able to educate/ advocate, etc. more effectively. Us vs. them mentality is not helpful.</p>  |
| <p>Social workers having aggressive clients and unsure how to support clients</p>  |
| <p>Social workers need more training and understanding of scope of practice. In addition, they need to know and understand the statutes and regulations of their own license</p>   |
| <p>Social workers receive no education about neuroscience - how the brain works. This is critical information if you are a clinician.</p>  |
| <p>Social workers using art and referring to it as art therapy. I have another masters degree in art therapy and it is a distinctly different practice.</p>  |
| <p>Social workers would benefit from more continuing education on diagnosing. I believe there is significant value in providing clients with more information regarding their diagnosis and engaging them in a collaborative exploration of what the diagnosis means for their treatment and overall well-being.</p>   |
| <p>Social workers would benefit from more education on documentation and documentation requirements with insurance.</p>  |
| <p>Some programs do not focus enough on the clinical side.</p>   |
| <p>Some providers have difficulties with feeling connected to others in the profession or well informed on updated research on previously well-known subjects.</p>   |
| <p>Specific interventions</p>  |

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| Specifically as it relates to Kansas Social Workers, I believe there could be more specific training around mandated reporting when it comes to emotional abuse and how that's categorized. I feel like my stance has been "if it's even remotely possible it could be harmful report it", however, this could potentially cause lots of reports to sort through and clog the system per say. I also think there needs to be more specific training for people who want to provide clinical supervision. I myself took 15+ CEUs related to this as I started supervising MSWs and feel my own clinical supervisors would have been better equipped had they had similar training. |
| Spouses of military assigned to Ft. Riley, Leavenworth, etc. often have miserable experiences getting Kansas licenses, and their families wind up on food stamps because they can't practice in Kansas. There needs to be serious and speedy reciprocity. There are clients who can't get services because of this, as well. If we care about clients getting services, this has to change.   |
| St. Francis Ministries, DCF, and other areas are handling affairs beyond their comprehension and capabilities.  |
| Standards of practice and maintaining SW values.  |
| Starting a practice. We have lots of trainings on the components of SW, but little on how to get an effective practice running that can serve multiple populations  |
| Struggles with insurance  |
| Students coming out of MSW programs are woefully unprepared for practice. I think the advanced-standing programs are a mistake (one year is not enough to be a therapist). Also, the removal of standards for the MSW clinical practicum (I know, done by the legislature) has made this so much worse. Overall, mental health providers need a lot more education in eating disorders and trauma treatment.  |
| Substance abuse and co-occurring dx   |
| substance use   |
| Substance use/dual diagnosis. IDD related disorders. Dementia co-occurring with history of a psychotic disorder.  |
| Suicide assessments, specifically related to when it is most appropriate to seek inpatient psychiatric treatment or when it is most appropriate to safety plan with the patient and discharge them home (with support). On low to medium risk individuals, it appears as though practitioners are more often seeking involuntary inpatient psychiatric treatment based on their own fear of persecution rather than taking into consideration the individuals support system, ability to be safety planned, and the statistics surrounding the rate of suicidality post an inpatient psychiatric stay.  |
| Suicide intervention and cultural competence  |
| Suicide, diagnosis, trauma, ai, telehealth  |
| Suicide/risk assessment, diagnosis of complex issues (i.e. personality disorders).  |
| <b>Supervision (2 responses)</b>  |
| Supervision- there is a lack of training or requirements to be a supervisor. Also a lack of social workers providing supervision. Documentation- insurance requirements for therapists.   |
| Supervisors need more training in knowing how to lead aspiring clinicians.  |
| Taking insurance and note taking  |
| <b>Telehealth (2 responses)</b>   |

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| Telehealth regulations (practicing by phone, patients in other states/countries, etc.), mandatory communication with primary care and psychiatry providers for clients with mental illness.  |
| The area I see that may need more continuing education with social workers is in the educational setting. School social workers seem to struggle utilizing more than one theory and applying various frameworks to their work with students.   |
| the board itself could use some ethics training  |
| The business of private practice, working in the court system.   |
| The costs out way the benefits in all areas. (Insurance not paying, Medicare audits, court orders for reports, FMLA's, disability determinations, etc.) At the highest level, I'm currently not making enough money to survive the field.  |
| The educational setting and clinical setting is vastly different. However this is not recognized as much by universities and there are not enough qualified social workers in the educational setting.   |
| The entry level competency of social workers new to the field is frighteningly low.  |
| The Kansas City VA Medical Center, due to DOGE dismantling services, the environment for staff has become a very disruptive environment for my ex-coworkers. SWers are working above their recommended case load.  |
| The legislature passing laws that interfere with Social Workers' professional judgement and relationship with clients, i.e. prohibiting any recommendations re: medical treatment for trans youth. Also trend towards deregulation/deprofessionalization.  |
| The most critical issue is not having enough SW's. So those helping are over loaded.   |
| The only thing I am concerned about is the high rate of burn out that social workers experience.   |
| The quality of clinical training, through academic work and practica, has declined significantly. New graduates are often very unprepared for practice.  |
| The requirements for LSCSW lowered was a big mistake in my opinion. And, allowing reciprocity from states with low clinical requirements has been disappointing. I am floored by lack of clinical expertise some so LSCSW's show in recent years. It hurts our respectability. In addition, I am more disappointed in those how many immediately jump into private practice when they do not have the expertise or skills. Its dangerous and appears to be money grab. I think the BSRB should go back to the old requirements of 4,000 supervised clinical hours, with 2,000 of those face to face in a therapeutic setting, and working with marginalized populations. What happened to NASW code of ethics and guidelines for SW's? Specifically, regarding social workers and social justice? With cuts to health care, social workers should be serving the "underserved" in the community. |
| The scope of diversity.  |
| The single greatest area would be trauma informed care.  |
| The state of Kansas requires 40 hours where Missouri requires 30. It is helpful my employer provides a stipend for CEUS, if in private practice this would become costly for quality CEUS  |
| The treatment of specific mental health disorders.   |
| the use of AI and social media and ethical boundaries along with alternative methods of treatment for substance use  |
| The use of AI in therapy services  |

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| <p>Therapists telling clients what to do as opposed to leading them to their own choice. Also, therapists appearing to practice in modalities they've just read about.</p>  |
| <p>There are numerous issues not addressed in school that come up once you're in practice such as suicide of a client, dual relationships in a small town, more complex cases, freaking with personal safety, grief, etc.</p>   |
| <p>There continues to be complications regarding billing and reimbursement from insurance agencies creating challenges and burdens for the client and for the clinician. There does not appear to be any amount of training to prepare for the inconsistencies and challenges in this area. I have chosen to move from primarily private practice to working in schools on a larger scale due to this. The ethics around managing these issues, providing needed services and maintaining a livable income are serious.</p>                     |
| <p>There is a great need for cultural competency. Many social workers do not speak another language and are not culturally knowledgeable.</p>   |
| <p>There is a lack of clinical level skills. Inability to use motivational interviewing or using it incorrectly. Lack of understanding what person-centered care is and client rights to autonomy. Lack of confidence in trauma and fear of liability concerns with suicidal clients.</p>   |
| <p>There is a need for better education around healthcare compliance in commercial and government plans.</p>  |
| <p>There is a need for more trainings on appropriate and updated language (suicide, diagnoses, LGBTQ).</p>  |
| <p>There is an immediate need for national licensure.</p>   |
| <p>There is an inconsistency in curriculum and expectations across schools providing Social Work degrees. This causes gaps in learning and sometimes in taking licensure tests.</p>   |
| <p>There needs to be a better system in providing a balance of clinical and other social work activities into a job. At the practice I work at, you are considered full time at 35 clients a week. That is too much for me, personally, but I enjoy my other part time work with primary care research. Make it easier to be on insurance panels! Offering insurance to clients is highly needed, yet many do not see the benefit of being on an insurance panel when you are paid lower amounts and have to do a lot of extra unpaid work.</p> |
| <p>There seems to be a lack of higher-level need professionals in the therapy services that I work under with active military and their spouses.</p>  |
| <p>There was a palpable shift in services and influx of clients during the pandemic and I do not believe we were able to keep up and have done nothing to address those issues.</p>   |
| <p>There's always room for more training on substance abuse diagnosis and treatment</p>   |
| <p>These new social workers are a joke. Teach them how to be social workers, please.</p>  |
| <p>This survey seems to be skewed towards the negative. There are always areas of growth, maturity and development in every professional's life and career, but these areas are often unique to the professional, and while I can give a few examples over the years, do not necessarily constitute a trend and are addressed in supervision or reported to the BSRB if there is an infraction that would violate ethics. I have also witnessed many examples of positive growth, maturity, and self reflection.</p>                            |

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| Through Covid, I have noticed hardship and maintaining the integrity of social work practice in systems. I think ethics should be a primary focus for social worker students, especially when dealing with oppressive systems.  |
| Too many disciplines now being licensed.  |
| Too many hours of ceu credit required and too often   |
| Training needed in running a business, navigating health insurance plans as a provider, maintaining security (particularly cyber security). Continuing education needs: clarification on what counts for continuing education credits. Guess and check afterwards would be laughable if our license renewals weren't on the line.   |
| Training on how to set up a private practice; training on how to avoid and/or handle claim denials; training on how to submit claims to the appropriate insurance when a client has multiple insurance coverage; offerings in community of peer consultation groups for professionals in the same field, such as behavioral health. |
| Training on the trend of utilize AI to assist with notes  |
| training or the education for practitioners is all over the place, depends on what you went to school for, location, etc.   |
| Transference and countertransference seems to be a struggle for a lot of the newer practitioners.   |
| Transgender issues in youth   |
| Transgender issues, Child welfare issues  |
| Trauma informed/ cultivating authentically curiosity and compassion   |
| Trauma and dissociation   |
| Trauma and its impact on developmental outcomes   |
| Trauma informed care (2 responses)  |
| Trauma informed care, management skills development, supervisory skills development, how to start private practices   |
| Trauma informed care, the impact of perimenopause and menopause on mental health  |
| Trauma informed care; working with insurance companies, particularly around parity; self-care   |
| Trauma informed practice, integration of behavioral health, Co-Occurring Disorders  |
| Trauma informed practice, working with immigrants and Spanish speakers  |
| Trauma related or trauma informed support/care  |
| trauma support  |
| Treatment of suicidal ideation and working with children  |
| Treatment Plan writing and documentation definitely could be improved. Social workers need to be taught continuous quality improvement measures and how to use this data to improve service delivery.   |
| Treatment plan, documentation and implementation  |
| treatment planning, clinical documentation, and the area of SUD to be able to identify and refer appropriate treatment.   |
| unaware   |
| Uncertain since I am a solo practitioner.   |
| Understanding how to handle the issue when a client makes an accusation.  |
| Understanding laws that affect social work practice and communities, understanding the intersectionality of different social workers in different fields, and understanding general social work safety practices.   |

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| Unknown  |
| Use of AI in SW, ethics related to telehealth and AI options, work ethic issues  |
| Use of AI; insurance compliance/clawback/records request fears; conflict between Trump admin policies and social work ethics; telehealth rules; updates regarding how interstate compact will impact/cost  |
| Very young children  |
| We could all use more, but especially in the child welfare world, they have really heavy case loads. Sometimes they still get a fair amount of continuing ed, but when they are run so ragged with high caseloads, despite their trauma informed training, they sometimes resort to client interaction that is not trauma informed.  |
| We do well, but changing social media landscape seems to present ethically challenges for some.  |
| We need support in the reality of our client and practice needs - such as practicing across state lines to serve more remote/rural populations. Also, quality in person trainings have become cost prohibitive so the trainings we seek to meet CE requirements are rarely informative to our actual practice with clients. Many are fluff.                                    |
| We need to have board approved supervisors in KS for clinical social work. I do not like that the Diagnosis requirement for clinical social workers was lowered  |
| We need to insist on diversity, equity, inclusion, and accessibility as central values that define social work. Protections around the use of terms like "therapy" so that AI companies cannot claim that their bots provide free or low-cost therapy. Protections to ensure the continued coverage of telehealth services at the same rates that in person services are paid. |
| We're in a competency crisis, primarily due to the exorbitant cost and time commitment of quality trainings. Instead therapists opt for lower cost one to two day trainings that are content-light and don't actually help with improving competency.  |
| What I have seen is the lack of keeping good, caring staff.  |
| What requires a social worker to make a report to CPS - there is inconsistency in both the guidance given and the interpretation of that guidance  |
| When I am working with clients for individual therapy that are in couples counseling with another therapist, I have heard and witnessed unethical practices i.e. referring my client to another individual therapist when they know they are already working with me, giving bad advice.   |
| When I last supervised in an outpatient setting, the MSWs seemed very unprepared by their graduate schooling. Education related to navigating insurance is a must as requirements seem to be becoming increasingly more strict.  |
| When I worked full time in a clinical setting less than two years ago it was frustrating that fellow clinicians had little understanding of how to impact policy change at the state and city level in order to better advocate for their clients and broader client systems. I think some CEUs even for clinicians should focus on macro level systems change.                |
| When it is appropriate and ethical to refer out and appropriate referrals for clients with personality disorders.  |
| Why CEU are so important. I was sad to see that the hours are lowered.   |
| Work with children on virtual platform.  |

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| Working in schools it is hard to keep constant access to more specific types of trainings to help provide therapy in a school settings. More trainings on schizophrenia, ODD, and DBT would be amazing for school based workers. |
| Working w/clients in the rural areas   |
| Working with clients who are financially scammed by overseas criminals   |
| Working with collective trauma that happens as part of large events/experiences such as COVID, ineffective systems, losing of rights/choices, being othered, etc.  |
| Working with elderly clients.  |
| Working with geriatric clients   |
| Working with neurodivergent individuals on the autism spectrum.  |
| Would love to see more CE related to advocacy in politics  |
| Writing skills need improvement. For example: mental health intakes (how to develop questions, gather information, and diagnosis), progress notes, court reports, etc.   |
| X  |
| <b>Yes (14 responses)</b>  |
| Yes- having more social workers in management/supervisory roles would be incredibly helpful. In my nearly 10 years of working as a social worker, I have only had 1 supervisor who was also a licensed social worker.            |
| Yes many practitioners seem to be inadequately versed in how to engage in trauma work, and most clients have some type of trauma.  |
| Yes! I am licensed in the state of Washington and Colorado to provide supervision for new clinicians. Since I only work with telehealth clients in KS, I am unsure what the need is. But open to helping!                        |
| Yes, I feel social workers need more training and continuing ed on 1. domestic violence and 2. dissociation  |
| Yes, most questionable issues are around ethics  |
| Yes, some areas of concern are ethical practice, more related to boundaries than anything else. Practitioners often do not have the training necessary to be good with diagnosis and specific treatment interventions.           |
| Yes, training in our code of ethics  |
| Yes. Definitely more specialty services needed in rule areas. Lack of concentration areas in autism, DBT, parent and child therapy.  |
| Yes. Need additional training requirements for trauma care.  |

**LBSW Q10. Over the past two years, have you experienced any issues concerning telehealth, either through professional practice or observations of other practitioners? (133 responses)**

A loss of connection to clients. You can't hand a Kleenex to a crying client virtually.

A lot of the clients I work with struggle with understanding how to use telehealth

Although I don't use Telehealth in my practice as a social worker, I am aware of its use by nurses in the hospice setting. I believe it can be a valuable tool in our rural areas.

Clients don't pay attention or have full attention with telehealth, in person is MUCH better

Counseling by telehealth is very generic. takes time to build rapport. though telehealth is filling in for in-person especially in rural areas, the mainstream teletherapy format makes it very easy to loose clientele because people can "switch" at any time. Also telehealth is very hard to connect with children/youth because the attention span is so different in person verses by a screen. concerns of confidentiality with telehealth social work because everyone has a device and not all respect the need for privacy.

Haven't worked in the last two years

I am an advocate for telehealth in limited circumstances. Unfortunately, in my experience telehealth cannot replace determining safety and health related to a vulnerable individual's environment. Practitioners note in documentation they "were able to verify the individual's environment is safe." Home visits are an important assessment tool as are in person visits. Some things cannot be observed through a telephone call or televideo meeting. On the flipside, practitioners should maintain the same level of profession while on a telehealth meeting as when meeting in person.

I do not use Telehealth.

I don't feel telehealth is beneficial to people at all. Yes it helps for those that have busy schedules or no transportation to get to the agency but that is about it. I work with kids that do telehealth visits with therapist, workers, families, court and often times we find that the kids are not engaged at all. Many times we find that the kid was looking at inappropriate stuff while participating in the meeting. In person seems better and more personal and therefore more productive in the long run.

I have no had exposure to this.

I have not

I have not experienced any issues with this area.

I think it hinders getting accurate information from clients and also puts additional barriers up for some individuals to receive services

In our rural area having telehealth for medical follow-up with specialist doctors is very valuable. In my role I do not hold telehealth visits.

I've not used telehealth, but I think it can be useful especially for persons dealing with severe anxiety.

**N/A (25 responses)**

**No (65 responses)**

No concerns, telehealth makes services more accessible but it's not the ideal method of delivery for services in my opinion so balance is needed.

No ethical concerns, just encouraging SWs to educate themselves to how to utilize the tool fully. (Sharing screens, passcode protected, setting up a waiting room, etc.)

No I don't do telehealth

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| <b>No issues (2 responses)</b>   |
| No negative experiences  |
| No observations  |
| No worries about telehealth  |
| No, I do not do telehealth.  |
| No, I have had to use telehealth with a medical issue once, and it worked out for me okay.   |
| No, I have not experienced or observed any issues with telehealth.   |
| No, it has made it so much better! For children who are moving placements often, telehealth helps maintain continuity with MH providers!   |
| No. I have not observed any telehealth. I think it could be an advantage in very rural area or where a client cannot get transported to a face to face appt  |
| <b>None (5 responses)</b>  |
| Not all practitioners are equally comfortable or proficient with the technology required for telehealth. Some may struggle with setting up and using video conferencing platforms, managing electronic health records, and ensuring secure communication. Training in digital literacy and the use of specific telehealth platforms can help practitioners become more confident and efficient. Workshops and ongoing support can be particularly beneficial. Many clients, especially those in rural or low-income areas, may lack reliable internet access or the necessary devices to participate in telehealth sessions. This can create barriers to receiving care. Social workers can advocate for and help clients access community resources, such as public libraries or community centers, that offer internet and device access. Additionally, providing alternative forms of telehealth, such as phone calls, can be a viable solution. Client engagement and motivation can sometimes decline in a virtual setting. The lack of face-to-face interaction can make it harder to keep clients engaged and committed to their treatment plans. Strategies for enhancing client engagement, such as regular check-ins, interactive activities, and personalized follow-up, can be taught through continuing education. Practitioners can also benefit from learning how to adapt their therapeutic techniques to the virtual environment. Conducting thorough assessments and making accurate diagnoses can be more challenging in a telehealth setting. Limited physical interaction can make it harder to observe certain behaviors or conditions. Training in virtual assessment techniques and the use of standardized tools can help practitioners gather more comprehensive information. Collaboration with other professionals, such as psychiatrists or psychologists, can also provide additional insights. The shift to telehealth has blurred the lines between work and personal life for many practitioners, leading to increased burnout and stress. Training in self-care and work-life balance strategies can help practitioners manage the demands of telehealth. Encouraging regular breaks, setting clear boundaries, and using time management techniques can also be beneficial. |
| Response to patients in crisis has been observed   |
| Some people do not have the technology or they struggle with it, especially when dealing with the older generation.  |
| Technology isn't always better. It is fine if it works, but the systems do not always gel with one another.  |

The profession is diluted by people using other titles such as case manager, case worker, client advocate etc. That don't have the training of a social worker, but often do the same type of job.

Virtual meetings are being held with people being allowed to attend by phone, therefore, HIPPA compliance cannot be verified.

Yes

Yes, I accompanied a client and their family member to a local Mental Health Center for an the clients assessment for admission to a Geripsych facility. My client was HOH and couldn't hear the mental health assessor. My clients speech was slurred and the professional couldn't understand my client. The assessor couldn't see or smell the dried urine one my clients clothing.

Yes, not being able to provide or use telehealth services due to it not being covered by Medicare.

Yes, unlicensed CPS are releasing confidential information.

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| <b>LMSW Q10. Over the past two years, have you experienced any issues concerning telehealth, either through professional practice or observations of other practitioners? (706 responses)</b>  |
| A lot of people aren't using it appropriately, clients aren't given the proper privacy   |
| Basic connectivity/Wi-Fi issues  |
| Clients' lack of access to technology or ignorance in how to operate said technology.  |
| Clients not understand why they can't be seen via telehealth if they are out of state (vacation), if their insurance is still active in KS.  |
| Clients, especially children having a confidential place to speak with providers   |
| concerns with location of provider when delivering telehealth services, platform used in providing services  |
| Confidentiality is a challenge because you have no way of knowing who is in the home also for DV cases and family violence cases with parents and children there is more risk because you are not there to make sure things are at a point where everyone is safe and being able to talk with members in a confidential manner   |
| Connectivity is vital, poor internet provides poor services, not all providers or clients can relate via screen.   |
| Continues remain confusing regarding the ability to provide therapy clients who might be out of state, particularly if the clients are residence of Kansas   |
| Difficulty in getting consent forms signed, etc.   |
| Do not use telehealth.   |
| Does not apply in my case.   |
| Ethical AI in practice   |
| Frustrations for myself and my clients in not being able to serve them when they travel or move outside of the state. Some practitioners become more fatigued during telehealth sessions and/or do not feel the rapport or session is as successful.   |
| Have appreciated the growth in the area of telehealth & social work. Have been concerned however, about the need for interstate compact agreements. At my medical work site, my medical providers (physicians) consult via telehealth in multiple states. I hold licenses in KS and MO and do not participate in consultations outside those states, much to my physician's chagrin. |
| HIPPA  |
| I am just now going to use it personally, so then I will be able to speak on it.   |
| I can't think of any at this time.   |
| I do not offer telehealth services   |
| I do t feel that it is affective with children and adolescents which is my main clientele.   |
| I don't like it but in my setting I don't have to do it. I prefer face to face service but glad that others who use it do so   |
| I don't provide tele-health  |
| I don't utilize telehealth.  |
| I feel like it creates opportunities of a lapse in professionalism. I was once having an initial appointment for therapy myself with a woman who was sitting on her bed in her bedroom while her cat wandered around. Needless to say, it was a one time appointment.  |
| I feel that the telehealth providers for individuals in the nursing home is ineffective when there is any degree of attention deficit or dementia. When the client is able to engage and understand, it is okay.   |

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| <p>I feel use of telehealth can be very useful to reach patients that are unable due to their health, transportation, or distance from health care reach a practitioner especially when practitioner has the technology and is skilled at it. I have also seen notes and have known staff to ignore notes on how best to reach a pt or guide a pt on use of telehealth especially in the mid to Elder-age population that have fear of scamming. Also due to limited physical abilities and often due to limited financial means to internet or even cell phone use. Examples are a healthcare system that will only reach out through their own chart system or text system and never attempts to just call pt. or may call pt but noted on chart to call daughter but note is not read or ignored</p> |
| <p>I hate telephone only I hate seeing my face in telehealth. If I had it my way 100% of my clients would be in person. Haven't seen anything negative, I just don't find it as effective overall. Especially audio only.</p>   |
| <p>I have been made aware of practitioners providing telehealth services while driving or on the phone while walking through public spaces.</p>   |
| <p>I have conducted telehealth sessions over the past 2 years. More training about how to conduct telehealth sessions would be helpful.</p>   |
| <p>I have coordinated training on the topic of telehealth ethics. I have received telehealth services myself. I haven't seen inappropriate use of telehealth.</p>   |
| <p>I have experienced family's more engaged and being very supportive of telehealth services. It makes it more feasible for families to have the option- especially working parents or those who don't have financial means to participate get to and from services! My families LOVE telehealth option.</p>  |
| <p>I have had hospital patients utilize telehealth for mental health assessments. It seems impersonal to me. I love virtual CEU opportunities, but something as personal as physical and mental health should be "in person" the majority of the time, unless it is just a follow-up sort of checkpoint meeting.</p>  |
| <p>I have heard that at least one practitioner has used telehealth while driving, which is extremely dangerous. They were informed that there is a reason we do not provide services while the clients are driving and the same safety concerns apply to them.</p>  |
| <p>I have no provided telehealth except during covid and with dangerous winter weather conditions.</p>  |
| <p>I have not been involved in telehealth.</p>  |
| <p>I have not experienced this issue</p>  |
| <p>I have not had an issues concerning Telehealth.</p>  |
| <p>I have not personally dealt with this concern</p>  |
| <p>I have not seen any issues. I do not use it at all.</p>  |
| <p>I have not used telehealth in the past two years.</p>  |
| <p>I have not used telehealth services directly. I often encounter the question of insurance converge and licensing of practitioners when determining if telehealth is an option.</p>   |
| <p>I have not. I have heard from another LMSW, that she took a telehealth training that was much more helpful that she had anticipated it would be. This indicates to me that it would be an area more training/education would likely be helpful for all of us.</p>  |
| <p>I have not. I've been approached by companies due to my LSCSW in Texas but with residence in Kansas they are always clear I could only be in clinical situations if I lived in Texas so they classify me as lmsw only. Seems very professional. I've not had other experience.</p>   |

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| I have noticed community partners and parents needing psycho education on if telehealth is effective for young children as some will ask for play therapy telehealth which is challenging or telehealth for people in precontemplation.   |
| I have observed telehealth and placed the call, but I haven't seen any concerns. Although the practitioner does not get to observe the room and the cues from others in the room and the interaction.   |
| I have seen misuse and misunderstanding of telehealth policies/procedures   |
| I have some concerns about providers moving away from in person care, especially for our older populations that struggle with technology or are isolated.   |
| I haven't experienced and issues.   |
| I just don't believe telehealth practices have enough evidence to support their efficacy. Especially when related to services for youth, it has seemed to do more harm then good.   |
| I know a lot of practitioners are still offering telehealth and that it exploded since Covid which is a good thing.   |
| I prefer not to practice via telehealth. I struggle with identifying non verbal communication via telehealth.   |
| I provide 8 hours of telehealth each week and feel pretty comfortable with it. It's effective for some clients, but not all.  |
| I rarely ever use it so I really can't answer this question.  |
| I see my own therapist by telehealth and it has greatly reduced barriers to seeing her. I see her more consistently and frequently than I would otherwise. Mr. treatment is only positively affected by virtual sessions.   |
| I think it is used too much   |
| I think telehealth has been a wonderful change for the most part. I am able to provide more services to those in underserved areas and also provide more expedient services for those in crisis.  |
| I was able to see the difference between telehealth and in-person visits. While I personally prefer in-person, I understand that telehealth has its purpose and it very beneficial to some clients.   |
| I was working at Pawnee mental health as well as working as a school social worker during the 19 20 covid year I haven't had any experience outside of that but I had left Pawnee mental health after 11 years because I didn't feel that you could provide services telehealth for what I was doing so for the last two years I've been in person in the school district |
| I was working for community mental health when Covid happened and we switched during that time to telehealth, I thought it was a wonderful opportunity. I was completing Afterhours hospital screens, running through dark hospital parking lots and garages, wondering about my safety and when we were allowed to use telehealth, it was a huge perk.                   |
| I work in a field, where I complete comprehensive environmental and psychosocial assessments. It's become common that clients request to do telehealth visits. The assessment is not nearly as accurate without seeing the person, face-to-face. In addition it excludes a large portion of population who don't have the adequate technology for this model.             |

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| I work in private practice outside my full time job at the hospital. I do not provide telehealth services and feel it is very impersonal. I feel telehealth should be provided for individuals who are more disabled and have a hard time getting to appointments. I think it is wonderful for that. Assessing a person in person is key to working with them.  |
| I work with a lot of teens so Telehealth just isn't very effective and sometimes client's will not be in a confidential location (even though they are told) and the session has to end.  |
| I would like to see greater support for organizations to have clear written policies regarding telehealth and technology in practice including using apps, social media and AI.   |
| I would love to provide telehealth support.   |
| I'm not a fan of telehealth as the primary delivery of services. I believe that in person contact is the best way to get to know clients. Telehealth is great in a pinch or a crisis but in person is more personal - I can read body language and voice tone. I believe being in person enhances the connection and capacity for clear communication and increases connection thus facilitating the therapeutic process. |
| In my current position, we had to provide corrective counseling to an outpatient therapist who provides telehealth because she was not providing accurate times on her documentation.   |
| Increased use from the county mental health providers (rural area).   |
| Issues are systemic and need to be addressed with policy. Burnout prevention, caseload mgmt., self care for providers so they can take good care of their clients.  |
| It is easy for children to walk away from the services.   |
| It is hard for outside agencies to accept Telehealth as an appropriate mode of interaction.   |
| It is more difficult to use when having to use the language line for translation  |
| It is not effective with children   |
| It isn't covered by Medicaid for IEP services   |
| I've found telehealth to be one of the best advances in provision of services. It has broadened access to care. It allows parents to fit sessions into their busy schedules and homebound individuals to access care.   |
| Just clients refusal to participate.  |
| Just limited view of social worker and of the client  |
| Knowing when to shift client to in person services.   |
| Lack of ongoing support, both clinical and technical  |
| Less no shows, but care has to be adjusted  |
| Limited access or unable to meet needs of the clients, or experience utilizing current resources.   |
| Lower client commitment to participation/ clients taking telehealth sessions less seriously. Need for confidential settings from which clients and therapists can join telehealth sessions  |
| Maintaining a strong signal is challenging at times.  |
| Making sure to keep the clients engaged is more difficult and for a shy client, it can be harder to get them to talk and open up  |
| Many clients lacked reliable internet, appropriate devices, or private spaces for sessions. This created barriers to consistent engagement and limited participation in care.   |

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| Mostly just technical issues, and occasionally clients won't be in quiet spaces alone for the session even after being told a session can only be conducted such way. But for the most part telehealth is a great resource and tool for people who otherwise couldn't access services.   |
| <b>N/A (81 responses)</b>  |
| N/A - The company I work for doesn't utilize telehealth.   |
| Network connectivity concerns  |
| <b>No (401 responses)</b>  |
| No - I don't have any experience using telehealth.   |
| No - I prefer it. It's a wonderful opportunity to remove additional barriers that would have otherwise prevented treatment. Many do not have transportation, especially in rural areas where there is no public transportation.  |
| No - limited experience  |
| No comment   |
| No concerns  |
| No I don't do telehealth   |
| No I've had good experiences with it.  |
| No issues  |
| No issues concerning telehealth  |
| No issues re: telehealth. I love it, my clients love it. I can attend virtual MD meetings w/them to give informed feedback re: client's observed s/s & complaints. Game changer for this medical social worker and improved quality of life and medical care delivery to the clients.  |
| No negative experience   |
| no other than people do not seem to engage quite as well as they do in person  |
| No, although I am concerned about the potential use of AI/Chat GPT and QMHPs overutilizing it, especially newer therapists with less skills and experience.  |
| No, but I don't provide telehealth services. In my prior employment as a supervisor with a foster care and adoption agency, I found tele-health to be unreliable and not very personable.  |
| No, but I've only had minimal exposure to it professionally. As a patient, my telehealth experiences have been positive.   |
| No, but telehealth has been a phenomenal tool, and I would find it hard to do my profession without it   |
| No, don't conduct telehealth   |
| No, I am fully remote and have experienced no issues   |
| No, I don't work a lot with telehealth, but I am thankful it's a resource available for professionals and patients.  |
| No, I have not experienced.  |
| No, I primarily work with patients over the phone or by telehealth and it is a valuable platform.  |
| No, I see it as a benefit. Often my clinics, in the hospital setting, allow patients to leave before SW would even be notified of positive SDOH responses (social determinants of health) so being able to utilize telehealth (really, phone calls) allows us to be able to follow up with these patients that we wouldn't otherwise be able to reach. |
| No, I work 100% telehealth   |

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| No, In fact, I work with a significant large population of remote clients and telehealth has been an game changer for effectively assisting those that are extremely remote who would otherwise be without services or assistance.   |
| No, I've done telehealth for the last 4 years and believe it was so needed.  |
| No, the only concern that I would bring up would be for those working with children, finding ways to ensure the child is able to express themselves freely, without fear of retribution. Some of this comes from ensuring that our patients are in spaces where they are away from their parents and not just off screen. And on our end ensuring that there are not other people who can walk through and overhear sessions. too. |
| No. grateful for the platform to stay connected during COVID.  |
| No. I think telehealth is beneficial in many ways. Lack of transportation, rural areas, lack of support and lack of finances.<br>Tech issues or connectivity problems can sometimes be an issue.   |
| No. Not doing telehealth   |
| No. I cannot speak to this.  |
| No. I do not use telehealth in my work.  |
| No. I feel we are well trained and directed on ethics and issues related to telehealth.  |
| No. I hope we can continue to provide services through Telehealth. And I hope we can still receive supervision through it.   |
| No. Just wish some of that accessibility didn't go away after COVID  |
| No; we do not do telehealth in my work environment   |
| <b>None (20 responses)</b>   |
| None its a great enhancement   |
| None observed  |
| None that I can think of currently. Other than lagging or not having good service.   |
| Normal technical difficulties and also privacy for adolescents due to their parents being in close proximity during sessions.  |
| Not applicable   |
| Not applicable for hospice   |
| not directly--only via practitioners' expression of need for/interest in additional training in the ethical use of technologies  |
| Not involved in telehealth,  |
| Not necessarily but it's been interesting to navigate telehealth.  |
| Not personally or professionally but have heard a few clinicians be surprised that Kansas doesn't allow telehealth services to occur when their client travels out of state, or that they can't provide their KS based clients telehealth when they have temporarily traveled out of state.  |
| Not properly assessing minor clients.  |
| Not really. While remote can be helpful on occasion we really need to get back to in person contact as so much of the non verbal communication is completely missed with remote and can't truly read the room or situation.  |
| Not that I'm aware of. If anything, it's minor, like technology issues taking up time in the session.  |
| Not that I'm aware of  |
| Not using a secure platform, working area distractions like pets, kids, visitors   |
| Office spaces/areas do not always fall under the confidentiality of our ethics   |

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| Only on the client's end: telehealth while in bed, in the store, etc. even though they are told they need to be somewhere confidential.  |
| Other practitioners encourage me to practice outside of my license area restrictions.  |
| Poor connections resulting in disruption during service.   |
| Practitioners providing services with their camera off the entire time.  |
| Problems with licensing from outside states and requirements.  |
| See #9   |
| <b>See above answer (2 responses)</b>  |
| Some clients do not have what they need for telehealth sessions such as device, internet, or understanding of how to use it  |
| Telehealth is great especially for client with no transportation   |
| Some insurance companies will not pay for telehealth services  |
| Telehealth practitioners have had to learn how to navigate on their own; learn by trial and error  |
| Sometimes Telehealth can be difficult due to connectivity issues and talking to couples via Telehealth is more challenging due to communication issues.  |
| Sometimes the tech fails and the connection is lost. It's not common, but it happens. Additionally, Zoom was not very loud in broadcasting the need to obtain a special version of it to not have clinical conversations containing PHI be used to train Microsoft's LLM AI. |
| Sometimes, telehealth is all that is available in the Southwestern part of the state.  |
| Supervisors wanting to expand telehealth services without training.  |
| Technology issues.   |
| Telehealth does not equate to the same quality as in person in my opinion. It's difficult to assess safety, assure security, and for children I believe the quality of care is nearly unethical  |
| Telehealth feels not personal and disconnected   |
| Telehealth has been an important part of my work with clients. Clients appreciate the flexibility of not needing to meet in person.  |
| Telehealth is a great way to provide services when there is no other option, but it takes away the personal aspect. You are unable to make an accurate observation of what is happening in the client's surroundings.  |
| Telehealth is helpful for our adult clients to receive services, as transportation is sometimes an issue.  |
| The only issue I have observed is that telehealth is less effective for some children.   |
| Telehealth is not always reliable due to network issues.   |
| Telehealth is not conducive to all clients.  |
| Telehealth is useful I just don't wish to provide my services that way.  |
| Telehealth isn't allowed at CCBHCs right now.  |
| Telehealth providers often seem unsure of what to do when working with a client who is shut down or unresponsive   |
| Telehealth remains an important aspect of my practice, to date I've had no issue with telehealth services.   |
| Telehealth was removed from my work place.   |

The CMHCs and other mental health facilities that are on call for any type of crisis doing telehealth for a crisis call that a client is in the hospital which is right down the road is unethical and very dangerous to the clients we serve. An example of this is the mental health center in Manhattan, Kansas. It's one thing if you were a rural community and you need crisis help to be able to offer telehealth services but if you are right down the road, not more than 5 miles away even it's insane to me that they do telehealth during the day, even versus having a therapist go to the hospital to help that person in crisis

The concern I have is that lower income families may not have the resources to do telehealth. I practice family therapy and many of my families only have a phone to utilize versus a computer which makes it difficult to do a family session with 2 or more people in the family. Also, many families may not have the unlimited data plan or have access to wifi.

The idea that insurance may no longer cover Telehealth at some point. Telehealth removes HUGE barriers that keep people from receiving surface.

The only issue I can think of is when we switched from Zoom to Microsoft Teams. I primarily work with older adults who struggle with technology. It can be beyond frustrating when I feel I can't assist them. I found a way to return to zoom and that resolved it.

The only issues I can think of with telehealth sessions are occasional connectivity issues.

The only telehealth concern I have is agency policies requiring fake backgrounds with the logo on it given some of the research about how those backgrounds tend to reduce trust in clients and lead them to feel like they have something to hide. Otherwise I've found telehealth to not only be an effective therapeutic space, but also has increased accessibility to work for me as a disabled therapist working towards my clinical license.

The younger generation doesn't love to have their camera on, and I've seen other practitioners continue to see them, even though that's not considered therapy by session and doesn't ensure confidentiality.

There are always concerns about safeguarding PII and PHI through electronic means. I haven't experienced any problems, but am always aware of maintaining privacy and risks associated with electronic communication.

There have been concerns with telehealth and maintaining confidentiality. For example, contact with clients in community-based positions. Finding HIPAA compliant means of communication as opposed to texting from a personal phone for example. I love that telehealth is available!! This increases access to services and intervention feel makes the profession more appealing.

Understanding the importance of having Business Associate Agreements (BAAs) on file with any third-party vendors storing or transmitting protected health information (PHI)

We need to continue to embrace telehealth especially as we strive to serve rural areas. Broadband expansion is a must.

We really do very little with telehealth.

We've gotten lazy with it allowing clients to utilize it that would benefit more from in person services.

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| When on Zooms or Teams people have AI assistants recording and then email summaries that include identifying information to large email lists.  |
| Wifi issues and clients taking the appointment while driving and having to reschedule because of that.  |
| Within the group setting, specifically when there is more than 3-4 in-person participants, those participating via telehealth are unable to engage meaningfully.  |
| Would love the social work pact to go through so we can start practicing in other nearby states without having to go through the process of being licensed there  |
| Writing skills, case management.  |
| <b>Yes (11 responses)</b>   |
| Yes have found telehealth has many limitations for social work trying to help with resources and applications.  |
| Yes, authenticity in the form of verification. Without picture verification can you really say that a Parent/Guardian are who they say they are or claim to be.   |
| Yes, I have several people who have come to my private practice therapy office for services after starting a telehealth program that didn't feel beneficial to them.  |
| Yes, I have.  |
| Yes, technology issues  |
| Yes, through observation. It is hard to come back from the telehealth burnout that was a result of 2020.  |
| Yes. Telehealth BH therapy services were offered as a pilot project initially to my understanding. The therapist offering those services resigned. Cases were transferred to remaining staff without question to staff. Training was minimal at best to the assuming employees in basic navigation and operation of the service. This delayed service to patients by simply connecting. |
| Yes. Confidentiality for the client is always hard when you do not know who else is in the room with them   |
| Yes. Practitioners need to be aware of emergency settings and have back up plans.   |
| Younger children struggle to maintain focus due to distractions   |

**LSCSW Q10. Over the past two years, have you experienced any issues concerning telehealth, either through professional practice or observations of other practitioners? (739 responses)**

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| A nice addition since COVID  |
| Accessibility for internet in rural areas  |
| AI and should we be using it in practice   |
| AI documentation   |
| And my workplace telehealth is an option. I spent 3 years working remotely, and many others working in person. Telehealth being beneficial more so than in-person work is the exception, not the rule. I believe it is too frequently utilized for convenience of the provider, at the cost of less effective service to the client. |
| Appropriate telehealth HIPAA compliance  |
| As a telehealth client and practitioner, I could hear my telehealth provider receiving text messages and looking at her phone while in a billable session with me. I felt this was very unprofessional.  |
| At times the app will not work in the sense of: not connecting the sessions, sometimes the sound does not work, and internet issues. This rarely happens though.   |
| Been a very positive experience / opportunity for my clients and me  |
| Biggest challenge is clients having consistent and stable internet connections.  |
| Boundaries with clients/ when they are doing other things while in session   |
| Concern that it will go away.  |
| Concerns over the legitimacy and trustworthiness of therapy platforms that are advertised on social media.   |
| Concerns with clients understanding of confidentiality. Often clients want to have their therapy session with others in the room, or at the grocery store, in the car with other people, etc.  |
| Confusion about laws and expectations given difference between states  |
| Consistent concern regarding what tech companies are doing with client data.   |
| Different states have different rules for reciprocity and it can be confusing.   |
| Difficulty with internet connection, at times, on the client's end which can contribute to disruptions.  |
| Distracted children, easy for people to disconnect, or check out of clinical intervention.   |
| Do not believe it is an appropriate not effective mode of intervention.  |
| Do not use telemedicine  |
| Documentation of client location and knowledge of local resources for emergency assistance tends to be neglected. Knowledge of setting up HIPAA compliant communication and back ups for technology failures.  |
| EMDR difficult via telehealth  |
| For many telehealth is not as effective as in person, and not effective with kids.   |
| Frustration around not being able to see clients when they travel, relocate, etc., to other states   |
| Have heard from other practitioners the pay is vastly different depending on telehealth service. Also, available clients decreased due to competition from unlicensed life coaches   |
| Have not observed  |
| I am in favor of multi-state licensing that allows practitioners to see clients in multiple states via telehealth.   |

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| I believe and see telehealth having opened doors for clients and made services more accessible. I have provided virtual care since 2017.   |
| I believe it's being relied on by providers who do not want to pay office overhead when it is a far less effective treatment form. Necessary to see full body language etc. to address underlying issues.  |
| I believe that telehealth has been a tremendous asset in the provision of social work services. I have observed that many individuals who may not have had access to necessary services in the past now have access because of the ability to utilize telehealth   |
| I do not do any telehealth. I feel the risk for fraud is too great in forensic cases and confidentiality is at risk. I feel I have a more accurate read on a client that I see in person.  |
| I do not know of any issues concerning telehealth. It has allowed me to see clients in more rural parts of the state that would not have access otherwise.   |
| I do not like telehealth because there is not a genuine connection between provider and client. Telehealth is not beneficial when trying to provide therapy with a young child. I only use it if I absolutely need to.   |
| I do not practice with tele health   |
| I do very little telehealth work. I know many people have tried it and didn't feel it was a good fit. Ultimately, led them to looking for a clinician in-person.   |
| I don't do telehealth  |
| I don't participate in telehealth services.  |
| I don't think telehealth is the best way to deliver mental health care at all. Using it through COVID was one thing, mild cases are another. But to consistently see someone virtually instead of in person (unless in a remote location such a deployment) again lacks the human interaction when already so many lack human interaction and have their faces in screens in every other aspect of their lives |
| I don't find Telehealth to be helpful or beneficial for all clients. There are sometimes issues with clients connection and can be dependent on weather.   |
| I enjoy telehealth service provisions and most clinician are adept at using it.  |
| I find telehealth to be a valuable option as service and resource to clients.  |
| I find that telehealth is not effective for small children.  |
| I found it harder to have a true safe place for deeper trauma work due to all the variables in the clients surroundings and internet issues. Teaching coping skills is fine.   |
| I have been very happy that we have been able to continue to provide therapy services via telehealth even after the pandemic. It has allowed some of my Medicare clients to have regular service even if they are unable to drive due to their disability, as well as allow people to participate in bad weather or even if they are not feeling physically well, but still want to attend.                    |
| I have great things to say about telehealth. The technology can mess up at times, sure, but the populations that can now access quality care due to location, flexibility etc. makes it an asset.  |
| I have had several clients report to me that they left their previous telehealth therapist because the therapist was distracted, or "going through the Starbucks drive through" during sessions.   |

I have heard other practitioners say telehealth is less effective or have the attitude that it is a "light" form of therapy. I find telehealth to be essential for managing the energy of myself and my clients, and it supports accessibility for clients in MANY essential ways. Research tells us telehealth is NOT less effective, but there seem to be some misconceptions in the field.

I have not as I became licensed during the pandemic and was working at a CMHC, so it was very much the "norm." I think it has been great for reaching those in rural areas.

I have not experienced any issues with telehealth.

I have not experienced any negative issues, only positive. I've conducted telehealth appointments as a practitioner, and as a client. Not only does it allow patients, and myself, time to be seen, but also allows patients to stay in the comfort of their home to discuss some of the most difficult parts of their lives. I support telehealth 100%.

I have not experienced telehealth at all.

I have not had any issues with telehealth besides occasional wi-fi failure. Telehealth has been beneficial for clients and families.

I have not, I believe it is an alternative for people to access services. I am pleased with telehealth as an option.

**I have not (2 responses)**

I have run into issues due to connectivity and lack of privacy. I prefer in person due to this

I have seen providers who transitioned to private practice (which just happened to be telehealth) have a difficult time working without supervision.

I have trouble using Doxy.me which is a HIPAA-compliant platform. I often resort to Zoom and I tell my clients it isn't HIPAA-compliant but it seems more stable.

I haven't provided telehealth, but I am considering it. Having easier direct, clear information on licensing requirements when one party is in a different state than where you're licensed would be nice.

I love the use of telehealth. It makes my job a lot easier. I do think that billing for insurance is sometimes difficult since the change of the POS 10 v. 02

I only practice through telehealth. I believe it is a valuable and necessary modality to make available to people who would otherwise not be able to access mental health services.

I prefer face-to-face interactions, but I am surprised by how effective they are when I do use them.

I prefer in person due to people not making sure their home space is private and technology challenges and glitches during a session .

I prefer in person sessions for many reasons but will do telehealth if needed for the client. I've had tech issues, and it's difficult to have a therapeutic relationship and practice EMDR via telehealth as it is with in person.

I prefer not to do telehealth, too impersonal

I really like the flexibility of telehealth

I saw difficulties with treatment engagement/commitment when sessions were remote.

I see a lot of reports regarding issues with certain EHR platforms that offer telehealth. But not necessarily with the method of providing services.

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| I teach a course on ethics at the BSW and MSW level and hear about shifts in practice to telehealth. The students and I express concerns about not being able to adequately see nonverbal communication- which represents over half of all communication. There are major risks and some benefits with this kind of practice.  |
| I think it is important to be able to serve clients if they move out of a state I am licensed in.  |
| I think it's easy to become less focused as a tele-health provider which is a concern when you're with a client.   |
| I think knowing when you can/can't see clients   |
| I think social workers should be able to continue to work with patients if they move out of state. Why terminate a support as a patient enters a big transition in life?   |
| I think telehealth is critical to reach rural areas and professionals/busy moms that can't get to a 9-5 practice   |
| I think that telehealth continues to be a vital link to care for many folks.   |
| I think the biggest challenge is the lack of connection/opportunities for consultation when in private practice. Most contracting agencies offer a Facebook page or slack channel but not often a zoom meeting. It can be a very isolating part of the experience.   |
| I use all Telehealth and know that it is EXTREMELY beneficial to my chronic health patients, moms on the go, people work, etc.!  |
| I will be grateful for the implementation of the licensing compact. I am currently licensed in Kansas, Colorado and Maine. It is a burden and challenge to maintain all 3 licenses separately.   |
| I wish laws would change around providing Telehealth to clients while they are in other states (like for vacation, business travel, or college).   |
| I work as a solo practitioner so I have not seen other practitioners working.  |
| I work at LSH and most of our psychiatrists provide clinical services through telehealth 100% of the time. They do not receive an accurate understanding of the patients' symptoms because most patients can hold it together fairly well for 10-15 minutes. While the psychiatrists usually consider the info provided by nursing and clinical staff, they tend to put more stock into their personal observations with the clients during those brief encounters. I do not provide telehealth services but I'm sure it would be effective for clients/patients with less severe symptoms who are higher functioning but for those who are severely ill, it is grossly ineffective. |
| I work in a CMHC. My experience with telehealth has been positive. We provide telehealth primarily for things like review meetings or case conferences where the client, parent, family supports, and treatment providers gather to discuss treatment and plan. Telehealth is much more convenient as parents do not have to miss as much work, kids don't miss as much school, providers are more likely to be able to attend, etc. We also will provide therapy or med appointments via telehealth at the client's request, if it makes sense clinically. If the client/parent is not able to stay on camera, it is likely that is not an effective mode of treatment.             |
| I work in a hospital setting, as my clinic expands the main issue I have is people not understanding I cannot meet with patients outside of the states that am licensed.   |
| I would like to provide telehealth for my clients when they leave the state on trips/family summer visitations, but we can't meet due to insurance requirement that client be in the state of Kansas.  |

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| I would like to see less phone options and more Televideo as I don't believe the rapport building is the best through phone, and it is important as a clinical mental health provider to be able to see the individuals I work with. As for using telehealth as a form or practice, I don't have any concerns.   |
| I would love to be able to see clients in other states.  |
| I would prefer to not utilize telehealth for therapy sessions.   |
| I'd like to see more agencies offer telehealth services and virtual  |
| I'm aware Licensed Professional Counselors are working towards passage of a Compact Law that would provide more reciprocity across state lines. I'm very hopeful Social Workers will pass something similar, as I have to maintain licensure in both MO and KS (I live/work in Kansas City near the state line)  |
| Impersonal   |
| In general, I think clients that prefer or are limited to tele-therapy are able to engage in the therapeutic process. There have been times in which I have had to speak with client about in office therapy due to lack of engagement, distraction, or other factors that inhibit them from being able to fully participate with the therapeutic process. |
| In my experience in private practice, most people are preferring in person sessions, at least to begin.  |
| In my position, I haven't had the opportunity to work with direct practitioners.   |
| In some cases it feels as if there is less connection between the social worker and client.  |
| In terms of working with young children, telehealth is a big challenge.  |
| In the past two years I have received the poorest healthcare services in my life. No one gives a shit about their patients anymore.  |
| Inappropriate use of telehealth such as using it when clients are contraindicated (such as in cases of domestic violence), not holding clients or the same standards of privacy or conduct as you would in person (such as allowing clients to have their children with them or not having privacy).   |
| Inconsistent connection issues   |
| Informed consent and safety should the technology have difficulties  |
| Insurance companies becoming less flexible   |
| Insurances are reducing telehealth rates even while telehealth is reaching rural areas and reducing barriers for people to access mental health services.  |
| internet connections   |
| Issues of the service quality? None.   |
| It has been a fabulous tool that allows many such flexibility. The internet can at times be problematic  |
| It is definitely harder to find clinicians who are willing to see people in person.  |
| it is easy to start to play fast and loose - the reminders to maintain professionalism are important   |
| It is frustrating trying to set it up.   |
| It might take two more sessions to get a good read on them. But, it is so helpful to those that would never come in the office because they cannot take that much time off of their job.   |
| It's convenient to some clients, especially working clients, but the vast majority of the clients I see prefer in-person sessions. I won't provide CPT over telehealth. The logistics of all the paperwork involved is too complex, and I can't check work.  |

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| It's helpful in some instances. I observe it be overused and in some instances it's the only service provided. These observations are not limited to social workers.   |
| It's used, no problems   |
| It's a concern when the client is unable to find a private place to have a conversation, and they have family walk through in the background or they attempt to talk while in public.  |
| I've seen practitioners who are woefully unprepared and not trained in trauma specific EBP's, attempt to conduct these modalities through telehealth. This has resulted in the re-traumatization of patients. It's deeply concerning that this is not better regulated utilize available best practices data. I believe things got "too loose" during COVID and haven't fully recovered in terms of the latitude given to providers. |
| Just concern that out of state providers are not familiar with local resources for the clients they are serving.   |
| Lack of universal access to technology and/or limited knowledge of how to use technology   |
| Less pay from Medicare for telehealth, potential to limit telehealth services  |
| licensing restrictions-we should b allowed to see anyone in the USA  |
| Low quality, client engagement, sloppy therapeutic interventions, low skill workers who can't get a job with an agency or think they know everything. Therapy is a relational process that is not limited by telehealth participation. New clinicians are more comfortable with its use but they don't know what good therapeutic interventions look like yet.<br>Telehealth is a lazy approach to therapy.                          |
| LPC ethics and practices create a conflict regularly. I have routinely had to share that there are implications for licensure for where the person lives and where we are licensed. I see less concern about being reported to a board than when I started my career in social work in 2001.   |
| Mainly technical difficulties, but not otherwise.  |
| Mainly with setting boundaries with clients so that they respect the time set aside for the session.   |
| Maintaining privacy in environments full of smart technology (i.e. Alexa, google nest)   |
| Many independent practitioners lack experience to practice without administrative and clinical supervision.  |
| More HIPAA compliant platforms that are free of charge (not part of a business suite or portal package) are needed. When I use one (which I pay for) and it doesn't work (sometimes mid-session), I switch to another that is free of charge.  |
| More so issues with clients and teaching them boundaries with virtual therapy locations and state laws   |
| My agency won't allow telehealth from my home. So when I have surgery in August I have to take the time off completely.  |
| My biggest issue with telehealth is the spotty wifi signal that my clients often have or occasional outages of service by our office internet provider (Cox Communications). It happens often enough to be disruptive to sessions.   |
| My telehealth clients seem less consistent and internet issues cause disruption to quality services. It's hard to prove trauma therapy when there is a delay, freezing, etc.   |
| <b>N/A (31 responses)</b>  |
| N/a - telehealth is important for access to care   |

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| Need to get the compact licensure rolled out so providers can continue to see clients when they move to other states.  |
| <b>No (353 responses)</b>  |
| No - I am a telehealth only provider for Kansas and California.  |
| No - Ideally we wouldn't be bound to only providing telehealth to those in our state. I have Ct's that have an established relationship with me and they have to move for work/school and I wish I could continue seeing them via telehealth   |
| No comments.   |
| No concerns with telehealth. It's a valuable service delivery mechanism.   |
| No current issues. Have observed that telehealth appears to work much better for adults than youth less than 18 years old. Difficult to engage children through telehealth.  |
| <b>No issues (4 responses)</b>   |
| No issues but it's caused extra work/efforts to protect my clients' confidentiality due to technology  |
| No issues experiences with telehealth therapy at all.  |
| No issues for most that use telehealth its due to living to far or not having transportation   |
| No issues- just desire for compact to occur  |
| No issues observed   |
| No issues other than setting the ground rules very clearly and having the client sign a copy of our telehealth policies and procedures that clearly explain that for a video session they must be fully dressed and wearing clothes and we do not want to see any alcohol, drugs, paraphernalia, or weapons in the background. |
| No issues that I have experienced.   |
| No issues, as an older clinician, I do prefer in person.   |
| No issues. Generally, have not found that the medium has compromised the quality of the clinical work. In fact, it has become much easier for working people who would lose time with travel and seniors who are at risk in bad weather.   |
| No issues. Using telehealth is standard practice now.  |
| No issues. Without telehealth a few of my clients would no otherwise engage in treatment due to no transportation or Other barriers.   |
| No issues concerning telehealth  |
| <b>No significant issues (2 responses)</b>   |
| No, but I don't think it's as effective as in person, from my perspective. I don't feel like I connect with the clients as well over telehealth.   |
| No, helpful when used.   |
| no, I believe telehealth is needed for access to services, though I also believe in person is best when possible if that does not create a barrier to care   |
| No, I enjoy the flexibility of telehealth services.  |
| No, I find it to be a positive way to provide therapy with set boundaries from the practitioners of creating an intentional space for therapy and encouraging the client to do the same.   |
| No, I find telehealth to be very helpful and beneficial for clients.   |
| No, I have given two seminars for using telehealth   |

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| No, in fact several of my client have made more progress than ever before because they're able to by obstacles to treatment by being able to do therapy in the location of their choosing   |
| No, in fact we fought very hard for telehealth coverage when COVID hit (I live in Northwest Arkansas where Tyson, JB Hunt, and Walmart all have self-funded plans, therefore could say what was covered for their members). Once it was approved, it has become a great way for clients to remain in outpatient care, despite having to travel in the state, stay home due to illness, or simply the convenience of a telehealth session in between work meetings. Telehealth has been nothing but an asset for my practice and our clinic. |
| No, it seems like a great resource and people are able to get care where otherwise they could not.  |
| no, it works surprisingly well and makes it more accessible   |
| No, I've not seen any issues regarding telehealth. I actually love telehealth and how it provides more accessible services in rural areas.  |
| No, no problems other than occasional bad internet connection.  |
| No, none negative. Telehealth has helped to serve many who would not otherwise have access to care.   |
| no, not that I can think of   |
| No, really liked doing telehealth   |
| No, telehealth has become a great practice tool and allowed me to reach more people than without it.  |
| No, telehealth has been a godsend to serving people in rural areas and in a timely manner.  |
| No, telehealth has been a helpful new practice for social workers.  |
| No, telehealth is a great option  |
| no. but in my setting, fewer and fewer clients want telehealth  |
| No. I am surprised that I have learned to like it after being forced during Covid. It is less exhausting than it was at first. I am also surprised how many clients prefer it. I even utilize hypnotherapy, EMDR, ART etc. over televideo and it works just as well.  |
| No. It has been a successful tool to help reach people who otherwise would not be able to get services or would not be interested in services if there was not a telehealth option.   |
| No. Some Clients are initially shocked but adapt quickly generally.   |
| No. Very pleased at how telehealth has vastly improved accessibility for those with limitations due to family (getting childcare), tough work schedules (only able to take 4 hours off at a time instead of just 1-2 hours, mandatory hours of work, or work that requires changes/lack of predictability), limited transportation or other factors that would prohibit in person treatment.  |
| no. works better than I'd expected.   |
| No. A lot of clients enjoy this form of treatment.  |
| No. Except my professional working environments would not allow telehealth for professional practice. I would like to know opportunities for part-time or full-time employment.   |
| No. I adapted well and learned to set boundaries quickly with clients due to my experience with in home family therapy, hospice. Where I developed in person setting environmental boundaries. Thus I was able to remotely.   |

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| No. I do think it's important to understand and occasionally be reminded that it's important to show up over telehealth the same as one would in person. Telehealth has given access to many who aren't able to access in person appointments. It's important and should be respected.   |
| No. I enjoy telehealth and clients have been positive and accepting.   |
| No. It has gone well for me and those I supervise. Offers therapy services to those not able to get to the clinic.   |
| No. Telehealth continues to be a benefit to clients.   |
| No. Telehealth has been a blessing for providers and clients. It has provided a fantastic tool to allow services to be provided to rural clients, at night when it might not be safe to see clients in person, when someone might have an illness that is contagious, or for a plethora of safety issues. Telehealth is an option that should always be available. |
| No. Telehealth has been great.   |
| <b>None (38 responses)</b>   |
| None - I try to avoid telehealth with children; I have used this service for working with parents.   |
| None except lack of client interest.   |
| None in particular other than importance and training possibly on the importance of a safety plan and how to address a patient in crisis via telehealth. Another clinician that I know experienced a patient masturbating on the other end of the session.   |
| none that I am aware   |
| None that I can think of.  |
| None to knowledge  |
| None to note   |
| None- we are in a rural and frontier setting and telehealth is extremely valuable and appreciated by our clients- allows ready access and specialty services   |
| Not always knowing where clients are located, even if they tell you where - concerns not actually where say they are   |
| Not applicable   |
| Not in clinical level but case management level of child welfare .... professionals not being present during videos just with voice  |
| Not in Kansas. Some other states do not monitor or penalize clinicians who are providing regular therapy to residents of other states without being licensed there.  |
| Not more or less than in person service provision.   |
| <b>Not particularly (2 responses)</b>  |
| <b>Not really (2 responses)</b>  |
| Not really. Higher demand for telehealth.  |
| Not specifically   |
| Not specifically with telehealth, no.  |
| Not that I am aware of.  |
| Not that I can think of at the moment  |
| Not that I can think of.   |
| Nothing outside of the technical and confidentiality concerns when people want to conduct telehealth in shared spaces.   |
| Often inappropriate for psychiatric assessments for psychotic and/or paranoid individuals.   |

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| Older populations more difficult to engage on Telehealth. People with paranoia do not appear to trust or prefer Telehealth. Hospitals have poor connectivity, results in delayed assessments, longer treatment times, greater financial burdens to the client.   |
| One issue that I have seen arise is when the therapist and/or client travel or when the therapist gets referrals from other states. Not all therapist completely understand the boundaries of their license and having something concrete to give to clients would be helpful as well.   |
| Only issues with inconsistent platform performance.  |
| Only my own experience and primarily with EAPs (Employee Assistance Programs. These clients do not tend to act as though completion of the paperwork from my office is necessary, even when I say this is just like your doctor's office. We have to complete paperwork before we can be seen.   |
| Only noting that lawmakers and insurance companies are looking for ways to cut coverage, and telehealth appears vulnerable to those cuts. Telehealth offers essential access to services patients would not otherwise be able to engage.   |
| Only that I would hope that it would continue to be a reimbursed option for clients and providers and that it would be reimbursed on par with in person services.  |
| Other than some technical issues, no. I don't prefer telehealth, but I will do it if necessary.  |
| Others in managing risk - not obtaining address or contact info of the patient   |
| Outside of technical glitches, no.   |
| Payment for services for clients needing them is still a big issue.  |
| People are sometimes unaware that they need a separate informed consent for telehealth. Also, there seems to be a general lack of awareness that you need to be licensed in the state where the client lives.  |
| People could use more support on how to engage in online activities during telehealth sessions.  |
| People should encourage their clients to not drive and do psychotherapy. The emotional strain compromises the ability to respond to traffic  |
| Platforms that are or aren't HIPAA compliant in protecting privacy and confidentiality.  |
| prefer not to address  |
| Problems with connectivity   |
| Providers and clients are in unprofessional, or personal settings- providers in family rooms with photos or in kitchens with family milking about, patients lying in bed half clothed. Both providers and clients are often distracted. Both providers and clients are in settings not private or conducive to therapy. It's impersonal and clients fee less invested. |
| Providers not living in this state or city providing telehealth to those who would be better served by local providers.  |
| Questions regarding practice across state lines when offering telehealth   |
| Questions regarding telehealth rules across different states   |
| reliability of platforms, at times. not useful with older clients generally. some are better at tech than others.  |
| Reluctance for many to use it such as inclement weather, they prefer to skip.  |
| Retired, so not experiencing such things.  |
| Securing electronics to ensure privacy.  |
| See #15  |

See above please. And I've had only two serious problems doing telehealth 5-10 hours a week for 3.5 years: one was an abusive client who was disallowed services after my report. The other required a health and welfare check and was actually fine safe but had messaged me in a dramatic way. When she did not answer by follow-up message to her I called law enforcement. Re: psychotherapy online is that as time has gone on, clients expectations seem increasingly unrealistic; such as anonymity, effortless, quick repairs, and the like. Clients who have previous experience with therapy seem to be the most attuned and ready to make some effort (makes sense, right?)

See above re interstate compact needs

See above regarding safety of children and the increase in frequency and use of telehealth. I do not use it for my staff, but it is taught in schools and encouraged within our professional and it can be confusing for new social workers on how to balance safety for children and what is the professional standard.

Setting expectations of patient environment during telehealth visits

Since 2020 when the pandemic began I have made use of telehealth on a HIPPA compliant platform to provide mental health/relational & casework services to clients. I no longer work with children directly as I think they benefit from in-person therapy. Remote work is now my preferred method.

So many families has been put on weight lists for months before getting scene when they were in desperate need of resources. Constantly I will advocate for families to get deeper into their health and then tell them to wait six months for that to happen because nothing is available for them.

Some inappropriate referrals although my specialties and credentials are advertising

Some insurers make it difficult, after the Covid era regulations expired, to provide flexibility to patients moving between telehealth and in-person sessions. I'd love to see the State mandate that insurers provide the same coverage for therapy in-person and virtual.

Some of the people accessing telehealth require a higher level of care

Tech issues

Telehealth can be helpful but I caution distractions like children at home.

Telehealth connectivity reliability seems like a constant issue.

Telehealth has been a God-send as it allows people to access care much more efficiently.

Telehealth has been a wonderful tool in helping clients be consistent in keeping their appts, staying active in their treatment. And especially with adults, seems just as effective as in person.

Telehealth has been an excellent resource for individuals who struggle to attend appointments for various reasons. Clients can have many obstacles to getting to the office at times, especially in rural areas (transportation, gas money, time needed off work to travel the distance to attend, etc.). In some instances, an individual's mental health may deteriorate on the day of the appointment and the ct. might cancel, but the appointment could be switched to telehealth and still be seen, which could prevent a hospitalization in some cases.

Telehealth has been fine except when experiencing technical issues.

Telehealth has been very beneficial to my clients

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| Telehealth has its inherent problems such as spotty connections, internet going down and being unable to connect, being unable to ensure privacy on client end.   |
| Telehealth is a very useful tool. And it would be helpful to have clarified guidelines on best practices of when in-person is recommended vs. when telehealth is acceptable. We understand that icy roads or illness may make telehealth the best option and yet some groups or persons are not best served by telehealth.  |
| Telehealth is a wonderful thing that does have it's own downfalls.  |
| Telehealth is an accessible means of service provision.   |
| Telehealth is effective if you have a relationship developed prior and depends on the presenting issues and the insight of the client and practitioner  |
| Telehealth is not a healthy form of practice when a child has abuse trauma. Adults tend to be in the background or the child feels like they are. I minimize how much this is used for myself and clients.  |
| Telehealth is not my preferred mode of providing service, however feedback from both practitioners and clients has been positive. It adds a convenience and removes barriers, such as transportation and child care issues. For clinical supervision it has also allowed much more flexibility and less cancellations.  |
| Telehealth seems to be similar, and the research on efficacy shows it to be similar.  |
| Telehealth services currently require a client to be in the state where the social workers' license exists, but does not require that the practitioner be in the state where the license exists. This does provide additional freedom for the practitioner, but limits the clients ability to experience uninterrupted services on those occasions when they are out of their home state for extended periods, which is more and more often the case for the very mobile society we live in and has disrupted my client's therapy schedules on many occasions. I hope that the interstate compact license will resolve a lot of these problems, but that will still be limited by the number of states willing to enter into such an agreement. Thus, this will still be a problem and needs to be addressed. |
| Telehealth: managing expectations and boundaries, creative strategies to engage clients on this platform  |
| The biggest issue I have had is parents sitting in on kids telehealth, I can't ensure complete privacy with telehealth even when I talk with parents and clients about telehealth and what is expected on their end as well as on my end.   |
| The biggest issue is not being reimbursed at the same rate as in person appointments.   |
| The continued requirement for practice address when doing tele health creates concern for private address being available to clients which opens a safety risk  |
| The limitation of the client and practitioner having to be in the same state is a barrier   |
| The only concern would be if we were no longer able to provide telehealth or bill insurance for those services.   |
| The only issue I've observed is a local hospital system redistributed their clinical social workers from the ER and now fully contract with a telehealth provider for all emergency room SW consults. This includes when a person comes into the ER suicidal. They get a SW on a mounted tablet instead of a person. Little dignity there for a person in crisis who is willing to seek help and endure the ER setting.   |

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| The only issue of telehealth I encounter is when I get someone who does not understand that their body must be in the state I have a license in order to have a session. I have had to turn away a few potential clients because they were going to do sessions at work which was located in a state that I am not licensed. Ex: Person resided in MO but worked in IL. I am licensed in KS and MO but not IL. |
| The requirements of telehealth and the need for more CEUs on understanding documentation of medical necessity and acceptable documentation to accommodate the services being provided.   |
| The state compact bill will be beneficial.   |
| Therapists multitasking while conducting therapy (i.e. driving, caring for family members in the room)- overall less professional.   |
| There could be a better focus on clinicians making sure they know where their client is located for safety planning.   |
| This continues to be an area of learning that did not start until 2020. I find that some areas of content are still be defined and developed.  |
| unaware  |
| Unprofessional setting, pets entering the session, camera issues... all of these things impact the experience for the client   |
| Until recently, I provided telehealth services more regularly. I, personally, have not had any issues.   |
| Verify location of client during session. Also having support from insurance to provide services for those who cannot attend in person. Continuity care for our clients includes adaptability to their needs in providing services well being fully trained to understand how to deploy that service.  |
| We seldom use telehealth. Used as a last resort.   |
| While I wouldn't describe it as a pervasive issue, I have been witness to the tele-health therapy format not being the best for teens addicted to technology and social media. It adds an element of temptation and distraction from engagement in the therapy process.  |
| While this has allowed increased access to mental health services to the community, it is easy to get diagnosed now and prescribed medications without fully meeting diagnosis functional impairment requirements and working through least restrictive options.   |
| Wonderful asset for clients who otherwise may not access services. Training should be required and more ethics courses offered that focus on this type of service provision.   |
| <b>Yes (10 responses)</b>  |
| Yes as explained in previous answer  |
| Yes not very friendly  |
| Yes some clients not understanding it is an appointment and appropriate expectations being set   |
| Yes- when a client has problems connecting and getting on, and it causes the session to be much longer than planned for the clinician who has other commitments. I also know there have been issues with confidentiality and clients who have family members who sit in or overhear conversations.   |

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| Yes, though it is convenient for accessibility issues. The connections and social subtleties necessary for rapport building and assessment are seemingly lost to some degree - in my opinion.  |
| yes, as it relates to difficulty with cross state jurisdiction and having to explain limitations to clients  |
| yes, changes to coverage in insurance providers covering telehealth  |
| Yes, clients working/schooling temporarily in other states have difficulty maintaining continuity of care.   |
| Yes, have had clients engage in unsafe/threatening behavior via telehealth and felt powerless/unprepared to intervene.   |
| Yes, I am not a proponent; I believe it needs to be substituted if face to face may not happen   |
| Yes, I struggle with understanding boundaries and what's allowed regarding clients and technology, as sometimes I text, email and talk over the phone with clients (on my work devices/accounts). I'm unsure if I'm supposed to be on-call for my clients. I'm unsure if telehealth can include telephone calls with clients or only video calls. Telehealth can be an amazing platform for patients to receive more accessible care. But I also think the patient has to be a good fit and still able to be in a distraction-free environment and willing to "do" the work. |
| Yes, not having a compact state license  |
| Yes, poor connectivity due to rural/remote areas.  |
| Yes, telehealth and trauma   |
| Yes, there have been some practitioners who have difficulty with managing their schedule and day-to-day job duties when working from home primarily doing telehealth therapy, some who have struggled with feeling as if they are a part of the team when working in another location while the rest of the team is working in the office, and others who have struggled with maintaining healthy boundaries with clients.   |
| Yes, we have been forced to utilize AI at our agency with no discussion around the drawbacks of this.  |
| Yes. Concern about quality of care   |
| Yes. Limited improvement in sxs, follow thru with referrals, presentation of sxs not observed  |
| Yes. People using telehealth to accrue hours in another state while seeking clinical hours   |
| Yes-difficult process managing clinical issues and technology issues at same time. At times does not feel as personal.   |
| Yes-ethic concerns created by privacy issues with telehealth and ability of SW to effectively observe and assess the patient's behaviors virtually vs in person  |

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| <b>LBSW Q11. Over the past two years, have you experienced any negative issues involving supervision? If so, please explain. (131 responses)</b>  |
| Felt management was gaslighting me. Past issues with a former staff person were continually brought up as an excuse to make me feel inferior as a supervisor. I retired early for my own piece of mind.                 |
| Haven't worked in last two years, so no supervision necessary.  |
| How to locate available ones  |
| I do not see the value in why a bachelor's level social worker needs to be supervised by a master's level social worker. The work is essentially the same. No real trouble with it, just don't know why it's necessary. |
| I don't have it? Live in a very rural area with few social workers  |
| I have not  |
| I have not experience any negative issues involving supervision. In my agency upper management has been crucial in my professional success and growth.  |
| I report to the Exec. Dir. of Nursing in our hospital-not the same as having a Dept. of Social Workers-but has worked well.   |
| In most of my recent work experience my supervisors have not been SW and do not know a lot except for what I have told them.  |
| In past jobs but not over the last 15 years.  |
| It is very hard to LMSW to supervise. The caseloads are so overwhelming it is impossible to get people on board to assist.  |
| Lack of intentional supervision to discuss concerns, cases, and strengthening skills. This may be due short staffing and time available to meet client needs.   |
| Lack of leadership qualities  |
| Lack of understanding social work practices and limitations in certain areas of job application.  |
| My current supervisor does not use our supervision time adequately. She uses the time to talk about personal issues or to speak poorly about the agencies leadership.   |
| My old boss was never available and did not support us which led me to find new employment.   |
| My supervisor is not a social worker, which can be difficult to navigate at times.  |
| <b>N/A (16 responses)</b>   |
| <b>No (73 responses)</b>  |
| No issues   |
| No negative experiences   |
| NO, HAD A FANTASTIC SUPERVISOR!   |
| No, I have had great supervisors.   |
| No, I have not experienced any negative issues involving supervision.   |
| <b>None (3 responses)</b>   |
| Not by the BSRB.  |
| Not clear boundaries  |
| Not enough coaching for new supervisors.  |
| See #3 & #9   |
| Some of the supervisors are not licensed professionals.   |
| Supervisor are overwhelmed and constantly doing more and more work for upper management that restricts their ability to work with their staff.  |
| Supervisor with questionable ethics and putting company over a family's wellbeing   |

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| Supervisors are getting even pickier on staff expectations  |
| Supervisors not caring about their team or the team's concerns.   |
| Unsure  |
| When concerns are expressed, very little is done to work towards solutions.   |
| <b>Yes (2 responses)</b>  |
| yes it needs to be provided   |
| Yes, again, I feel this is something that persons (students) needs more training on basically how to interact, provide support and empower their employees. |
| Yes, agency specific but SFM will promote "yes" people instead of qualified individuals that might challenge them to think outside the box.                 |
| Yes, supervision has written information on evaluation without discussing it with employees prior to writing information on the evaluations.                |

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| <b>LMSW Q11. Over the past two years, have you experienced any negative issues involving supervision? If so, please explain. (702 responses)</b>  |
| “Open door” but not supportive or willing to listen   |
| A complete lack of supervision. I have been chasing licensure for five years and when I finally get a training plan approved with a supervisor, they either quit, move, or tell me they can't take me on anymore. It took over a year to find my last supervisor and we met four times in six months. There are other states that allow social workers to get half of the clinical supervision hours from other clinical licenses (LCP, PsyD, etc.) and I think Kansas could definitely benefit from this as there are not many LSCSWs and even less who are <u>willing to give supervision</u> |
| A lack of integrity   |
| Absolutely -- and this largely occurs with higher education institutions (and their junk/unethical professors who typically never worked a real job in their lives).  |
| All around supervision at Stormont vail was awful. The worst experience so far.   |
| Aside from it being difficult to find a qualified supervisor via employment that doesn't incur financial hardship, no.  |
| Asking for time off and first question supervisor asked me was how I was going to make up my billing/contacts. She did better moving forward  |
| Availability of supervisors and cost is a challenge towards working on LSCSW  |
| Because I am out of state, I have not been in supervision, under the BRSB in Kansas. As a federal employee, I would have referred to work towards Kansas LSCSW and not get a third social work license. While federal regulation does allow me to work with any state license. Working towards independent clinical licensure depends upon if the state allows an individual to gain hours physically outside of the state. The FAQ on the Clearly states that that's not possible and does not show any exceptions for federal employees.  |
| Conflicts of interest with owner of private practice providing clinical supervision to contracted social workers in private practice, risks of exploitation to contracted social workers  |
| Cost associated with it   |
| Current directors are only focused on productivity... despite using the ccbhc model   |
| Difficulties maintaining the schedule on my supervisors part.   |
| Documenting changes to the supervision plan took a while and there was minimal communication from BSRB to confirm receipt of the forms or progress on approving the forms. It's also hard to know if mistakes are being made during the course of the plan as far as tracking hours in supervision or clinical hours without much oversight during the couple of years. An online tracking system from the BSRB would be awesome!   |
| Does not apply in my case.  |
| Finding a supervisor for my LCSW has not been successful, due to cost and availability. Peer's supervision has been horrible, do to the supervisor's inadequate behavior  |
| Finding time  |
| Foster care agencies across the board, provides little oversight or supervision to their workers  |
| Foster care lacking supervision of getting services needed when members discharge from PRTF.  |

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| Had a great supervision experience   |
| Hard to come by  |
| Having difficulty finding a supervisor   |
| I am not supervised by a social worker.  |
| I am technically supervised by people who are not social workers and they very much do not understand social work ethics and guidelines - school setting. A director of special education should have some training in social work ceus, ethics, legal issues etc. when they are our supervisor.   |
| I cannot speak to this.  |
| I can't find a supervisor  |
| I can't think of any at this time.   |
| I do not always get challenged or get a chance to learn from other social workers which can not always be accountable.   |
| I don't have supervision   |
| I don't feel like my supervisor is very helpful in my journey I wish there was more education around how to pick a good supervisor.  |
| I don't receive regular supervision.   |
| I feel I lack any supervision as a social worker because as an LMSW working in healthcare we are rarely supervised by a social worker. KDHE and KDADS administrate my program and have mandated that MSW's be the minimum standard. However, I do not believe any of them hold the degree themselves, therefore do not understand the profession.              |
| I had a student who had mental health issues.  |
| I had a supervisor (non social worker) who was very cold and standoffish most of the time but would take it to the opposite extreme and cross my boundaries and I felt highly uncomfortable around her. I was glad when she left the position.   |
| I had issues with the individual who was supervising me. Notes had to be done their way. I tried explaining that each individual doing notes has their own style, but to no avail.   |
| I had some confusion with my license come up over supervision, but it was resolved.  |
| I have found it incredibly difficult to obtain any supervision/guidance that is not excessively expensive.   |
| I have had a couple supervisors who I have felt were wonderful people, but were not great supervisors. The biggest factor being a lack of practical help for questions asked. I often felt like I was having to be my own supervisor when it came to handling difficult situations needing assistance, or when trying to come up with ways to help my clients. |
| I have had clinical social workers offer to provide supervision for my clinical social work license, even though they do not have expertise in the issues I am passionate about  |
| I have had multiple experiences of supervisors who were not yet ready to be a supervisor. Most need more time to develop leadership skills.  |
| I have had three clinical supervisors and in my journey to earning my clinical licensure. I have had clinical supervisors who do not understand basic requirements of licensure and it ultimately cost me in the long run. I think there should be more monitoring and requirements for people to be in the capacity of being a clinical supervisor.           |
| I have never had a position that offered me supervision. Which is unfortunate.   |

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| <b>I have not (2 responses)</b>  |
| I have not experienced any negative issues.  |
| I have not experienced any negative supervision.   |
| I have not had any experience with this.   |
| I have not had much supervision from a social worker   |
| I have not had any issues. I had some great supervisors.   |
| I have not personally dealt with this concern  |
| I have observed professional being in a supervisor role but do not have the experience and tools to provide appropriate supervision.   |
| I have primary worked for persons that were not SW in a health setting   |
| I have reported a supervisor on numerous occasions for bullying and unethical relationships with subordinates, but it was turned back on me. Again, being unprotected, I had to digress.   |
| I have seen social workers without their clinical license move into private practice not understanding they need a clinical supervisor.  |
| I have supervision regularly and have had a positive experience so far.  |
| I have very little contact with my supervisor. Communication is not always the best in regards to changes in how things are done or computer programs.   |
| I haven't been afforded the opportunity to work towards my clinical hours. I haven't received supervision.   |
| I look forward to receiving clinical supervision as I don't feel I receive any useful supervision currently. It's strange to me that an organization wouldn't want their newest staff to engage in clinical supervision, I feel we need it most. It's not just a benefit, it is a benefit to our clients to be supervised and grow professionally.   |
| I prefer not to answer.  |
| I really have not had a whole lot to do with supervision because I do not need it for my line of work.   |
| I served 12-24 months ago as a paraprofessional in a high school. This last year, I have primarily served within a home health agency as a caregiver-companion.  |
| I think it's unnecessary to do so many clinical hours. If you do the hours then I don't think you should have to take test.  |
| I think pricing for clinical supervision is a bit high across the board and not quite as affordable  |
| I'm not supervising any social workers at this time. I did in the past.  |
| If you aren't receiving clinical supervision, supervisors in middle management don't really get supervision like if you're in a macro role.  |
| I'm not in social work supervision   |
| I'm supervised by a PsyD who isn't familiar with the type of helpful supervision situation that I desire.  |
| In a correctional setting there is always an issue with power trips, which seems to carry through to the MH department as well.  |
| In my school district I am the only social worker, so yes. My administration in my school district do not fully understand the role of school social work. I am a member of the special education coop, but social workers are often forgotten about. I was assigned a mentor my first year in the district, 5 years ago, whom I did form a close bond with, but she is not in the same school district as me, only the same coop. Outside of her, definitely have experienced negative issues with supervision. |

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| In my school setting, I have extremely limited supervision provided by a consultant type with a school counselor. I miss social work supervision and am Glad to begin receiving it with my LSCSW training plan.   |
| In the last two years no but in the past yes. Supervisors that find numbers more important than people.   |
| increasing difficulty to be supervised by LMSW due to the lack of hiring licensees  |
| Issues between states - but not with Kansas   |
| It can be hard to find time to do supervision, where both me and the supervisor is available  |
| It is difficult to find supervision from social workers within certain fields, such as medical. Typically the supervisor is licensed in another helping profession.   |
| It is hard to find a supervisor that has the time to dedicate to supervision.   |
| It is really hard to find a good supervisor. Additionally, the cost is a huge barrier to getting a supervisor for clinical licensure.   |
| It is very expensive  |
| It's always challenging   |
| Its been a while since I have had supervision; however, I have supervised.  |
| Just lack of clinical judgement.  |
| Lack of commitment on supervisors end. Ending the supervisor relationship after I left the practice the pp the supervisor was at.   |
| Lack of guidance with how to be a direct supervisor to staff.   |
| Lack of regular supervision within my current role  |
| Lack of supervision opportunities in healthcare. KS does not require master's for several positions with no one available to provide supervision. In general, I think supervision needs to be required upon graduation. I had no one to in my agency to go to for guidance.   |
| Lack thereof. It would be helpful to have a list of practitioners willing to provide supervision.   |
| Last two years, I had really good supervision at my job.  |
| My 1st year in supervision my supervisor was not supportive or helpful.   |
| My current supervisor is not a social worker  |
| My experience has been positive   |
| My experience in the hospital setting is that your supervisor could be any professional and switched up at anytime. I understand that in that setting. My goal was always to bridge understand of the SW role and practice as part of a team process and foster respect for that role and advocate for patient focus and positive outcomes. |
| My role does not have someone to provide supervision so it can be hard at times to know who to go to for guidance   |
| <b>N/A (80 responses)</b>   |
| N/A - I love my supervisor!   |
| N/A - unless you count not being able to find clinical SW supervision   |
| Needs to be more test success focus.  |
| <b>No (377 responses)</b>   |
| No - not applicable.  |
| No but I would like to know if there's a list of providers who deliver supervision for LSCSW.   |

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| No but it's difficult that schools don't have social workers to supervise them. It's the principal or director who doesn't know much about social workers and the profession  |
| No comment  |
| No even though often in Healthcare, my work supervisor is not a SW, I do feel there is an understanding with other SWers in the organization I could go to with SW questions; I feel supported. I also belong to enough SW professional organizations and have a strong network of SWers through these. |
| No I have a wonderful onsite supervisor while getting my LSCSW  |
| <b>No issues (2 responses)</b>  |
| No issues, it has been a great experience.  |
| No my supervisor is amazing   |
| No my supervisor is wonderful for my LSCSW.   |
| No negative experiences   |
| No supervision in obtaining licenses  |
| No, I have had great supervision.   |
| No, I provide supervision for SSDs in nursing homes, and I have an LSCSW, who provides supervision for me. I also provided supervision for a BSA student at FSHU. I had no problems with these.   |
| No, but current supervisors are incredible.   |
| No, I have great supervisors.   |
| No, I've been provided excellent supervision at Cornerstones of Care  |
| No, I've not been in or provided supervision in past 2 years.   |
| No, just cost barriers  |
| No, my experience with supervision has been amazing   |
| No, my supervisor was amazing!  |
| No, not being supervised as I'm not providing direct clinical services to clients or working towards my LSCSW.  |
| No, not for me personally.  |
| No, supervision for my clinical license has been great. Having supervision with my boss can be difficult at times due to the differences in licenses but these get worked out after further conversation.   |
| No. Not in this profession.   |
| <b>None (25 responses)</b>  |
| None experienced.   |
| None, my supervisor is very good.   |
| None. I have excellent clinical supervisors.  |
| Non-social work supervisor in public education, not understanding my code of ethics and how it impacts my work  |
| Not always feeling like there is the time to obtain and maintain adequate supervision, but this may just be within the agency I work in as a CCBHC/CMHC   |
| Not as it pertains to my social work license. I think any training that can be provided for supervisors would be good.  |
| Not clinical supervision. I am supervised by an RN who, while supportive, does not have a complete understanding of the standards of SW practice  |
| Not enough availability   |
| Not in past 2 years. When I worked at Bert Nash the upper level focused solely on the upper level for success.  |

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| Not listening when staff have issues, get told to "get comfortable with it" "make it work"  |
| Not personally, however I have a wonderful support for supervision. I do believe there should be another advantage to the supervisor to help reduce the cost to the supervisee, or have limits as to what can be charged...for the amount of hours and requirements, it's very costly!!   |
| Not personally.   |
| Not really.   |
| Not receiving supervision   |
| Not regarding another social worker, but yes regarding a direct supervisor.   |
| Not sure what this question is asking?? Supervision at the LSCSW level?<br>Work/employment supervision?   |
| Not with my current clinical supervisor, no. But my practicum supervisor, Lindsay Sanner (owner of Andover Family Counseling in Andover, KS) was incredibly hands off and did not ever check on me or do the required amount of supervision each week. She signed off on my timesheets without reading them, and used ChatGPT to write my end of the semester evaluation because she had no idea what I was doing every semester. Thankfully I had several therapist friends who were able to guide me through my practicum experience. |
| One time my supervisor ordered food in a drive through during a team meeting.   |
| Ongoing failure to listen to staff and refusal to develop procedures to meet the needs of staff and patients.   |
| Only in my practicum experience. Supervisors who were burnt out and critical, more than offering teaching.  |
| Only with my supervisor who is not a social worker and is very clinical based vs person centered  |
| Please see #9.  |
| Poor management skills  |
| Pricing and lack of availability unless working for certain agencies.   |
| questioning the quality of my supervision. IE: will I be prepared to sit for the clinical exam?   |
| Required to receive supervision from someone who is not a licensed social worker.   |
| RNs attempting to supervise SWs in health community   |
| School social workers need social work supervisors.   |
| School supervision is lacking.  |
| So many demands are placed on supervisors from agencies they do not have time to supervise.   |
| Some...just overlooked not respected in positions not given enough opportunity for growth   |
| Struggling to find a supervisor   |
| Supervision is expensive.   |
| Supervision is too expensive and there aren't many LSCSW available to provide   |
| Supervisors are not supported to provide enough 1:1 support for their providers, allow for adequate self care or focus on prevention of burnout. Many supervisors are promoted to management because they have become burned out in providing services directly.  |

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| Supervisors in public school system have educational backgrounds, not social work backgrounds - different values  |
| The cost of individuals providing supervision   |
| The cost of obtaining it.   |
| The cost of supervision keeps going up.   |
| The documentation required for licensure can be repetitive.   |
| The only negative issues experienced are with students who do not want to work.   |
| The only problem I have with supervision is the fact that supervisors treat supervision like it's therapy for them.   |
| The school district where I work asks social workers to do things we ought not to be doing  |
| There is an inadequate supply of supervisors in the region and not enough opportunities for graduates to receive free supervision through an employer or another entity   |
| There is an insufficient supply of professionals able to provide supervision in many parts of Kansas.   |
| There is not enough people who can provide supervision .  |
| There seems to be a disconnect with forward thinking practitioners as to making a correlation to the ideology needed to address social issues and concerns impacting communities now.   |
| Throughout my 25 years as a social worker, there have always been negative issues regarding supervision. There has and still is a disconnect between upper management and those who are in the field doing the work directly. In my experience, field workers who are having every day contact with families and children to know those they serve well, but are <u>restricted by agency mandates and policies.</u>   |
| Too expensive for the number of hours needed and limited choices of who can offer the supervision.  |
| To my understanding, supervision by other disciplines was supported for those involved in the training plan. An initial application for supervision was denied for 2 reasons. An out of facility supervisor was denied by upper management for confidentiality reasons despite this person being one with LSCSW Licensure that also operates under confidentiality mandates. This decision was pre-application. Number 2. Another candidate for supervision was denied who was not a Social Worker despite the Training Plan allowances and who was a PH.D licensed psychologist . A back-up supervisor for LSCSW however, was allowed by agency for a PH.D professional; both psychologists. These decisions were made by the agency and not KSRB. |
| Took a long time to get approved by the board to start my supervision and get my training plan approved   |
| Very hard to find time for supervision in the community mental health setting. Too expensive to obtain outside of agencies that don't provide it for free.  |
| Where I currently work I have not had students under my supervision - we usually have zero or one student this is hospital work and not therapy.  |
| Working in a school system, trying to continue ethical standards while politics are at play and supervisor works for the superintendent. It makes for ethical dilemmas.   |
| <b>Yes (3 responses)</b>  |
| Yes - I am stuck unable to get supervision following my employers requirements  |

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| Yes - lack of access to social work supervision for LMSWs and lack of oversight for LSCSWs.   |
| Yes but not from social work supervisors  |
| Yes, as a school social worker I received no consistent supervision from another social worker.   |
| Yes, I had an extremely contentious relationship with my previous administrative supervisor. She and I did not see eye to eye, and I often felt judged and misunderstood by her. She also gave me advice and direction that I disagreed with. I ultimately left my previous practice site because of our relationship.  |
| Yes, I was assigned a supervisor through an online service and unfortunately the person was unprofessional and did not provide me with the clinical support that was needed.  |
| Yes, I was supervised by a person with a MBA who did not respect the profession and was not helpful in supporting my career growth and potential.   |
| Yes, inexperienced supervisors attempting to lead seasoned sw's   |
| Yes, lack of empathy and training. My supervisor was burnt out and needed more support or a break from her work and it moved into her supervision work as well.   |
| Yes, lack of guidance   |
| Yes, my supervision was not so good. I am unmotivated to continue with pursuing my LSCSW  |
| Yes, my supervisor believes everyone has ADHD so it is very difficult to discuss some cases because instead of focusing on the real issue - focus is put on the possibility of ADHD even though they don't meet criteria. ADHD is soooooo over diagnosed.   |
| Yes, my supervisor came to work at a second job with me. She sent me a text, about me, that was meant for somebody else. She was degrading me and falsely stating that I was doing things which I was not doing. Basically being highly unprofessional. When I said something about this she never replied to me and has stopped, without notice, being my supervisor. I was going to try getting clinical hours somewhere but gave up based on this. |
| Yes, never given quite enough time for documentation  |
| Yes, not enough knowledge about disability  |
| Yes, prefer not to say  |
| Yes, sometimes supervision isn't structured.  |
| Yes, supervisor is not having an agenda or guiding discussions themselves.  |
| Yes, treatment of administrators towards those starting in the field.   |
| Yes, within an educational setting as a practicum student in my advanced year. When I would address issues directly to the supervisor, I was told "I am the supervisor, you are the student, you are supposed to do everything as told". When addressing it at the university level, I was dismissed.   |
| Yes. Biases and unprofessional behaviors.   |
| Yes. Having a Clinical Supervisor who brought nothing to the table except to sort of respond to what I brought. He said his approach was not a "dialectical" approach. Found a new one. Also, extreme difficulty in finding a Clinical Supervisor in my area (Wichita) or a group to join.  |

Yes. Approved supervisor has been refusing to provide supervision. I now am stuck between trying to find a new supervisor at a reasonable rate while also faced with the dilemma this supervisor has to sign off that they recommend me as an LCSW when the time comes despite ongoing issues/complications with no resolve. Supervisees should be able to sign off recommending this person as future supervisor for others or be able to report them to the board.

Yes. Changed supervisors due to former supervisor's unpredictability and unfounded / falsified accusations.

Yes. Clinical Supervisors are not consistent in how they supervise. My supervisor provided hardly anything other than case consultation, which got repetitive. Other supervisors are providing a much more rounded level of learning opportunities, professional support, clinical exam prep, documentation, and private practice. There should be minimum expectations of what a clinical supervisor does with and for supervisees.

Yes. Communication issues, hard to get in touch.

Yes. Do not feel there is good structure. Would prefer a more set curriculum or at least set of literature we should all be reading. For a standardized test, there is no standard of teaching and therefore we may not be taught all that is being asked of us on the exam. Does not need to be classroom or homework based. But I feel there should be some direction that we are all learning the same basis of what we need to know.

Yes. Erin Kaminska made me use my personal cell phone to call clients at Four County Mental Health if I called in sick. Then they had my number and it was inappropriate.

Yes. I have been working in schools, and I have found that many administrators in education lack an understanding of the role of social workers. I had to quit a job because the superintendent wanted me to go against social work practices, and I refused to put my license at risk.

Yes. I often have felt that leadership/supervision bends our code as needed to benefit the company/themselves.

Yes. I had an awful social work supervisor

Yes. My clinical supervisor is also my team lead and I feel she should not be both ethically as I sometimes wonder if things that should be confidential are reported to my director whom she answers to. However, I work in community mental health and there isn't any clinical supervision available in my company with clinical supervisors who work primarily with children and adolescents except the one I currently have.

Yes. My former practicum supervisor was a predator. He sexually harassed me and ultimately, had his license revoked by the KS BSRB.

Yes. My former supervisor was not helpful. She gave me very little feedback, questioning, or support overall. I sought out new supervisor after 1 year. This was especially disappointing as I was paying privately for her time.

Yes. My primary clinical supervisor effectively abandoned me and several others. They were constantly canceling individual supervision due to either overbooking or not setting clear boundaries with their immediate staff to effectively engage in the supervision process. When they canceled sessions, it was near impossible to get them to reschedule within that same week. They preferred group supervision on individual as they were able to make the time for group. And when they went on medical leave without warning, they wanted no contact because they were on medical leave. I had three hours left of supervision. My alternate supervisor has been unavailable as well. I managed to find someone else. But the experience left me feeling wholly unprepared and inadequate.

Yes. My supervisor seems preoccupied by her personal life sometimes which affects the quality of our sessions.

Yes. My supervisor would only meet with me about once per month for one hour. She was very unprofessional and I did not feel supported by her.

Yes. Quit my last job due to supervision by a non-licensed person who was supervising case managers and promoting non-licensed people to perform training...had high expectations but did not take care of their professionals and turned their back when help was needed.

Yes. The clinical supervisor does weekly group supervision then when the supervisee hits their limit, then they switch to weekly individual supervision. I don't think that is how it is supposed to work. Also, the clinical supervisor used ChatGPT to answer a question I asked which felt strange, and not what I was hoping for in a response.

Yes. Translation of code of ethics is different than the way BSRB translates it regarding illness

Yes. When I was at an agency, I was completely unsupervised despite having been told I would have clinical supervision. I ended up hiring my own.

Yes, issues with retaining supervisors at my current job. Supervisors not know how to provide good supervision. It would be nice if there was a training or guide to help them provide beneficial supervision. My experience is they want me to bring my own situations to work on which is nice but feels more like a therapy session processing my information rather than guidance and professional resources and support

**LSCSW Q12. Over the past two years, have you experienced any negative issues involving supervision? If so, please explain. (701 responses)**

A supervisee making a social media post then conflict with another clinician of a similar profession taking offense with a threat of using the regulatory board as a shield. How disconnected social media can make people, even professionals.

An administrator was trying to force me into providing graduate level practicum supervision to a LBSW who had consistently displayed very poor judgment and receptiveness to feedback.

Before I started supervision it was very hard to even find a clinical supervisor.

Dealing with clinicians in private practice or clinicians waiting a very long time to take their exam

Difficult to move into supervision from full direct practice. I still maintain a caseload as a supervisor which I feel is essential. I use my clinical and social work skills in my supervisory approach. Still social workers experience low job satisfaction and burn out from the system including the productivity and paperwork completion pressure when the most important part of this job is what happens in the therapy room. Hustle culture alive and well in social work practice.

Discrepancies in qualifications for BI waiver clients.

Employers not understanding the significance of our role but seeing us instead as a threat instead of a valuable team member!

Entitled employees (self-focused, not team players), operating out of fear of burnout, difficulty communicating

Entry-level supervisees do not know how to utilize supervision.

Frustration at amount of clinical hours required. (Full-time practitioners providing evidence-based services)

Gen X inability to process critical thinking

Hard to keep track of the hours when they have more than one practice area and supervisor

Have not

Have not provided supervision past 2 years

Having to have conversations with individuals at risk of losing their jobs because temporary licenses are two years, they are well established in their role but can not pass a test.

I am concerned about the constant changes in supervision requirements, the length of time completing forms for supervision and reciprocity, and overall the difficulty pursuing a clinical license. I have been a social worker for over 30 years and provided clinical supervision 25 of these years. I have served on the Social Work Advisory for almost 10 years. The added work and further complications in my opinion are not necessary and make it harder to pursue licensing at a time when we need more clinical social workers.

I am still new to Kansas (August 2024) but the lack of overall quality supervision for LMSWs has been concerning to me.

I assume this question is referencing clinical supervision for MSWs seeking LSCSW licensure. In that case, I have not experienced any negative issues as I do not currently provide that type of supervision.

I did share above- medical social workers do not have the setting, experience or experience to leave the hospital or hospice setting and open up a practice with anything other than grief & loss. I know isn't possible- that's why we should not allow MSW in these settings to be eligible to earn clinical hours.

I do not provide supervision for licensing, rather I am a people leader in my job.

I do not supervise anyone in Kansas.

I don't think that the hours should have been reduced. I think that it should be harder to become a clinical social worker, as it is a huge responsibility and if someone wants to become clinical they should be willing to do the hours and the tough exam-if they cannot do it or can't pass the exam they need to work harder. It should not be easy

I feel like there should be clearer guidelines on what is expected during clinical supervision for provisionally-licensed clinicians. It may be beneficial to have small training requirements for supervisors.

I feel like when I supervise if there is an issue we discuss it and I share the reasons behind why I am either telling them not to do something or encouraging to change something - I try to provide evidenced based information to help them grow and understand why there needs to be a change.

I had 3 different supervisors leave the agency I work for while I was their supervisee, and the frequent changes made continuity of information difficult for me.

I had to transfer supervisors when I relocated and had a great experience with my ending supervisor. My original supervisor would cancel often, fail to reschedule, give minimal guidance, and kept poor records. She would often suggest Google-ing interventions/resources when she did not have an answer. I feel as though having an equipped supervisor for the last 2 years of supervision made me realize how ill-equipped my original supervisor had been. My original supervisor was also my direct supervisor, and I feel that also made certain situations complicated

I have absolutely experienced negative issues involving supervision, but the culture discourages naming them. Therapist-to-therapist harm is more common than anyone wants to admit. Whether it happens in supervision, consultation, or even during a clinician's own personal therapy, there is currently no safe, structured way to report or process these experiences without risking retaliation, disbelief, or professional consequences. I have been deeply harmed by another licensed clinician in the context of my own therapy. And like many others, I remained silent-- not because it didn't matter, but because I had nowhere safe to bring it. I feared being disbelieved. I feared professional backlash. And above all, I feared that what happened to me would be treated as a private failure rather than a systemic gap. I'm not sure why this isn't an option already--because, believe it or not, we live in a professional community filled with incompetent, ideologically motivated therapists who actively perpetuate systemic harm. And they are doing so under licensure that protects them more than it protects the people they hurt. If the BSRB wants to protect the public and uphold ethical standards, it cannot only respond to harm between clinician and client. It must also acknowledge the power dynamics, exploitation, and emotional manipulation that happen between professionals. An anonymous reporting system--even if initially informal--would be a small but crucial step toward transparency, safety, and systemic accountability.

I have not

I have not experienced any negative issues

I have obtained an individual who was being clinical supervised by another Clinically licensed person and there was a lot of bullying and intimidation from the supervisor to the supervisee. We have discussed in previous sessions their rights to report but out of fear or retaliation they choose to not report and completely removed supervision from this individual. I have heard of other supervisors being this same way to their supervisees.

I have only had positive experiences!

I have only supervised MSWs as I am a new LSCSW. I have supervised MSWs since I first got licensed because there are so few non-abusive practicums. Absence of legislation leads to agencies taking advantage of and not supervising their students into burn out before people even graduate. So many talented social workers/ therapists are traumatized by the education to practice.

I have rarely had a completely positive experience in supervision, both in school and outside. The power dynamic is often taken advantage of, and the relationship rarely feels safe which impedes meaningful learning.

I have supervised students in the past and their individual personalities and life experiences have been beneficial or detrimental in their learning experiences. One size does not fit all in supervision.

I provide administrative not clinical supervision. The basics of the profession & of professional practice are lacking

I recently completed my clinical licensure and had struggles with the quality of supervision with my supervisor. It created a weird power imbalance within the relationship. Genuinely I am not aware of the steps I could have taken. Possibly more guidance or education could be given out when starting the process on options someone has if situations like this were to occur.

I revieve no social work supervision and my work setting doesn't allow the social workers of different offices to staff cases.

I see a lot of people who feel supervisors are just placating them and not helpful or they are over charging and being bossy. I hear a lot of these two issues but idk if those are just because they are the extremes

I supervise someone with a Missouri license, but I have not had any negative issues.

I supervised for many many years but do not currently.

I think more trainings for supervision could be helpful for supervisors.

I wanted to supervise an LMSW in a private practice but her agency wasn't practicing ethically, so I didn't.

I was a back up supervisor for someone and they began having issues, I was aware and in a bad spot about bringing it up to the active supervisor. But we did and they addressed the concerns.

I wish there were more opportunities for training for those who are supervisors!

I would say the biggest issue is finding the best way to fill in gaps in supervisee skills or knowledge. Additional regular trainings are always appreciated to assist in the process.

I've had non-payment for services and being irresponsible in attending supervision when it's scheduled on a weekly basis

I'm currently in an investigation due to what I believe is a retaliation for terminating the supervisee.

I'm new to supervising.

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| In my previous job I received supervision from a social worker who acted with dishonesty and disrespect towards me and others.  |
| In my role I have had to work with supervisors who are not recommending the supervisee for licensure. At times the supervisor finds out the person was given a license anyway, and are upset but I remind them they are only giving a recommendation and that it is ultimately the Boards decision. I do take it as an opportunity to educate them on always giving their recommendation no matter what "might" happen and to stay true to their decision. This is an area I do think supervisors could use more training/education on. |
| In rural Kansas especially, it would be beneficial to increase the amount of supervision that could be provided remotely versus face to face.   |
| Individual supervision is expensive.  |
| Issues usually arise when supervising individuals that are experiencing their own personal issues or lack adequate training and are not skilled enough to practice ethically in private practice therapy.   |
| It is unclear if you are asking about supervision in general or specifically clinical supervision like under someone else's license. I did have an issue with a practice manager that my supervisor at the time handled unprofessionally and poorly. That is the only time I have had a negative experience with a supervisor on any level.   |
| It was at times difficult/impossible to keep up with payments for supervision as I saw someone outside of my agency. I didn't want to be tied down in a supervisory relationship within an agency in exchange for working for them for years after obtaining my LSCSW. This was a personal choice; however, it does contribute to additional difficulty when searching and paying for outside supervision.  |
| It was difficult to find a supervisor initially.  |
| I've had more experience with supervisors in leadership positions that have had no supervision training. One example: a supervisor that had so much anxiety over simple one on one discussions that they instead would begin a formal inquiry with a third party rather than have the conversation. In situations where boundaries are firm, such as a therapist with a client she did well, but outside of that it was a disaster.   |
| I've heard current social work students discuss how they are being utilized as direct care with patients without receiving adequate training and ongoing supervision due to difficulty finding enough staff to cover patients.  |
| I've seen more people in our profession who struggle with their own mental health issues. I think it can be hard for supervisors to advise in this scenario - many manage this just fine, but some do not.  |
| Juggling production vs ct need  |
| Just dealing with the know it all attitude  |
| Just issues already listed in question 9. It involved a great deal of extra supervision, which we provided to ensure the individuals were prepared to provide appropriate services to our clients.  |
| Just the expense of it all  |
| Just the poor educational training/prep   |
| Lack of supervisors in rural areas  |
| Lacking   |
| Managing personalities  |

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| Most pressing issue is the quality of practitioners coming out of college. They are getting into the field and their knowledge base is pretty small.  |
| My last student violated many boundaries creating undo harm to my patient panel. On top of poor boundaries, she violated my number one rule "do no harm." Practical students are becoming soft with the decreased practicum hours. They're expected to do. Decreased practicum hours, don't create good social workers. I think if there was a standard of practicum hours across the board that could be met with volunteer hours should their school not provide provided I think that would be better. |
| My supervisees are in Missouri, another state where I hold a license. I was not their initial supervisor, and getting licensed in Kansas should have begun then! I wish it was easier to add Kansas to a Missouri license.  |
| My team supervisor at work is provisionally licensed and does not intend to work towards clinical licensure. This is extremely common for treatment team supervisors at my place of employment. I have to seek other avenues for quality consultation which can be difficult.   |
| <b>N/A (106 responses)</b>  |
| N/A I don't supervise anyone  |
| N/A No  |
| N/A to me at this particular time.  |
| N/A. (I was employed at a mental health center out of Newton from 2021 - 2023. Terrible experience. Poorly run organization.  |
| NA. Been licensed since 2010  |
| Needing more time for supervisee to complete direct clinical hours if they are not seeing clients on a full time basis, changing jobs just for this requirement is not always workable in certain areas of the state or could push them to more virtual practice which does not seem the best option for someone in a learning phase  |
| New MSWs believing that they can read an article and engage in a specific practice area without training. For example, you need specific training and certification to say you do play therapy. I've seen people take one class or read one article and think that they can say they are doing play therapy. That is dangerous.   |
| <b>No (379 responses)</b>   |
| No I haven't had any issues   |
| No issues to report.  |
| No more than usual! Note that all of my supervision is in Missouri  |
| No negative experiences.  |
| No negative issues, but I would appreciate clarity on criteria for quality, valuable, and growth focused supervision.   |
| No negative issues, but would prefer to be allowed to have group supervision for the full two years. They learn so much from each other.  |
| No negative issues.   |
| No, because I refuse to do it. These new social workers are terrible.   |
| No, I am grateful to have highly skilled, competent and insightful supervisees.   |
| No, I've had really good students. They are engaged and humble, want to find healthy ways to be effective agents of change.   |
| No, none.   |

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| No, not in supervision of SW students or prospective licensees. I supervise lots of other staff of various disciplines in my professional role, but social work supervision has historically been less problematic in my experience.   |
| No. I find Joan Hahn very helpful when I have questions!   |
| No. I supervise Behavior Therapists working funded by the brain injury waiver.   |
| No. I supervise social workers as their mentor not for their clinical hours.   |
| No. I think we should get more hours for CEUs for supervision. Good supervision requires much more effort than the hours we are awarded each year, and those hours are capped.   |
| No. Loved the experience   |
| <b>None (45 responses)</b>   |
| None come to mind.   |
| None to note   |
| None. I do think some supervisors don't follow the protocol they should be following and there is a lot of fluctuation when it comes to getting hours under supervision. I think you all could be more attentive and strict about ensuring honesty and following ethical protocol. |
| None. One SW was not honest about hours but I didn't realize it until after the fact   |
| None. Other than the difficulties in credentialing becoming terrible since January.  |
| Nope other than the systems I work in don't make any sense moving from theory to practice.   |
| Nope- Solo for more than two years.  |
| Normal conflict as a supervisor  |
| Not applicable   |
| Not currently working  |
| Not directly, but I hear stories of people who have had either bad supervisors or bad supervisees.   |
| Not enough time.   |
| <b>Not in the past two years (2 responses)</b>   |
| Not in the state of Kansas   |
| Not necessarily. I have noticed an increase in my encouraging supervisees to seek out their own individual therapy due to their own trauma impacting their work.   |
| Not on the Kansas side   |
| Not personally.  |
| Not providing or receiving supervision   |
| Not really. It's my first time supervising. Although I took the class I would love I have a more regulated outline of topics to review with resources from the board. I would honestly supervise more people if I didn't have to create so much of this for myself.                |
| Not within the past two years.   |
| Nothing comes to mind.   |
| Nothing major  |
| Noticing more of freshly graduated clinicians getting into "private practice," where learning and growth are limited.  |
| Often very poor clinical supervisors with little support in how to supervise someone.  |
| One of my past supervisors, not for my license but for work wasn't focused on helping or learning. She was very negative, never seeing positive in the work I did  |
| One supervisee had very poor attendance and I discontinued being their supervisor.   |

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| Past supervisee was not allowed to count hours during a period where she had transferred to a different inpatient mental health treatment unit within the same facility because she did not request a plan amendment within a satisfactory time frame for the board. The rigidity of the board's decision resulted in additional time required in our supervision that was not necessary.   |
| Power struggles and not being heard to be understood. Allowing unethical things to continue or showing favoritism.  |
| Providing supervision has been one of my favorite experiences & I have not experienced any negatives.   |
| Providing supervision to young people who have not had experience in the field other than practicum is difficult as they often lack an understanding of professionalism and the importance of work life balance.  |
| Recently licensed practitioners moving rapidly into private practice or supervisory roles and underutilizing supervision.   |
| Retired, N/A  |
| See above   |
| Sense of entitlement among some new staff and less of a generalist practice approach ( often unwilling g to see wide range of client population)  |
| Some challenges navigating personal friendships developing in the supervision relationships and navigating how to maintain necessary boundaries without personal fractures that effect morale   |
| Some supervisee need more structure than others   |
| Supervisees are sometimes late due to client sessions running over and due to boundary issues. I've also observed that I need to continually encourage self-care for those I supervise and some do not use vacation time or take breaks as needed.  |
| Supervision and field instruction in a clinical setting have been difficulty.   |
| Supervisors are assigned based on tenure rather than on supervisory skills. Supervision in the workplace is often the least prioritized and focused more on policy and procedure than on practice and ethics.   |
| Supervisors in private practice who provide supervision to those employed at a large agency, are not able to ethically say yes to the license renewal form. They are not able to know the hundreds of pages of policies and procedures, to assure the law is providing the or the contact info of the supervisor or to otherwise be actually overseeing the work. There is a req or rule prohibiting this , for good reason.  |
| Supervisors not being available enough when needed.   |
| Supervisors who are abusive and negative  |
| The death of a supervisor and the impact on the supervisee(s)   |
| The only negative aspects I've experienced with supervision is the length of time it takes to hear back from the BSRB regarding training plans or approval status for supervisees. It can take up to 45 days to hear back, which greatly impacts a supervisee's ability to start practicing. Additionally, I wish there were more trainings for clinical supervisors offered through Kansas. As a clinical supervisor, I want to continue improving my skills and understanding of the supervision process, yet I have to seek out trainings in this area from other sources. |

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| The only negativity I have observed is the less effective supervision being provided by those who had fewer hours of clinical supervision themselves. While I understand and can appreciate the reasons for the reduction of required clinical supervision hours, it appears to have weakened the social work profession overall. |
| The reduced amount of clinical training hours is creating issues with how prepared social workers are to work.  |
| Training could be offered for clinicians providing clinical supervision. At times difficult to decipher criteria as it has changed in several areas over the years.   |
| Unsure if question 11 is BSRB endorsed clinical supervision or supervision with staff who already hold a clinical license   |
| VA management appear intimidated to advocate for staff  |
| When I was receiving supervision, I had wished that she would have had me do more case conceptualizations with her to better understand my clients and their needs.   |
| Work place settings, especially no -social worker owned and operated practices are taking advantage of young social workers. I have routinely had people come to me to explore taking on their supervision partially through as they have been abandoned by their supervisor.   |
| Workers having a hard time completing notes and dealing with that.  |
| would be nice to have required training hours specifically for social work supervisors  |
| Yes   |
| Yes- licensees not understanding the importance or meaning of consultation, if clinical oversight, or the importance and normalcy of regularly individual supervisions.   |
| Yes- supervisees not practicing within their scope or not adhering to statutes and regulations, or practicing while impaired, leading to termination of the supervisor/supervisee relationship.   |
| Yes which resulted in me feeling traumatized. Lack of empathy for feeling isolated, unprotected and unimportant to the agency for its lack of diversity and inclusion in professional roles and failure to act in an effort to protect me and other minority members from blatant racism and threats from its consumers.          |
| Yes, but not with the BSRB. My supervisee was argumentative, unwilling to learn and difficult to work with.   |
| Yes, clinicians sharing information about shared family systems and that impacting their work with their specific client.   |
| Yes, I have clients who are practicing therapists who share about their supervision experience. I have been made aware of boundary issues, abuse of power, and what appears to be a lack of knowledge/skills. This feedback is specific to clinical social workers supervision.   |
| Yes, lack of agreed upon payment for supervision.   |
| Yes, many LMSWs are not familiar with ethics, statues, regulations, and appear to feel they are option while under supervision. Additionally, MANY MANY MANY providers in private practice seem to be practicing without any supervision or oversight.  |
| Yes, previous boss supervises other younger clinicians and  |
| Yes, see above  |

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| <p>Yes, some of the individuals i recently took on were receiving supervision prior to me and from their reports of the supervision it appears it was both inadequate and at times unprofessional i.e. dual relationship, using supervision time (as the supervisor) to vent about management instead of focusing on supervising cases.</p> |
| <p>Yes, the board did not include 4 months of my supervision hours when I moved to a different role in the same agency doing the same work. My clinical supervisor at the time told me I did not need to update my training plan. Thankfully I reached out to the BSRB but by that time I lost out on three months worth of hours.</p>      |
| <p>Yes, the supervisor I had was not at all accommodating to different styles of practice and if you did not do exactly as she did. she negatively criticized you. She made false reports to the board when I ended my supervisee relationship with her.</p>  |
| <p>Yes. Biasness towards others and retaliation from senior LSCSWs against other social workers.</p>  |
| <p>Yes. Clinical supervision where the supervisor and supervisee are in the same organization can become problematic.</p>   |
| <p>Yes. Lack of transparency, communication, and unwillingness to have conversations around areas of growth and improvement.</p>  |
| <p>Yes. Participation, resistance and attendance issues</p>   |
| <p>Yes. The mental health of my supervisee negatively impacted their clinical work. I've reported them to the BSRB.</p>   |
| <p>YES. There seems to be a lack of commitment to staying up to date on new practices (from a clinical lens), not enough people of color as supervisors. There needs to be a more intensive on boarding with routine check ins for people providing clinical supervision.</p>   |
| <p>Yes. Untrained supervisors providing poor training and supervision</p>   |
| <p>You can tell generational gaps. Younger social workers wanna save the world and know everything and want to have empathy for everything. Older social workers are grumpy and set in their ways. Thankfully, when it comes to crisis and our mission though, everyone steps up.</p>   |

**LBSW Q12. Do you currently use artificial intelligence (AI) in your practice? If you do, in what areas do you use AI? (142 responses)**

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| I do not   |
| I do not, but I see a lot of use on social media so there are  |
| I occasionally use AI to develop activities and training guides for my teams.  |
| I use AI to help me write/word goals and identify barriers of those goals.   |
| I would not use if I were practicing less  |
| In writing.  |
| I've used it here and there to summarize my documentation notes  |
| Looking up information for my clients.   |
| <b>N/A (7 responses)</b>   |
| NA, but no I would not!  |
| <b>No (101 responses)</b>  |
| No and do not plan to.   |
| No but it would be nice  |
| No I do not use AI. I prefer to do certain things myself rather than to rely on AI and forget how to be resourceful and utilize creative thinking, I'll pass.                          |
| No!!!  |
| No, I do not.  |
| No. I want to though but agency won't allow due to costs.  |
| No. it takes the person out of the equation.   |
| No no  |
| Not at this time.  |
| Not that I know of.  |
| Note writing   |
| On occasion with help in rewording   |
| Policy and procedures  |
| Rarely sometimes to find new or better wording for notes   |
| Sometimes to correct my emails.  |
| Very limited usage, usually for writing skill proofreading.  |
| We started using AI to write summaries without personal identifiers  |
| Yes- for ideas for group, developing framework for policies, creating forms, polishing narratives in emails, understanding articles  |
| Yes, Documentation   |
| Yes, I use AI across nearly every aspect of my work—including budgeting, financial analysis, data tracking, writing support, research, tool development, and simplifying complex data. |
| Yes, to assist with writing letters, creating images, and developing lessons for my adult education classes.   |
| Yes, when writing a note or court document I will use it to make my thoughts and writing sound more professional   |
| Yes. I use Alto assist in creating info to present in training.  |
| Yes. Clinical charting is AI   |
| Yes. We utilize AI to ensure documents are worded so that clients are able to clearly understand the information.  |

**LMSW Q12. Do you currently use artificial intelligence (AI) in your practice? If you do, in what areas do you use AI? (755 responses)****Absolutely not (2 responses)**

Absolutely not and will never even consider it.

Agency uses Eleos to listen to sessions and help with progress notes

AI assists my practice in completing progress notes and documentation.

assist with finding research

At times it can be super helpful for suggestions for affirmations, journal prompts, to assist with vague statement reframing (only for training purposes and with all client identifying factors removed)

At times, to help me outline trainings I've led.

Autonotes to help write progress notes

Bert Nash has started implementation of Eleos, and it's supposed to help with notes and learn from them. Essentially, BN is training an AI to replace as many line staff as possible.

ChatGPT and Eleos

Communication and ideas for resources.

Definitely not. I do not trust it.

Documentation and I love it.

Documentation.

Does not apply in my case.

Eleos. For therapy and TCM

For clinic reports

for progress notes

For resources, for helping compose letters, notes, helps with documentation, goals and interventions.

Formulating smart goals

Grammarly and ChatGPT sparingly to assist with emails, marketing materials, etc.

Help with lessons/ standards, schedules and emails

Helping reword emails to increase the tone of professionalism, also AI has given me some concrete mindfulness exercises in a pinch

Helping write letters

I at times use ChatGPT to assist me in developing outlines for work political in nature, and also to synthesize information, such as comparing pieces of legislation.

I create curriculum and teach Dementia Care education. I utilize AI to refine my writing. I never use it to create the content originally.

I currently do not, however, in my prior position, they began to look at recording all client interactions so AI could generate the summary/narrative documentation

**I do not (4 responses)**

I do not at this time

I do not currently use AI.

I do not use AI and while sometimes my supervisor suggests it, I have been able to hold a boundary against incorporating it into my work so far.

I do not use it.

I do not, but agencies in the area use AI platforms made specifically for therapists to help with note taking

I do, to assist with documentation

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| I do, to come up with different interventions, coping skill activities, ideas for general iep goals, how to word emails, etc.  |
| I don't practice. I do use AI for writing in some of my work.  |
| I don't use AI in my practice.   |
| I have been told Eleos is not AI but augmented reality? It acts as a medical scribe writing our notes.   |
| I have heard clinicians use chat gpt to help dx. And documentation.  |
| I have not been involved with AI.  |
| I have not used AI in my practice.   |
| I have not used AI.  |
| I have not yet but would like to, it appears like it would be beneficial and time saving.  |
| I have used AI to create titles from learning objectives; I have used it to help me create trainings and get fresh ideas about current topics. I always fact check the AI references and don't use ones that are not reputable (peer reviewed journal articles being the standard) |
| I have used AI to lesson plan, but that's about it. It helped to generate some ideas.  |
| I only use AI (Grammarly) to improve the numerous reference letters I have to write for students seeking scholarships.   |
| I sometimes use AI to get ideas for what to talk about in session. I never use AI for note taking purposes.  |
| I sometimes use talk to text and that is all of the experience I have  |
| I use AI to assist me and editing and ideas on different ways to write goals so I'm not using the same thing over and over again.  |
| I use AI to help my write notes.   |
| I use AI to help with IEP goals and different types of social skills groups.   |
| I use AI to research interventions and strategies.   |
| I use AI to summarize articles occasionally for patient education.   |
| I use an AI platform to help me formulate parts of my intake assessments, treatment plans, and weekly progress notes so that they are in line with insurance guidelines.   |
| I use ChatGPT to assist in developing written materials. I am concerned about the many organizations that are jumping into using AI for notetaking during sessions.  |
| I use it for clerical tasks such as letters and polishing written material.  |
| I use it for spell check and to prioritize tasks   |
| I use it in my work for tasks and creation but not specifically when dealing with clients  |
| I use it sometimes to help write behavior plans  |
| I use it to help curate emails to other professionals, help create worksheets, type up intakes, give treatment goals/objectives ideas, and to help give me creative ideas of activities to do with my clients in session   |
| I use Therapy Notes for my scheduling, billing, and client notes.  |
| I utilize it for assistance in goal writing and phrasing of goal writing   |
| I utilize it on occasion to brainstorm activities to implement in class for social work students.  |
| I utilizes AI for group therapy topic(s) and material(s). Utilizing this tool has increased the ability to summarize and make information more easy to understand.   |
| I would absolutely be opposed to using AI  |
| I'm not currently practicing, but I wouldn't use AI in my practice.  |

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| In my practice, it helps me create discussion questions and activities for my classes and even some assignments.   |
| In process of implementing   |
| In telehealth I use AI. I find it to be helpful, but do review all notes that it helps to dictate to ensure accuracy. Allows me to spend more time with my client focused on them versus writing notes.  |
| It assists me in writing goals that include all the things the school districts requests while reaching several problems a student might have  |
| It is available. I do not use it.  |
| It's been offered by I refuse. Anecdotal evidence already being reported that Joe Anybody starting to default to using AI for writing is getting predictable results: The brain, like all the muscles and functional aspects of the body is a Use Or Lose organ. To have clinicians default to an AI service instead of doing their own documentation is a slippery slope. For new clinicians coming out of MSW programs and not getting the opportunity to develop clinical documentation skills... It's like all our kiddos and teens who are addicted to their devices and couldn't communicate with a live human for love or money because they don't have the skills. |
| I've used to help draft emails.  |
| Just beginning to dabble in AI   |
| Just beginning to explore and train on options   |
| Just started to utilize AI - however, I am very careful and 'vague' with identifying information. Once I get a 'draft' generated from AI, I copy-paste it from my internet tab and create a word document.   |
| Just started. Not enough experience with it to have an opinion   |
| Lesson planning  |
| little to none at all currently - but I'm considering using it to create lovely handouts to school personnel to help them remember practical tips on trauma informed care, attachment, de-escalation, etc...   |
| Mo   |
| Mostly for help with wording in emails or letters.   |
| Mostly to help with building program evaluation and project management tools.  |
| Moving toward use of auditing documentation.   |
| My agency has an AI embedded in our EHR that is HIPPA compliant and helps with writing progress notes.   |
| My agency is about to begin using A.I. to assist with progress notes, but I haven't received training on it yet.   |
| My CCBHC has provided Eleos for assistance with note-taking. I occasionally utilize ChatGPT for help with writing treatment plan goals & objectives  |
| <b>N/A (42 responses)</b>  |
| Never  |
| <b>No (448 responses)</b>  |
| No - but our department an outpatient behavioral health in a hospital health system setting does have AI trialing with psychiatric medication providers.   |
| No AI is used.   |
| No and have no reason to. I believe in using real humans.  |
| No and I won't due to all of the negative effects of using AI.   |
| No but I wish there was more guidance on how to use it ethically in practice.  |

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| No do not like AI   |
| No I am not.  |
| <b>No I do not use AI (5 responses)</b>   |
| No I do not, least none that I know of  |
| No not at this time   |
| NO WAY!! AI needs to be researched much more before social workers let it enter their practices. Personally I am anti- AI. I don't use AI for notes. Finding out some providers do, that actually disturbed me. |
| NO!   |
| NO! I have big ethical concerns about using AI.   |
| No, AI gives me great trepidation.  |
| No, and I don't think we should.  |
| No, and I will never do it. Potentially giant HIPAA violation, plus information in AI is less than secure.  |
| No, because it is not fully HIPPA compliant and it is bad for the environment.  |
| No, but I am interested in learning a little more about it and the role in which it might be appropriate.   |
| No, but it is coming soon to my private practice EHR program.   |
| No, I do not.   |
| No, I don't use AI at this time.  |
| No, I have not used AI at work.   |
| No, I try to actively avoid the use of AI and think that therapeutic professionals should do the same. I worry about using AI for counseling or documentation reasons will lead to problems in the future.      |
| No, I'm not actively using AI   |
| No, not that I am aware of. Although I will research a topic and at first, AI generated answers come up so I sometimes will research a topic with evidence-based sources from that general information.         |
| No, only very recently has AI been approved but haven't yet received guidance on what areas we can use it in.   |
| No. I am not personally in favor of AI for use in mental health or social work services.  |
| No. I think AI is terrible.   |
| No. There are several ethical issues with the use of AI   |
| no-interested in finding something.   |
| None  |
| Nono provide more information to licensees.   |
| Nope  |
| Not applicable.   |
| Not currently but open to and want to learn ethical ways to do so.  |
| Not currently, but I have looked into ways to help it simplify notetaking.  |
| Not directly but use it for research purposes.  |
| Not directly. I use search engine AI to summarize certain topics for my own information and use.  |
| Not in practice; I use AI for brainstorming in some of my educational/adjacent work, such as crafting titles for events and creating rubrics for assignments.   |
| Not much. Only for wording recommendations, not replacement for thoughts or implementation of practice.   |

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| Not practicing   |
| Not that I know of. YIKES!   |
| Not with clients. I have used it to prepare presentations  |
| Not yet, but "augmented Intelligence" is coming to help improve notes.   |
| Not yet, but may soon. Documentation most likely. Possibly assisting in writing a treatment plan.  |
| Not yet, but will soon.  |
| Not yet, it will be implemented in august for note taking  |
| Note writing only  |
| Note writing.  |
| Notes through EHR platform   |
| Occasionally for documentation support, I prefer to not utilize it.  |
| Occasionally on how to word things when writing reports.   |
| Occasionally to polish an email.   |
| Occasionally, will use AI to assist with documentation mainly for documenting my EBP, never adding any personal identifiable information.  |
| On occasion, I will use AI when writing a letter to families to make sure the wording is clear.  |
| Only administratively to summarize department meetings and inform notes for these meetings. Have used it to help refine process steps outlined in complex procedures.  |
| Our clinic is exploring the benefits of utilizing AI.  |
| Our clinicians use Eleos for clinical, chart documentation. As an administrator I have also used ChatGPT for assistance, suggestions with policies, job descriptions, job evaluations format/questions, updating resume, creating competency questions related to a PowerPoint, creating a PowerPoint from agency document, etc.   |
| Our hospital has used some prior insurance authorization portals through different commercial insurance providers that utilize AI for automatic approval for post acute care, like rehabs, using keywords, etc.  |
| People are able to utilize it to write notes but I do not use that feature   |
| Preauthorize CEUs like Missouri does and sends certificates to their regulatory board to reduce burden on licensees.   |
| Proof reading to ensure clinical language can be broken down to those who don't have the educational background. Licensing questions for degrees other than social work.   |
| Rarely   |
| rarely if ever, sometimes during searches for resources AI jumps in, but I do not use it for notes, I do not use it for diagnosis or any other client specific uses due to confidentiality, ethics, and knowing what I know about how much AI takes from sources that AI interacts with (artists, writers and copyrighted material and do not want to risk any similar thing). |
| Rarely, sometimes for social stories or lesson plans   |

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| Rarely. Sometimes comes into use on websites and resources I am interacting with for pts. If I seek to use, may be to create an email or preparing a document for myself in organizing my own resource information.  |
| I feel I use more in personal writing and organization at this time although I know it is available, I think I do not choose to take time from work. I did attend an AI workshop through employer and am on the company's AI work group chat to try to keep up with what is happening there. |
| Research, help creating forms.   |
| Scripts for social stories. Possible social emotional lessons. I'd like more training in this.   |
| Some note writing  |
| Some. Writing emails and coming up with social and emotional lessons   |
| Sometimes - help with writing goals  |
| Sometimes I use AI to help polish my email responses to others, letters, presentations, etc.   |
| Sometimes I use it to help develop activities for students during sessions.  |
| Somewhat and usually to frame a difficult email  |
| Starting AI listening for documentation soon as our agency   |
| The center I work at uses AI to help with documentation  |
| There are times that I use it to give me ideas when I am struggling with a possible solution to an issue.  |
| This is new for our practice   |
| This is very limited in my profession. The only place I can think of that we've used Ai would be to help write obituaries for patients. You just plug in all their demographics, a few characteristics, and it does the rest beautifully.  |
| To assist with writing progress notes and polishing documents.   |
| To generate pamphlets and homework and note supports.  |
| To help form emails  |
| to help plan therapy sessions  |
| To improve the accessibility and reading level of printed materials  |
| To search for SW resources   |
| Very little - sometimes to generate activities or practice scenarios for therapy sessions  |
| Very rarely. I will use it to help me develop and create lesson materials for whole group instruction.   |
| We do not use AI.  |
| We do not use any artificial intelligence yet in our practice.   |
| When writing individual progress notes, my agency allows us to use an AI support system name Mara to help capture the essence of our clinical summaries before submission.   |
| With help in the creation of documents, agreements, and business oriented paperwork.   |
| Writing letters and newsletters  |
| <b>Yes (3 responses)</b>   |
| Yes - assist with clarifying my ideas, helps me create plans for sessions  |
| Yes - Occasionally when crafting a professional email.   |
| Yes - proofread chart notes, draft occasional letters  |

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| Yes. Generate ideas on helping youth with current issues   |
| Yes chart notes  |
| Yes- documentation utilizing Eleos   |
| Yes for conversation prompts for groups with students, or ideas for emotional regulation for children K-5th grade.   |
| Yes for emails, letters, brainstorming tool for behavior plans   |
| Yes for Medicare questions or finding resources  |
| yes sometimes to help me get a framework/ideas with treatment goals  |
| Yes to assist with clinical documentation  |
| Yes- to look at treatment plan ideas and also my EMR includes AI in it to write soap notes.  |
| Yes we use AI for documentation  |
| Yes with writing progress notes  |
| Yes writing notes.   |
| Yes. I use it to write generic letters or memos  |
| Yes, progress notes for case workers   |
| Yes, and love it! Eleos is awful, but upheal is a real help.   |
| Yes, but I choose not to engage anymore with computers than I already do. People want to talk to real people.  |
| Yes, documentation   |
| Yes, Eleos for notes.  |
| Yes, for my psychotherapy notes.   |
| Yes, for progress notes  |
| Yes, formulating notes.  |
| Yes, general questions on resources or patient concerns  |
| Yes, help with writing stronger written communication. I submit my original work and get suggestions   |
| Yes, helping with goal development   |
| Yes, I use AI but not regularly. It is used to compose notes.  |
| Yes, I use AI in private practice.   |
| Yes, in education  |
| Yes, in our CCBHC we utilize ELEOS to help write our notes, to ensure we are focused on the session and the client but also have a higher note compliance. |
| yes, in the EMR as well as free app use. usually to bounce ideas or find better wording to clean up what I am making.                                      |
| Yes, it has been a good addition to our agency and been super helpful.   |
| Yes, it helps me create engaging visuals for students I work with  |
| Yes, my progress notes that are submitted to insurance.  |
| <b>Yes, notes (4 responses)</b>  |
| Yes, notes and creating games  |
| Yes, notes completion  |
| Yes, occasionally I use my notes that I have made during session to be made into SOAP notes.   |
| Yes, our EMR IS AI based   |
| Yes, planning for group.   |
| Yes, report writing  |
| Yes, revising emails. Generally to staff in the office or referral sources.  |

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| Yes, Session Note Assistance  |
| Yes, simple practice  |
| Yes, Therapro for writing psychotherapy notes and analysis of possible diagnoses and treatment plan.  |
| Yes, to assist in goal making and creative solutions  |
| Yes, to assist with charting.   |
| Yes, to help with mindfulness scripts, advertising psycho educational workshops.  |
| Yes, to support in writing notes with client consent  |
| yes, voice recording software for progress notes.   |
| Yes, with assistance writing grants and reports.  |
| Yes, writing notes and treatment plans  |
| YES. DOCUMENTATION  |
| Yes. In research AI is used for protocol development, topic searchers, review of materials, etc.  |
| Yes. AI for assistance with documentation/progress notes.   |
| Yes. AI is being used as a teaching tool to support social work educators in building more accessible educational materials. It's used as an enhancement. In the classroom, the program I am teaching in and overseeing teaching for as an administrator is beginning to incorporate teaching students about the ethical use of AI in practice and teaching the next generation of practitioners about the social and economic justice issues surrounding the large data centers required to host these services. |
| Yes. Chat GPT to write biographies and presentation summaries.  |
| Yes. correction and template creation   |
| Yes. Development in process development. Creating workflows and flow charts for our staff.  |
| Yes. Emails and to help create surveys for my practice.   |
| Yes. For use of creating documentation.   |
| Yes. I have found AI to be beneficial with writing IEP goals for students. I mainly use it to generate ideas and then modify to specific student needs.   |
| Yes. I have used Canva to put together training seminars on several mental health topics, and I developed a four week intensive peer support training program.  |
| Yes. I use a HIPAA-compliant AI tool (Simple Practice Software) to speed up routine documentation and calendar management. I do not use AI for diagnosis or treatment planning, and all clinical decisions are made by me and reviewed with a supervisor when needed.   |
| Yes. I use chat gpt to help how to address emails to coworkers, help me tighten up my bio for a speaking event and asking it for support group activity ideas.  |
| Yes. My company have invested in Eleos. This will listen to our sessions and provide suggestions for documentation.   |
| Yes. My company uses the program "Eleos" to help with service note writing.   |
| Yes. We use AI to help us with documenting progress notes.  |
| Yes; drafting emails and monthly newsletters to parents; help with wording for social stories; help with wording on IEP Goals and 504 accommodations  |
| Yup, everything   |
| Zoom translation which I believe is AI on a certain level   |

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| <b>LSCSW Q13. Do you currently use artificial intelligence (AI) in your practice? If you do, in what areas do you use AI? (841 responses)</b>   |
| 1-2 x to formulate a letter.  |
| a HIPAA -compliant product that provides assistance with the completion of progress notes. Chat gpt for research and summarizing research.  |
| A little not initiated by agency. Part of a purchased program   |
| Absolutely not  |
| ABSOLUTELY NOT. And I would encourage the BSRB to consider adding information/training about ethical use of AI and the companies that run them. There are many therapists who use AI to make notes easier (relatively minor concern) while ignoring that many of those companies seek to create AI therapists and drive us out of business to make a buck. Many of those companies also sell client data and record therapy sessions. AI uses information given for free (or sometimes even paid for through a subscription!) to build and hone an AI without giving credit to its sources. Master plagiarism. So NO, I will absolutely never be using AI in my practice and would discourage anyone from doing so. |
| Absolutely not. Tech companies are motivated to collect and sell personal information, including PHI.   |
| Absolutely not. We are provided with Eleos to do our notes, but Eleos notes are too vague to be of any use.   |
| Agency has an AI note taker for clinical services like therapy as well as case management. I used it for a few months but experienced too many errors/poor quality of notes. I advise especially newer practitioners not to use it as I feel it impairs developing their own documentation skills.  |
| AI in editing notes and completing requirements of insurance company  |
| AI is sparingly used via google searches online for information gathering.  |
| AI is utilized for writing session notes.   |
| AI notetaker, AI treatment planner,   |
| AI notetaking   |
| Aid in documentation language; interested in new features that record and provide documentation samples, but need clarity on privacy protections/legal risk   |
| ALMA-Note Assistance  |
| An AI option is available however I have not utilized this yet.   |
| As a glorified search engine currently, however that is expanding to using it with writing or research.   |
| As a social work professor, I use Chat GPT, but carefully and ethically. We've had MULTIPLE problems with students using it and we are revising our assignments to prevent easy use of AI in academic work. Many of our students report using AI in practice; especially for progress notes and other note taking.  |
| Assessment, individual therapy, family therapy, group therapy, search for therapy information.  |
| Assistance in writing notes   |
| Assistance with notes   |
| Barely for a presentation   |
| Beginning to use it with writing progress notes.  |
| Charting assistance   |

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| Copilot, to assist with interventions and/or PIRP notes   |
| Creating handouts   |
| Currently using AI to transcribe sessions and put them into clinical notes  |
| Currently, no, but I would like to regarding progress notes and treatment planning.   |
| Development of trainings  |
| Dictation   |
| Documentation and research.   |
| Documentation.  |
| Documentation...but I do not record sessions.   |
| Documenting   |
| Don't use.  |
| Draft notes, identify resources, draft letters  |
| Filming appointments  |
| for notes   |
| Heck NO   |
| Help with compiling community presentations on wellness topics- not for clinical data but ideas for presentation flow and layout.   |
| help write clinical notes   |
| I am not, but wondering about it for clinical notes   |
| I do not at the time but I am researching it for potential future use.  |
| I do not but more of my colleagues are using AI technology to listen to sessions and auto generate notes. I have concerns about privacy as well as the environmental impact of these practices. It may be beneficial for some guidelines or best practices to be released.  |
| I do not use AI   |
| I do not use AI   |
| I do not use AI in my current practice. I have used in in the past at the school to support writing social stories or used general technology like speech to text.  |
| I do not use it. It is not used in my department. I can tell when people are using it for reports etc. I don't think it's helpful to the practice and further removes licensees from the doings of the work and exposure to actual practice and techniques. I'm worried that new licensees are only functionally literate.  |
| I don't use AI if I can help it.  |
| I don't use it, but would really like knowing more about it as it relates to our work.  |
| I experimented with using AI to assist in developing an outline ( It was helpful)   |
| I have been considering it for note taking through my EHR platform Simple Practice. I have not used it yet because I'm not sure it would be valuable for play therapy notes. I wonder if it really is HIPAA protected. It would save time so I'm considering it as an option.   |
| I have been using on a trail basis to assist with notes   |
| I have just in the past two weeks started using it with my EHR.. Simple Practice to help compose notes. It was a test run but I do like it and find it to be useful and time saving. I still review every note, but I love how it uses clinical language and its understanding of the nuance of what we did during session is amazing. Simple Practice states it is HIPAA compliant . |

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| I have just started trying it out for session documentation. I will not use an AI program that requires listening in on the session. I've used it as a copy/paste of my own notes, to generate another.   |
| I have used AI to help me design consent forms or other documents for my practice. I always check them for accuracy though and consider the sources.  |
| I have used AI to type up my clinical notes, which is a system provided by my employer. I have also used AI to write work accommodation letters for me.   |
| I have used it before as a trial for notes, not using currently.  |
| I just use it as one means to gather information or collect data.   |
| I look up a few topics.   |
| I only use AI for marketing purposes such as blog content and social media posting.   |
| I only use it for grammar check. I make sure to take out any HIPPA related information before using it.   |
| I plan to use it in the near future for note taking.  |
| I use a the assisted note generator through my EHR Therapy Notes  |
| I use AI for notes.   |
| I use AI in treatment planning and note taking. I leave out PHI.  |
| I use AI to aid in treatment plans and group topic blurbs. Also sometimes to organize my thoughts discussing a new topic or trying to create a "program" of topics over several weeks. Also to aid in ethical checks regarding emails I send to managers/ "leadership". |
| I use AI to convert session narrative to SOAP note. I do NOT record sessions.   |
| I use AI to help with creating progress or court reports, and seek information. I do not use it for documentation.  |
| I use ChatGPT when I need to work on social media and email posts for a retreat I host.   |
| I use it rarely, and only when obtaining/creating therapeutic resources for clients or group sessions.  |
| I use it sometimes for help with document, treatment planning and social media marketing  |
| I use it to edit emails and generate lesson plans   |
| I use it to help design trainings, as a rough draft then fix it up for final.   |
| I use it to help with professional wording and clarity for emails and psychology today.   |
| I use it when completing treatment plans otherwise I am not that comfortable with it yet  |
| I use sometimes use Google Workspace Gemini and Chat GPT for assistance with wording things or to help generate ideas for therapy activities, to help summarize a book or movie that I haven't read or seen to help me connect with a client's interests.               |
| I use therapy notes software for my EHR and it has a note assist component for my progress notes. I use that, but will modify when it is not accurate.  |
| I use to assist in wording for treatment plans and objectives. I also use in wording for marketing.   |
| I used ChatGPT to assist in cleaning up language or better writing format.  |
| I utilize AI to assist with documentation completion  |
| I utilize AI to assist with treatment planning and ensuring that goals meet SMART goal standards  |
| I will use it for myself to look up definitions   |
| I work for the government- no   |

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| I've used AI to assist with writing social narratives for some of the students I provide services for   |
| If I can, I do.   |
| In telehealth. It summarizes the sessions and provides insight for the following session  |
| In writing my notes I use AI through Therapynotes   |
| Information   |
| It is an option to use it for notes but not required  |
| It is available but I don't use it  |
| It is available to me for session documentation but I rarely use it.  |
| Just for research or references.  |
| just looking up brief facts when clients have fears about different things. IT helps with getting some general facts.   |
| Keep the diagnosing credit at 6, include domestic violence and have the field safety as a requirement every two years   |
| Limited. I recommend mood tracking apps to clients that we review in session at times. Increasingly questions are surfacing in supervision regarding use of AI for documentation.   |
| Looking into it but not using   |
| My EMR has AI features integrated into the documentation section. I use it occasionally.  |
| My main use is when I refresh myself about personality disorders, AI typically chimes in now but I don't like to use it as my sole source. There are also diagnostic criteria and research papers and articles that I review. |
| My medical chart offers an AI scribe to do the charting. I am comfortable with it because it is in my chart. I worry about external AI scribes and would like to ensure that they do not violate HIPAA                        |
| <b>N/A (30 responses)</b>   |
| Never, I think it is unethical  |
| <b>No (468 responses)</b>   |
| No - not allowed (government work)  |
| no and I am against it/think it's unethical/not HIPAA compliant   |
| no but I am thinking about using it for progress notes and letters  |
| No but we are interested in learning about it for documentation.  |
| No I do not   |
| No- n/a   |
| No not at all.  |
| No- won't use it  |
| <b>No! (4 responses)</b>  |
| No, and I am opposed to the use of AI for notes or any other purpose. It's a learning system and giving our clients information can't be protective of our clients' privacy.  |
| No, and I don't plan to.  |
| No, and I have major ethical concerns with its use.   |
| No, and I have no intention to do so. It's impossible to know what's ethical vs what's legal in this area right now. AI is basically the Wild West, and I'm not getting caught in a metaphorical shootout.                    |
| No, but at the treatment facility they are using Eleos for documenting sessions and creating notes.   |

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| No, but considering it for future documentation if able to be ethical and protect minority clients without risking their safety in this administration   |
| no, but hope to eventually add the use-primarily for easing documentation  |
| No, but I have experimented with using AI to review a practice report to see what it would do. It was limited and not remarkably helpful.  |
| no, but probably need to figure out how to   |
| No, but would like to hear the Boards thoughts on the practice of using it in different capacities.  |
| No, however the agency I work for is considering possible options for this. We are taking our time with this in order to reduce potential issues for our clients if we move forward with use of AI.  |
| No, I am very hesitant to bring AI into my practice.   |
| No, I do not currently use AI in my practice. The individuals I supervise do use AI for notes, treatment planning and goal setting.  |
| No, I do not use AI  |
| No, I do not.  |
| No, I don't get how that would help.   |
| No, I don't think AI should be used in our field.  |
| No, I feel it violates client's rights to privacy.   |
| No, I have looked into it for notation. My EHR offers it. I'm waiting to see what the BSRB as guidelines.  |
| No, I prefer to continue to use my own brain and enhance my own clinical skills.   |
| No, I think that is still a controversial subject. I believe it will compete with real professionals.  |
| No, I'm pretty anti AI   |
| No, other than how my emails get offered edits or the practice program editing (Therapy appointment).  |
| No, scares me.   |
| No. I do not.  |
| No. I worry about the ethics of it.  |
| No. But our agency is experimenting/testing out ways to see if it can help   |
| No. I am against this. I think this is one of the reasons why people can not pass license exams.   |
| no. I am reluctant to do so.   |
| NO. I do not trust AI and feel it is an ethical problem that it has become so common in our field, so quickly. It poses environmental, intellectual property theft and bias issues in how AI models were trained, as well as privacy concerns. |
| NO. I do write WORD documents, which may use a form of AI.   |
| No. I don't fully trust it.  |
| No. My team of Case Managers use Eleos.  |
| No. None. I watch this closely and have yet to be swayed.  |
| <b>None (13 responses)</b>   |
| Nope! I will not use AI to make treatment plans, write notes, or make summaries of time spent with clients. Our meek understanding of the power with this technology will only cause harm in the long run.                                     |
| Nope.  |
| Not at present. Studying the issue to ensure protection of PHI   |

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| Not at this time  |
| Not at this time. We will be starting to use augmented intelligence later this year.  |
| not at this time; will be exploring in the future.  |
| Not currently but looking into an AI documentation tool called Blueprint.   |
| not currently working   |
| Not formally but have started to utilize AI for help with documentation phrases   |
| Not if I can avoid it. It is used by platforms for telehealth and in-person psychotherapy.  |
| Not intentionally (embedded in electronic charts like EPIC)   |
| <b>Not yet (4 responses)</b>  |
| Not yet, but I am looking into AI for documentation   |
| Not yet, but I just attended a webinar about how the platform we use (Simple Practice) has an AI component where it records sessions and creates case notes for you (that the clinician still has to review/edit/approve but supposedly it takes less time to do them). |
| Note completion   |
| Note taking for meetings. So far I don't trust it to accurately help reduce work load. I have been at suicide prevention conferences where AI is being used to dictate best practice to trainees and I am quite concerned about that.                                   |
| <b>Note writing (2 responses)</b>   |
| Notes   |
| Notes and website   |
| Notes enhancement   |
| Occasionally to assist with notes.  |
| Occasionally to help me with the wording for writing goals.   |
| Occasionally use for assistance with lengthy progress notes.  |
| occasionally, looking for activities for students.  |
| Online marketing  |
| Only in strategic planning on a macro level when it comes to systems of operation, they have to deal with clinical work.  |
| Only to assist a client in pursuing a goal or objective   |
| Our agency has a software that helps to write progress notes  |
| Our agency uses an AI note taker (Eleos) to help organize and craft session notes.  |
| <b>Progress notes (2 responses)</b>   |
| Progress notes on EHR   |
| Quick access to info  |
| Recently started experimenting with AI thru EMR to complete progress notes  |
| Recently used it to help create a document for a couples session about avoiding and evading communication and it was very useful for them   |
| Research.   |
| Retired, N/A  |
| Scribe  |
| Sending emails  |
| Session documentation for notes   |
| Session notes   |
| Software programs use AI technology with the health insurance employer  |
| some, to assist with notes  |

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| Some. Mostly to create social narratives for elementary kids. I take pieces of it then add things that relate to the student individually. So I would say more for ideas.                        |
| Some. There are some new AI tools for creating notes and occasionally use them for ideas on treatment programs.  |
| Sometimes to draft SMART goals, always tweaking them to ensure it is accurate, and confidential  |
| sometimes to look things up, help with wording and editing (of documents or content not related to clients)  |
| Sometimes, usually with note completion.   |
| Sometimes; Only recently discovered how it can be of help. I use it to help me brainstorm IEP goals, treatment plan goals, etc.  |
| Somewhat. Currently use it to brainstorm ideas for projects, how to pose questions, etc.   |
| Support in writing blog posts  |
| Telehealth. Secure messaging.  |
| Through Therapynotes.  |
| To generate ideas  |
| To help develop treatment plan goals.  |
| to help generate notes, after providing a written summary  |
| To help with creating social stories.  |
| To help write letters  |
| To help write notes and come up with next step ideas.  |
| To identify thoughtful, personalized journal prompts for self-reflection and personal development.   |
| To provide synonyms for words for documentation.   |
| To research  |
| Transcription and Progress Note creation.  |
| Transcription of notes during meetings   |
| Use AI for writing emails, proposals, contracts, etc.  |
| Use it to help compose treatment plans and notes   |
| Use magicshool AI to help draft IEP goals, accommodations and develop communication to parents.  |
| Utilize dictation software for documentation   |
| very limited   |
| very seldom. I don't use AI for my practice.   |
| We have just begun testing an AI platform for progress notes. A portion of the staff are voluntarily testing it to see if it will be integrated into our normal practice for all clinical staff. |
| We have just started using to help polish up notes and offer treatment plan suggestions.   |
| We use ai for editing.   |
| We use AI to help with documentation, write letters, and coordinate care with medical professionals.   |
| We will be getting by fall 2025  |
| Worksheet templates and spreadsheets   |
| <b>Yes (3 responses)</b>   |
| Yes - for progress notes   |

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| yes - for helping to create training and presentations; letter writing   |
| Yes - Grant writing  |
| Yes - I use a hipaa compliant ai scribe for note taking. Clients have provided consent and can opt out, and I provide notes to them as requested. These notes are often helpful for the client in remaining focused on their short term and long term treatment goals.   |
| Yes - it is helpful in summarizing notes to meet insurance requirements.   |
| Yes - note taking.   |
| Yes - to assist with writing notes   |
| Yes - we use AI to write individual, family, and group notes. It is so helpful, written professionally, and saves lots of time so we are more free to invest in clients!   |
| Yes. Turn it on and it listens to the session and then produces a note. It's fantastic! Picks up on this I miss.   |
| Yes- documentation   |
| Yes for clinical notes   |
| Yes for progress notes   |
| Yes- help with notes.  |
| Yes I do. Court reports, and notes for billing insurance.  |
| Yes I use it for notes. Our EHR allows us to type brief notes then based on that write a comprehensive note that can be edited as needed for clarity and better accuracy if needed   |
| Yes in creation of written notes. Not in sessions.   |
| Yes my employer uses Bells to help with documentation.   |
| Yes- note taking   |
| Yes- notetaking  |
| Yes progress notes   |
| Yes research   |
| Yes- Support with writing/documentation  |
| yes to assist with staying current on documentation deadlines and medical necessity and or lack there of.  |
| Yes to capture a live session and help write progress notes  |
| Yes to help with note taking.  |
| Yes to some degree. Example: Educating clients on how to use ai tools like ChatGPT to help with executive functioning skills for clients with ADHD   |
| Yes writing more concise communications  |
| Yes. Documentation. Treatment Plans  |
| Yes, administrative wise.  |
| Yes, and it assists w/being able to complete progress notes w/in a timely manner.  |
| Yes, as a feature on my EHR. This is not a listening feature but does assist with wording. This is a new feature which does assist in cutting down time for each note with increasing some confidence with potential insurance audits. I am not comfortable with a listening feature at this time due to potential ethical issues. |
| Yes, clinical documentation  |
| Yes, documentation and grammar-related needs   |
| Yes, for assistance with progress note writing   |
| Yes, for letter writing  |
| yes, for my progress notes   |

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| Yes, for notes and documentation purposes, as well as creating social media posts and drafting emails, etc.   |
| Yes, for progress note completion, this allows full attention to be given to the client. I struggle with note taking while in session but I also have ADHD and struggle to remember accurately after session to complete notes. AI has helped this tremendously.                                      |
| Yes, for progress notes.  |
| Yes, for progress notes/documentation.  |
| Yes, for session notes.   |
| yes, for social media post  |
| Yes, for writing notes.   |
| Yes, formatting notes   |
| Yes, I have recently begun using AI-assisted note-taking.   |
| Yes, I have used it to make Social Stories for kids.  |
| Yes, I use Berries to help with progress notes and treatment planning.  |
| Yes, I use Blue Print for note taking.  |
| Yes, I use it to help me write marketing content for our Blog, YouTube Videos, Course Content, Sales Page Content, etc.   |
| Yes, in session notes   |
| Yes, it is a tremendous help in completing notes.   |
| Yes, it is integrated into our billing platform for use with notes and dictation.   |
| Yes, just started this week with session notes. I waited to use one offered by my EHR to avoid security and confidentiality issues with using a third party.  |
| Yes, my EMR uses AI to generate progress notes.   |
| Yes, note dictation.  |
| Yes, note taking  |
| Yes, note taking within Telehealth platform.  |
| Yes, note taking.   |
| Yes, note transcription   |
| Yes, notes  |
| Yes, private practice   |
| yes, progress notes through Electronic health record  |
| Yes, progress notes.  |
| Yes, recording of session for notes. It's been helpful. Only for clients that sign a release and consent to it. Most clients want me to read what it says at the end of session and it's pretty accurate my clients feel. I make worksheets, print out some good coping skills that it comes up with. |
| Yes, some of the therapists have a tool called ELEOS that they use that records and summarizes sessions. The documentation is very clinical and doesn't match the typical communication style of the therapist.   |
| Yes, telehealth platforms   |
| Yes, to help compose and summarize non-clinical email communications.   |
| Yes, to help me write policies.   |
| yes, to help with documentation   |
| Yes, to record session so that I have more thorough notes   |

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| Yes, to summarize our session notes with direct oversight and review by the licensed therapist to ensure accuracy. It is helpful in reducing the amount of time spent writing notes in session and after session so more attention can be on the client directly.  |
| Yes, to transcribe notes after a session   |
| Yes, to write blogs and website text   |
| Yes, transcribing notes  |
| Yes, treatment planning  |
| yes, visual and creative tools.  |
| Yes, we are forced to for documentation for our notes.   |
| Yes, we are just now implementing it into our Electronic Medical Record and I am excited to see how it plays out. At a National Conference recently I heard them say "technology is now a member of the treatment team" and I believe that to be true. It's an enhancement that could make the client experience better, and staff satisfaction higher because documentation has become so burdensome with everything practitioners are expected to measure/collect. |
| Yes, when preparing workshop or psychoeducation.   |
| Yes. documentation   |
| yes. I use AI to support the documentation of my individual therapy sessions.  |
| Yes. Notes (2 responses)   |
| Yes. A starting point for research, marketing, and document creation.  |
| Yes. Assistance in wording & writing reports. Large group activities   |
| Yes. Curriculum building   |
| Yes. Grok and Chat GPT both have been very useful in ruling out differential diagnosis IF you feed it correct information.   |
| Yes. HIPPA compliant platform with no identifying information to create treatment summaries  |
| Yes. I use it to help explain concepts to clients (sometimes it says things clearer and/or more detailed than I can) and to look up things I don't know - basically general Google searches.   |
| Yes. I work for a large insurance company and we recently started using it to generate notes. Frankly, it's horrible and I spend more time than I did before (when I did my own notes) editing and making sure everything is accurate.   |
| Yes. Lesson planning, student support ideas, written social story songs for students, etc.   |
| Yes. my agency has a program that summarizes sessions and creates editable notes on the content and processes of the session (eleos).  |
| Yes. Note taking.  |
| Yes. Policy writing.   |
| Yes. Summarizing progress notes.   |
| Yes. To generate educational materials for patients.   |
| Yes. We sometimes have access to AI generated note assistance through our charting software. We write a synopsis of session and the AI software takes the information and creates documentation.   |
| Yes; meeting with patients, helping to summarize and generate visit summaries.   |
| Yes; to help write progress notes  |
| Yes-note taking AI   |