

# **Behavioral Sciences Regulatory Board**

## **Survey of Social Workers**

**December 2025 Update**

DRAFT

## ***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.

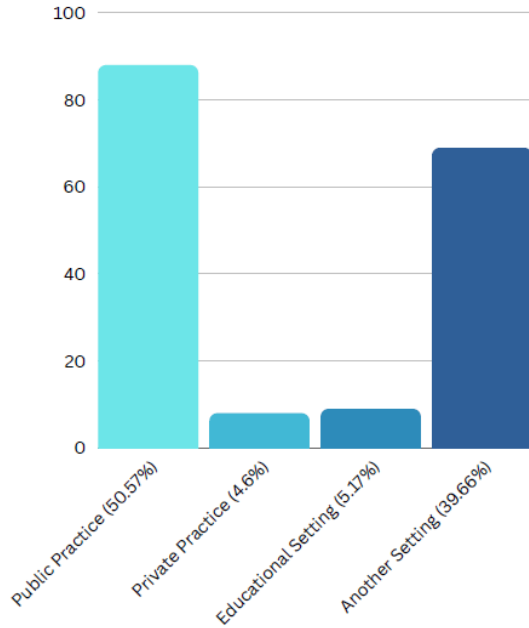
As of July 2025, the total number of licensees in the social work profession in Kansas totaled 8,624, including practitioners with a LASW license (4); LBSW license (1,126); LMSW license (4,151), and LSCSW license (3,343). From June 17, 2025, to July 21, 2025, all LBSWs, LMSWs, and LSCSWs under the BSRB 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.

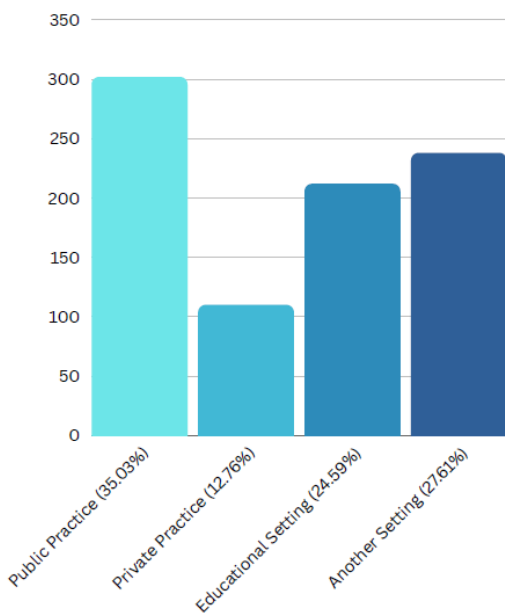
**Question 1 (LBSWs, LMSWs, and LSCSWs). Do you primarily work in public practice, private practice, an educational setting, or another setting?**

**LBSW Responses**



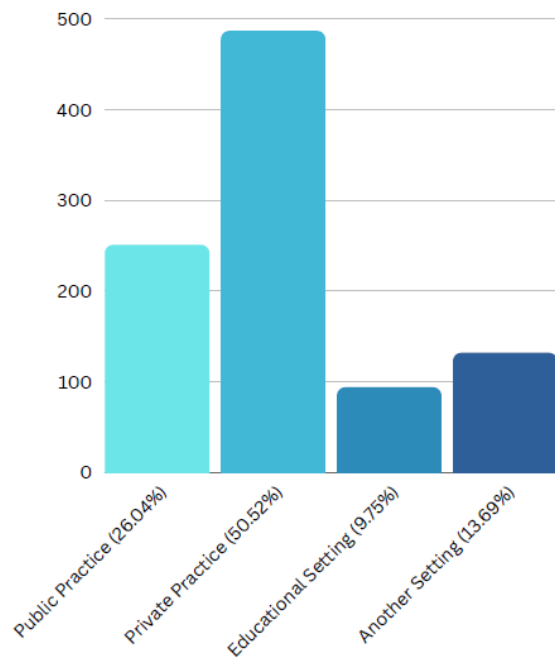
Of the 174 LBSWs that answered question 1, 88 reported working in public practice (50.7%), 69 reported working in “another setting” (39.7%). All other responses were less than 6%.

**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%).

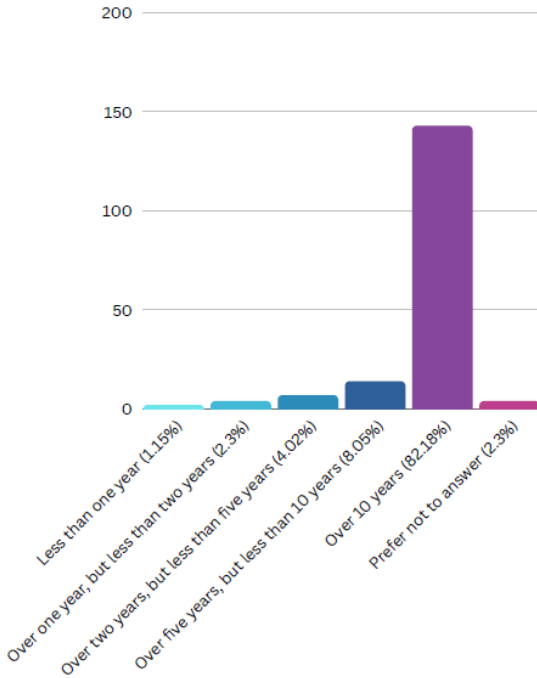
## LSCSW Responses



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%).

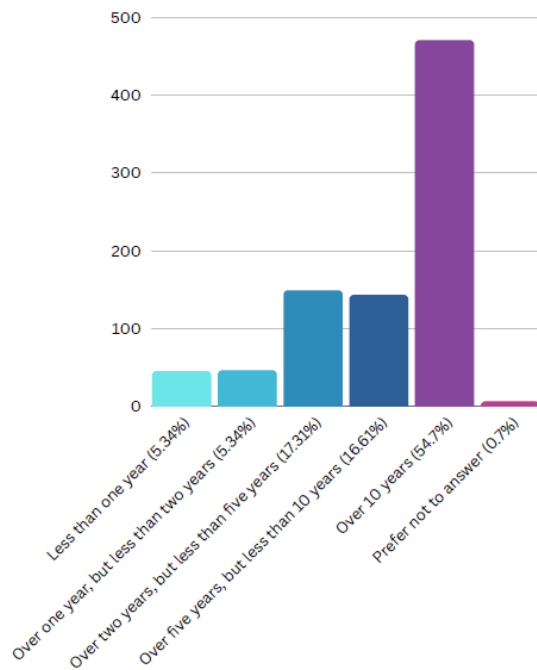
**Question 2 (LBSWs, LMSWs, and LSCSWs). How many years have you practiced as a social worker (between Kansas and other states)?**

**LBSW Responses**



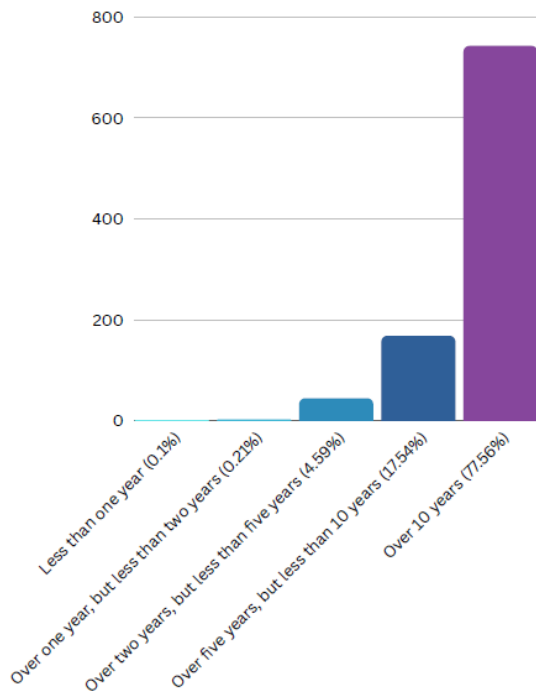
Of the 174 LBSWs that answered question 2, 143 individuals reported practicing over 10 years (82.2%); and 14 individuals reported practicing over five years, but less than 10 years (8.1%). All other responses were less than 5%.

**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%.

***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 35).

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 38).

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**

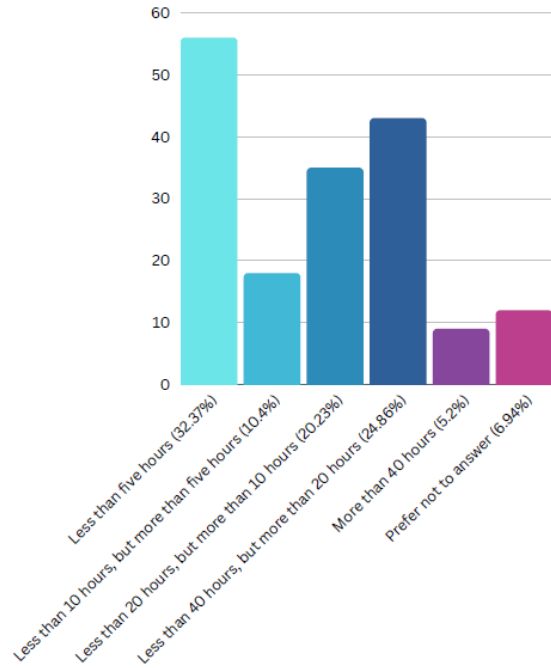
Five hundred and ten LSCSWs answered this question, providing insight into reasons why licensees might maintain an active license but not provide services. (Responses for all licensees can be found in Appendix 3 on page 46).

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.

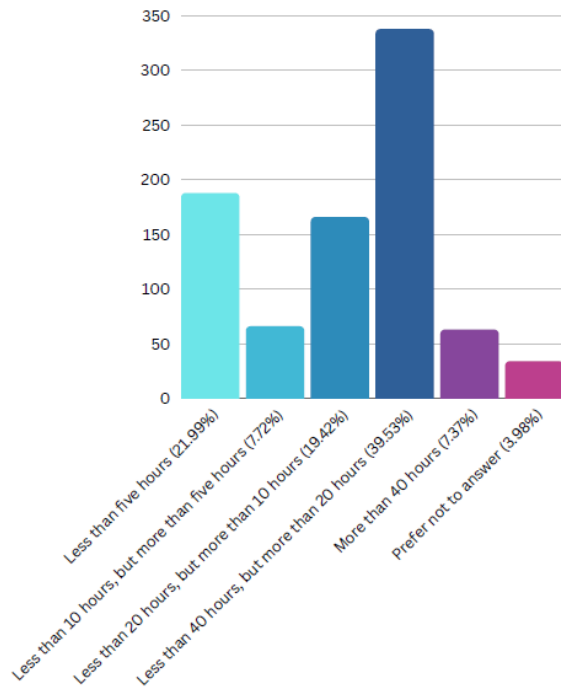
**Question 4 (LBSWs, LMSWs, and LSCSWs). In a typical week, how many hours do you provide in-person services to clients?**

**LBSW Responses**



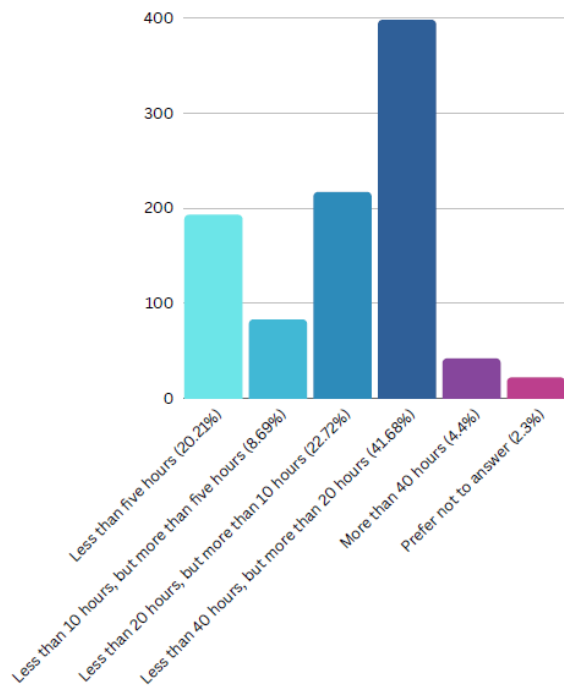
Of the 173 LBSWs who answered question 4, the most common response was from 56 individuals who provided less than five hours per week (32.4%); followed by 43 individuals providing less than 40 hours, but more than 20 hours (24.9%); then 35 individuals providing less than 20 hours, but more than 10 hours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

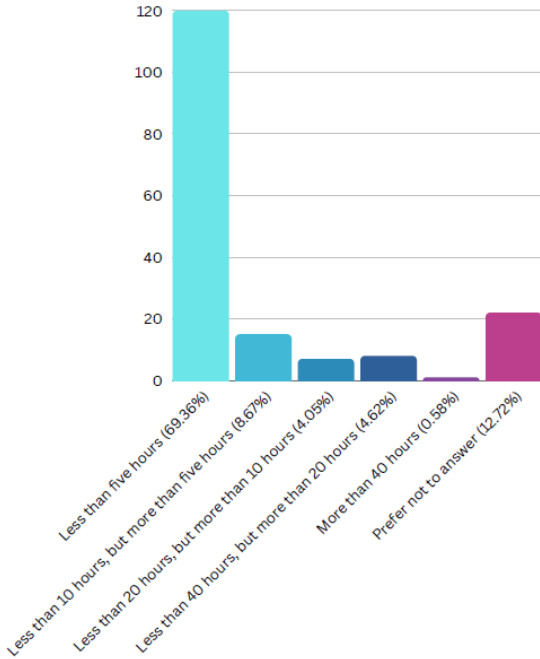
## LSCSW Responses



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%.

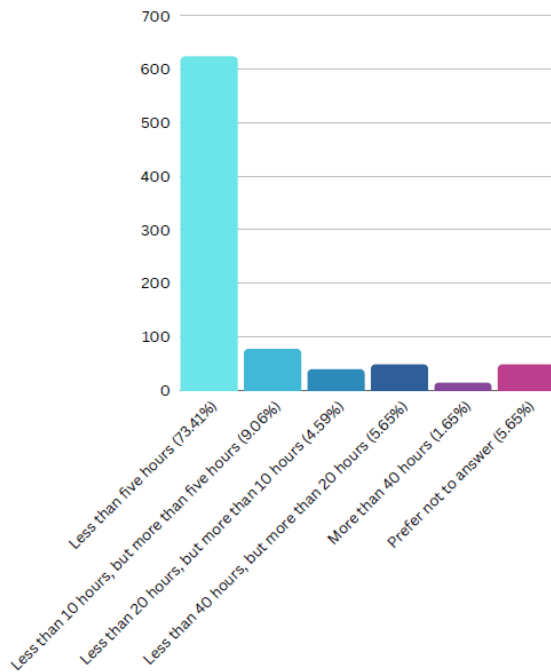
**Question 5. In a typical week, how many hours do you provide telehealth/remote services to clients?**

**LBSW Responses**



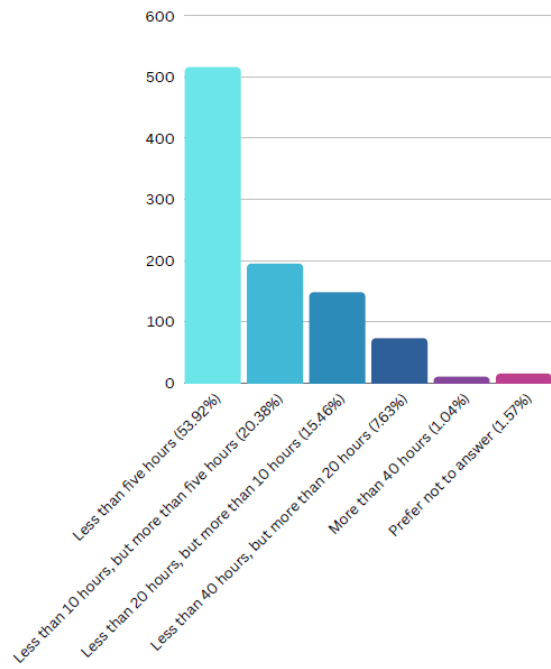
Of the 173 LBSWs who answered question 5, the most frequent response, 120, was from individuals providing less than five hours of remote services per week (69.4%); then 22 individuals preferred not to answer (12.7%). All other responses were under 9%.

**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%.

***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 51).

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).

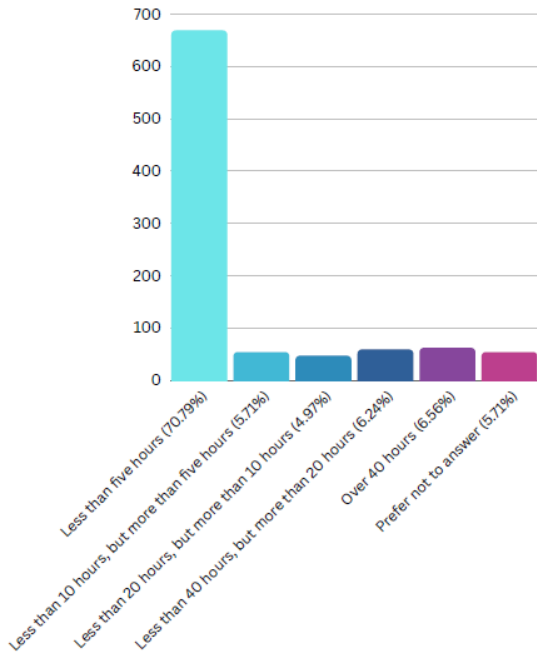
### **LMSW Responses**

Eight hundred and one LMSWs answered this question. (Responses for all licensees can be found in Appendix 5 on page 56).

Some respondents noted concerns about cost of supervision or the time necessary to attain sufficient clinical hours to advance to a clinical license. Other respondents noted their current employment does not require a clinical license and they are unsure of the benefit in achieving a higher-level license. Some respondents noted that, due to their age or plans to work in other fields, achieving a clinical license would not be beneficial for them. Other respondents noted not pursuing a clinical license in an effort to achieve a better work-life balance. Some individuals noted a plan to pursue clinical licensure in the future, but not at the current time.

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

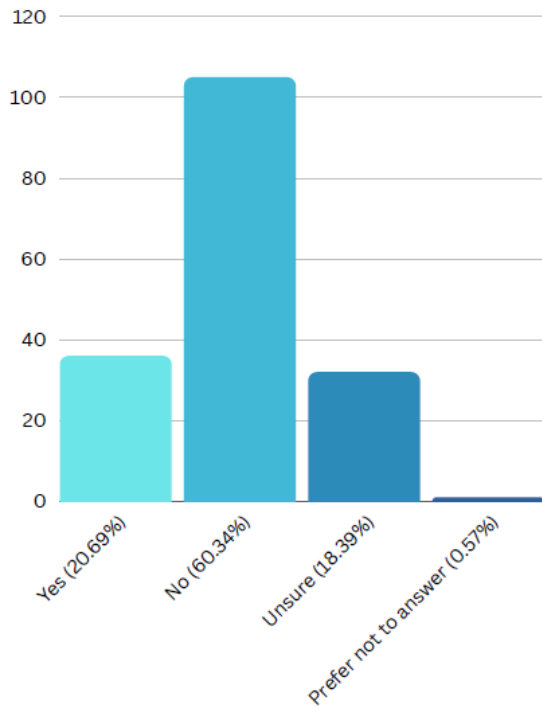
**LSCSW Responses**



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%.

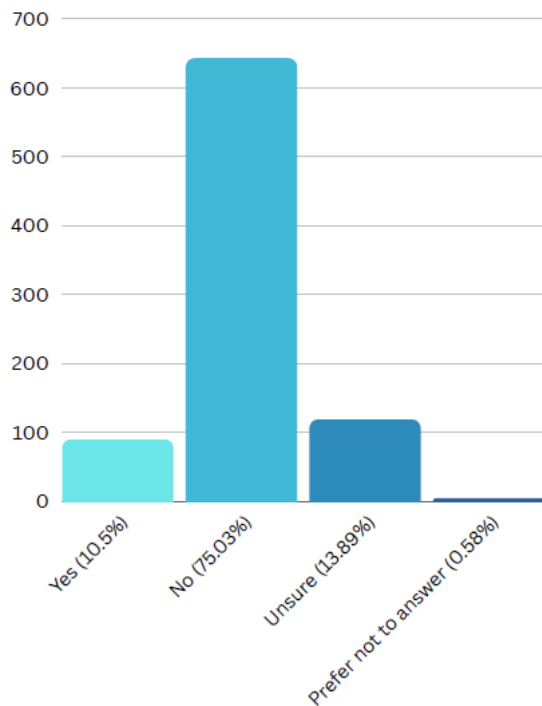
**Question 7 (LBSWs, LMSWs, and LSCSWs). Do you anticipate retiring from the social work profession in the next five years?**

**LBSW Responses**



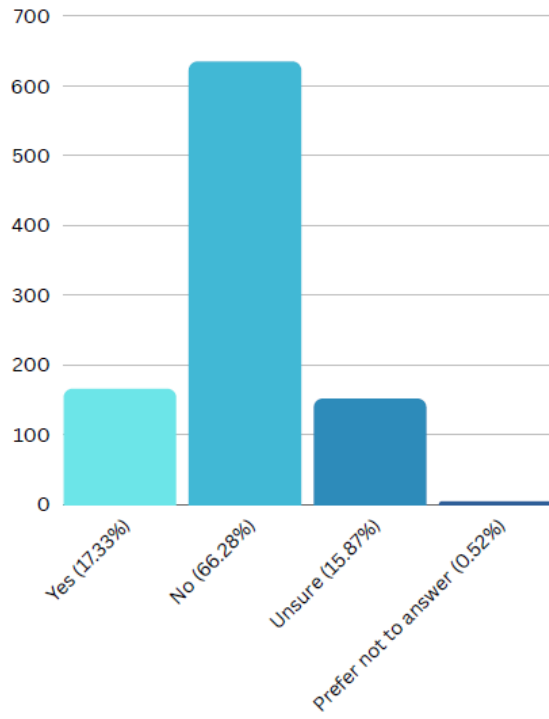
Of the 174 LBSWs who answered question 7, the most common response was from 105 individuals answering “no” (60.3%); followed by 36 individuals selecting “yes” (20.7%); then 32 individuals responding “unsure” (18.4%). Other responses were less than 1.0%

**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%.

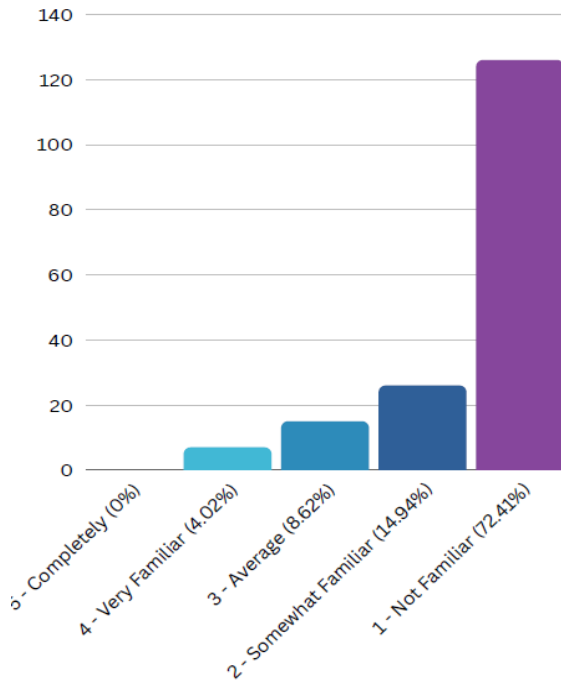
## LSCSW Responses



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%.

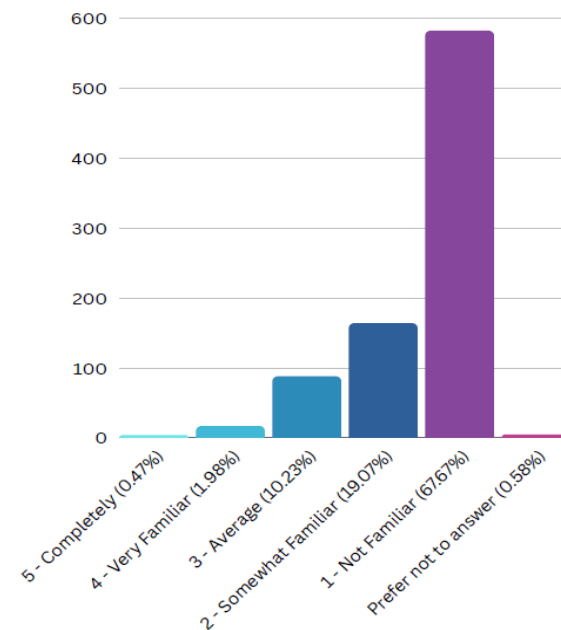
**Question 8 (LBSW, LMSW, and LSCSW).** To assist the work of the Board, the BSRB has seven standing Advisory Committees (one for each profession regulated by the Board), which are primarily composed of licensees in each of the seven professions. Advisory Committees discuss topics relevant to the work 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**



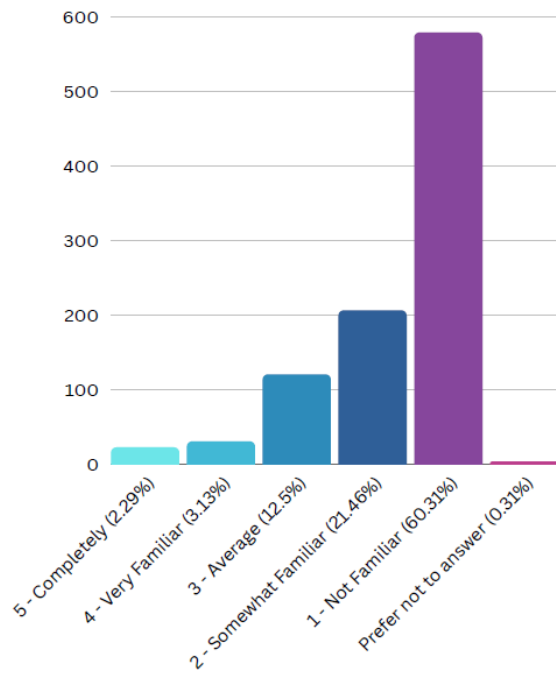
Out of the 174 LBSWs that answered question 8, the most common response was 126 individuals selected “not familiar” (72.4%); and 26 individuals noted they were somewhat familiar with the work of the Advisory Committee (14.9%). All other responses were less than 9.0%

**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%.

***Question 9 (LBSWs, LMSWs, and LSCSWs). 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 76).

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. (Responses for all licensees can be found in Appendix 7 on page 81).

The most common responses were “no,” “none,” or “not applicable” (155 combined responses), while others respondents commonly answered a version of no with additional comments or clarifications.

Frequently reported practice-related negative issues included ethical issues, insurance, areas needing more education and training, and political factors.

## **LSCSW Responses**

Seven hundred and twenty-three LSCSWs answered this question. (Responses for all licensees can be found in Appendix 8 on page 106).

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.

***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 135).

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 138).

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 147).

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.

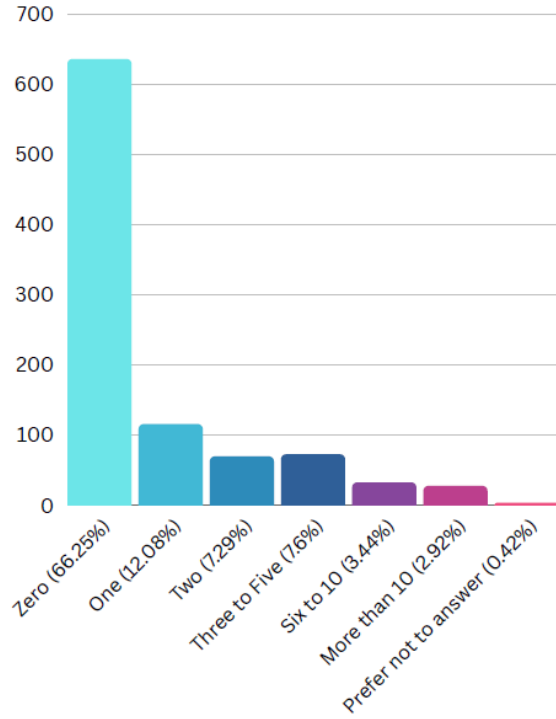
The following were frequently reported issues experienced concerning telehealth:

- 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%.

***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 161).

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 163).

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 173).

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 182).

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 183).

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 191).

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 (LSCSW). 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 201).

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 204).

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 14 on page 219).

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 240).

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 244).

The most common response was a combination of “no,” “none,” or “not applicable” with 287 combined responses. Others responded with a version of no, but with clarifying comments. A number of respondents expressed thanks for being asked to provide feedback through the survey.

Some respondents expressed concerns with changes in educational requirements for licensure or continuing education requirements. Other respondents requested additional communication or advocacy for the profession or increased reimbursements for social workers.

### **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 259).

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

**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)**

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.

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.

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.

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

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

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.

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

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.

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.

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

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.

Appendix #4

**LBSW Q6. Are you currently working towards attaining a Licensed Master’s Social Work (LMSW) license in Kansas? If you are not taking steps to receive such license, please explain why you made that decision. (155 responses)**

At this point I have partially retired. At my age it is not worth it to work on getting a LMSW

Because I am 64. I am raising 4 more grandsons. I started through KSU through Fort Hays one summer semester and was going for Accelerated 1 year LMSW and got a b-. I was told after the b- that I would need to take the 2 year classes. I could not do that to my family. Prior I had addictions counseling and was a CADCI. Right when I went to get my CADCI The licensing went to LAC.

Been a long time since graduating college. MSW schooling has been expensive. would prefer advanced enrollment of a one year program but see that having to add in study time and an additional 20 hours a week on average for practicum atop a 40-60 hour work week is overwhelming to think about being able to accomplish.

Cannot afford

Cost and time

Covid hit when I got my masters and now I feel like it's been to long and I wouldn't even know where to start

Do not need for the work I do.

Does not matter to my job

Don't have the time to return to school and the cost/benefit ratio isn't there for me.

Don't need for my job and don't want to return to college.

Due to the cost of schooling.

Higher education is too expensive, still in debt from my bachelors

I am 64 years young and am returning to workforce in a hospital setting.

I am considering enrolling to obtain my LMSW

I am currently working towards an MSW and plan on getting licensed.

I am happy in my current position and do not desire to work in a role that requires a LMSW

I am interested in perusing a LSCSW in the future to provide trauma informed counseling to first responders.

I am not considering a LMSW license as I don't intend to work until I'm 90 and I feel that it would take that long to pay off the school loans. I did not pursue a LMSW when younger due to being the lone income earner and have a child with special needs.

I am not currently working towards a LMSW but I plan on pursuing it.

I am not working toward and LMSW because it doesn't match my current family dynamics. I am hoping in the future to get my LMSW.

I am not. I do not want to pay for the tuition.

I am not. I got my LBSW in 1988, worked full time as a case manager in child welfare, then went to PRN work when I had twins in 1992. Just returned to full time SW 5 years ago and too close to retirement age to have a desire to go back to school.

**Appendix #4**

I am older and there was not any way to have completed my LMSW but, I did start on it when I lived in Missouri. With kids and husbands, I was not able to work on it. So, I quit and settled with being a LBSW.
I am planning to remain in case management and my LBSW is all I need at the moment!
I chose to obtain my MBA to allow for more opportunities in my career.
I currently have my MSW and am working on LMSW.
I decided I didn't want to complete any further schooling.
I don't want to go to grad school because it's expensive.
I feel like I've achieved a level of income that is already as high or higher than people with MSWs are making. I can't go into debt for a position that wouldn't get me access to positions paying more than what I currently make.
I have a good job with my BSW and I don't want to have a student loan again. It doesn't seem worth the money to get
I have a LNHA license
I have a MSW but that was in 2004. I would like to go for my LMSW, but it may be too complicated after so many years have passed. I am a LMAC
I have a Rehabilitation Counseling certification (RCC) Masters
I have been practicing for 22 years and do not wish to return to school at this point in my life. It is also cost prohibitive for me now.
I have been working 32 years in child welfare. Due to family obligations I am not able to return to school.
I have my MSW but have not passed my exam to get my LMSW
I have no desire to return to school now. I should have continued my education without stopping at my bachelor.
I have worked as a Social Worker since 1990 and do not feel the LMSW will do anything further for my career.
I prefer more day to day client contact. Higher degrees appear more involved with administrative issues like establishing policies, procedures, ect
I would like to enter an advanced standing program soon.
I would like to have the license as I have the MSW. However I took the test twice and didn't pass by 1-2 points. It's the financial costs that prohibits my return but still have my LBSW. Prefer the LMSW though.
I'm too close to retirement
I'm retired
I'm semi retired and work part-time.
It is not cost effective at my age!
It's not required for my position.
I've been graduated from college for over 10 years, I wouldn't have the time to continue working full time on top of taking college courses.
LBSW has been appropriate for our rural hospital.
Life got in the way, family , kids, and now too expensive to go back
Love my bachelor level job

Appendix #4

My LBSW debt is already high, and I need to work for living expenses. The LMSW practicum and education hours would be too much on top of a 40hr paid work week, and with young children.
<b>N/A (3 responses)</b>
<b>No (29 responses)</b>
No - I cannot afford to not work full time & lose insurance. If I could do my practicum at my job I'd go back.
No - I considered, was accepted to a program at KU, yet at the time my employer was not flexible with my hours. As I got older, I was able to get promotions without my Masters. At this time, I'm not sure if it's worth the money due to SW salaries.
No I do not want to provide therapy services and my job does not pay more to have a Masters degree
No I don't need a masters for the company I work for and I do not want to relicense.
No increase in pay to take on school debt. No desire to change positions.
No my job does not require an MSW
No retired
No- school is too expensive. No time to go back
No time available to consider it. Also, in my long-time position, I haven't needed it.
No time for the practicum hours
No worked 23 years in community mental health! Liked supervising case managers. No desire to do therapy
No, too old
NO, ABOUT TO RETIRE
No, but working on LMAC
No, do not have the schooling needed and I'm getting closer to retirement.
No, don't currently live in KS
No, due to chronic health conditions.
No, due to the cost and I do not need a MSW for my employment
No, have my LBSW and a master but never took the MSW exam
No, I am no longer working in the social work profession. I have not for 20 years, & not likely to return.
No, I am not currently pursuing my LMSW. I have spent the majority of my career in senior leadership, management, and supervisory roles within the nonprofit sector. Because of these responsibilities, I do not have the time to return to school or complete a practicum. When I earned my LBSW, the practicum experience felt underwhelming. It added little to what I was already learning through my full-time work in child welfare and felt more like a box to check than a meaningful educational opportunity. The idea of paying to work somewhere for free—especially when the experience may not add real value—is frustrating and impractical for professionals already established in the field. Additionally, there doesn't appear to be a clear financial or career benefit to obtaining an LMSW in my current trajectory. Given the time, cost, and lack of return on investment, it's not a feasible or worthwhile path for me at this point.

#### Appendix #4

No, I am not. It seems the social work field has become captured politically. I've been appalled by the amount of damage done to young people by those in the LCSW field by convincing physically healthy, but mentally unstable young people to do damage to their bodies with hormones & surgeries all in the name of following a lying pedo. I've seen many social workers become violent & brainwashed. It's absolutely frightening. Some even calling for the deaths of Jews & Trump supporters. I care about helping people, but I also believe in reality. I don't want to go back to school so professors can attempt to brainwash me. I've seen what Columbia University School of Social Work has done to young minds. It's sickening.

No, I can not afford to go current and it would be in Georgia

No, I cannot afford to.

No, I do not need an LMSW in my current position.

No, I don't want student loans again or know if I want to get my master's in social work.

No, I have an advanced degree in another field

No, I have found that at my age it does not help to get an LMSW, if I was younger I likely would have pursued this goal. I have been a SW in the field I prefer for over 25 years.

NO, just don't feel the money spent would be worth it at this point in my life.

No, no benefit in current job

No, not interested at this stage of my life.

No, very close to retirement.

No.

No. Cost of furthering education does not result in financial benefit worth the effort. I can do the work I want to do as a social worker with a bachelor's degree.

No. I don't have any plans to leave my job and my job will not increase my pay when I get an LMSW.

No. I don't want to take classes for msw and test for bsw was hard enough.

No. It's not necessary for my career path.

No. Not worth the expense this close to retirement.

No. Can't afford college and there's no program available where I can work full time with school and family

No. Financial costs for college.

No. I am fine with only having an LBSW

No. I am less than 15 years from retirement. Distance to a university with a master's program while raising a family was definitely a deterrent to pursuing an advanced degree. Also, I had a poor research methods instructor during my undergraduate studies and did not feel confident about my pursuing a master's because I lacked the research background.

No. I am mostly retired. Working very part time

No. I am not working in the social work field.

No. I am over 50 and it doesn't make sense to do that

No. I do not think licensure is worth it. It's too expensive and I don't need it for my job.

No. I have had my LBSW for more than 20 years. I do not have the time or the money to go back to school to obtain an LMSW.

Appendix #4

No. I'm happy in my current position & do not want to accumulate debt.
No. It is not required for my current position.
No. It wouldn't make any difference in the pay I receive in my current job/role.
No. Not interested plus I don't want to accrue the debt! If I'm going to pay for a master's, it will be in education.
No; Age
Not yet I just finished getting my LAC license two months ago and my LBSW license the previous year. I am tired of school and studying for licensures plus the fees are not cheap. I need a break from the stress.
Now too old
Open to but not actively pursuing. An advanced degree would not benefit my current position.
Pursuing a graduate degree is not in my family's financial best interest. The debt burden would not be offset by income -- ever.
Retired
The cost to obtain a LMSW.
The ROI is not there.
there was not a public health track back in the late 90's, just clinical
Thinking about it
Too old
Trying to pass the LMSW test but am struggling. Wish that we could take the test at home, and that there was a clear cut program to help study. College education did not prepare me for this test at all.
Trying to study for the exam. It's difficult.
Used to be financial but then became close to retirement and in my organization it doesn't make a difference.
Working for the
<b>Yes (3 responses)</b>
Yes, I am attending West Virginia university for my MSW
Yes, I anticipate setting for the LMSW license eventually. However, my current schedule hasn't afforded me the time to study.
Yes, in school now.

Appendix #5

**LMSW Q6. 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. (801 responses)**

A clinical license is different in Kansas than in the state in which I obtained my MSW. I am not significantly interested in providing therapy and or Serving in private practice

A clinical license is not required for my current role. The cost and time commitments have been a barrier as well.

About to test

Age and plans to move from Kansas

Already have a license

Attempted but was too difficult for states I was not native to

Because of the cost. In order to get the in person hours, I believe that I would have to quit earning income for over 2 years. By then I would be 73.

Beginning process now.

Cannot afford the cost of hiring a private clinical supervisor (have looked into it many times in last 10 years or so) and hard to find time outside work hours to schedule private supervision sessions. Clinical supervision has not been offered at any of my SW work settings (total of 3 employers) since obtaining my LMSW. Super disappointing.

career path took an administrative focus

Change in practice direction and no desire or need to have LSCSW.

clinical supervision costs

completed required hours and studying to take clinical exam this summer.

Content with LMSW

Cost and there being no pay increase in my current position if I did obtain my LSCSW.

Cost and time

Cost of and work involved

Cost of supervision is unattainable for me

Cost too much and the benefit won't pay

current role doesn't allow for enough clinical hours

Current training plan

Currently hold an LMSW.

Currently I am doing volunteer work part time (I'm 64 years old) and in April I was in a serious car accident - I still have months of recovery ahead and the goal of LSCSW is not for me.

Currently living in Colorado, but hope to eventually have LCSW or LSCSW

Currently not working towards it. I just wasn't sure I would enjoy practicing therapy. But I've been doing it for 4 years now and I am considering it. I wish that the time that I have practiced would count towards my LSCSW because I am practicing under someone with LSCSW and have supervision hours.

Currently unsure of the benefits and availability in life schedule.

Currently working on attaining an LSCSW license.

Currently working towards my clinical license.

Difficult to find someone to help obtain hours and too expensive.

Do not need a clinical license to work in a school setting.

Appendix #5

Do not need for my position
Do not want to provide therapy
Don't need it for my job
Due to not being able to obtain supervision hours.
Expense
Expensive, process complicated and hard to balance while already working full time as social worker.
Family life balance, financial, and not needed for my job
Have considered doing this. But somewhat cost preventative
I actually just submitted my clinical supervision plan this month and am waiting to hear back on the decision.
<b>I am (2 responses)</b>
I am 79 and I am slowing down, but I don't want to stop. I love my work.
I am almost 50 years old and I am currently less interested in working one on one with folks, rather I am currently working with 150 folks in housing- the only reason I am in social work. I will need to retire in you early 60s
I am an LCSW in MO..... I do not require a LSCSW for more my job, so have not pursued a KS LSCSW.
I am awaiting clinical supervision at the agency I'm with.
I am but the test is difficult and confusing. Have taken it 3 times now.
I am considering it. However, after being in the practice for 20 years, the hours and licensure feels daunting.
I am currently considering it.
I am currently waiting to get my NPI number so I can get credentialed and start a private practice. I was working at my practicum, but it doesn't seem like they have enough work at the moment to hire me back. I am currently not working, I graduate in May.
I am currently working on remaining hours before taking clinical exam. I would like to teach at the college level and have more options for practice and insurance by getting the clinical license
I am currently working towards an LSCSW license.
I am currently working towards independent clinical licensure in a different state, and am under clinical supervision in that state (Montana) and work for the federal government.
I am done with clinical supervision waiting to take the test
I am going to start this process within the next month!
I am hoping to begin gathering supervisory hours for a clinical license.
I am hoping to pay off my student loans. I don't want to continue this career path p
I am in clinical supervision.
I am interested I just haven't taken any steps at this time. It's not necessary for the position I am in currently.
I am interested in working towards my LSCSW. The barriers have been finding supervision that is affordable and available with me also working a full time job.
I am just beginning to

Appendix #5

<p>I am not currently although I would like to however, I chose to go into leadership positions that make getting direct hours difficult.</p>
<p>I am not currently working toward an LSCSW license as I have had a difficult time identifying a supervisor; however, I am interested in pursuing clinical licensure to advance my professional development.</p>
<p>I am not currently working towards attaining one. However, I may in the future.</p>
<p>I am not in a clinical role I am in an administrative macro role</p>
<p>I am not in a setting that requires an LSCSW as I am not doing therapy. I think the biggest barrier for me is the supervision piece and finding an employer that pays well and still provides supervision.</p>
<p>I am not interested in becoming a clinical social worker. I also have young children that I am prioritizing now and could not dedicate enough hours to work towards my LSCSW.</p>
<p>I am not interested in clinical work.</p>
<p>I am not interested in paying for supervision, taking an additional exam. I'm not a clinical social worker, providing clinical mental health services. I am a social worker who prefers to work in policy and program administration and do not see a direct need for a "clinical" specialty.</p>
<p>I am not pursuing an LSCSW license because it would be too difficult, or maybe not possible, for me to complete at my current job, and would not offer a pay raise. LSCSW is not required for my work.</p>
<p>I am not sure where to try to get clinical hours or clinical supervision. I would like regular part time opportunities while working my current job.</p>
<p>I am not working toward LSCSW as the time and cost is prohibitive for supervision hours.</p>
<p>I am not working toward LSCSW license; I am maxed out on the pay scale, so this license would not increase my salary and I feel my LMSW is sufficient for the duties I perform.</p>
<p>I am not working towards a LSCSW at this time due to ongoing work changes and inability to collect hours with clients at this time.</p>
<p>I am not working towards an LSCSW. I have no interest in pursuing that credential.</p>
<p>I am not working towards an LSCSW. It is due to cost and time. Also, it would increase my pay in my current position and I have no plans to leave my employer.</p>

Appendix #5

I am not working towards any other license. The 3,000 hours of work as a LMSW, needed to obtain my next license wasn't practical for me. When I received my degree, I was 49 years old and I was working as a conductor at the BNSF railroad. I had hoped to become an Employee Assistant counselor for the BNSF railroad when I graduated, but I was told that in 1999, that type of job no longer existed through the Railroad, but it was contracted outside of the railroad. I had only 10 more years left working as a Conductor at the Railroad, and it seemed clear to me that I ought to remain as a conductor, until I could retire from that position with 36.4 years of railroad service. With my LMSW, at 49 years old, had I up and quit the railroad, it could have been a dumb financial move on my part. In 1999, I was over loaded with debt from going to school and quitting the Railroad and becoming an active LMSW, would have cut my income in half. So in a sense it was a sheer matter of finances. But too in 1999, I had invested 29 years at the Railroad. I would get a pension from the Railroad in 2009 when I retired from there. The amount of the railroad pension is based on number of years worked at the railroad. The taking of financial risks to get my degree was extremely stressful, and I wasn't in a financial position nor an emotional position to take on more risks by changing my Careers. My nerves from going to Grad School were frayed. I needed a stable income and an emotionally stable life.

I am not, my job does not require it

I am not. I completed an administrative track during my MSW and am missing clinical classes needed to pursue the next level of licensure.

I am not; primarily wanting to settle into my current role first and trying to find someone to supervise me that will fit my role.

I am pursuing a clinical licensure in Missouri. Once received, I will apply for reciprocity in Kansas.

I am sending off my application to try for my LSCSW again. I have tested twice and then became sick with ESRD requiring dialysis three times per week while maintaining my jobs so I did not pursue the exam directly again. Failing by two points for a magna cum laude graduate was tough for me. I have never failed anything in my life.

I am stuck waiting for supervision. I work for the VA and the VA requires supervision from other VA employees but can't provide one.

I am too lazy

I am trying to find a supervisor to start

I am waiting for my 90 review at work then I can start it

I am working toward the steps to receive my LCSW in the state of Missouri.

I am working towards attaining my LSCSW; I have had to take breaks bc of my disability. However, I started studying and collecting hours working with my supervisor beginning in 2013. We are still in touch and she is extremely happy to continue on my journey.

I am, but I currently live in TX. I left my KS license open in case I need to move back to KS.

Appendix #5

I completed my clinical hours 17 years ago, took the clinical exam twice and didn't pass. I found it too exhausting to continue to study and stress about passing the exam. I have continued to do clinical work all these years, but have not re-entered the process starting clinical hours again or a desire to take the test again to the amount of stress I feel. Historically have not been a good test taker.

I completed my hours and tested but missed by one

I completed my MSW while working in a career. Even after graduating with MSW did not need license but always a goal. Licensure did help open up opportunities I was looking for but I do not wish to ever work in private practice. If a bit younger I would invest the time and effort into LCSW.

I completed the clinical supervision hours I needed, had children and stayed home with them and when I returned to the field I was told in order to sit for the LSCSW exam I would need to return to college and take a pharmaceutical course.

I consider myself a macro social worker. I am interested in a higher licensure but full-time work and family does not allow sufficient time to get direct hours through other means.

I decided not to years ago due to my age and not wanting to spend the time and money.

I decided that I did not need it, as I was not planning on going into private practice or need for employment in senior living.

I did complete the 2 years post graduate and the supervision that is required to get my LSCSW. I took the test 3 times, the first time I missed the score by one point, the second time I scored so low I appeared incompetent and the 3rd time I missed it my one point so I said forget this. That has been 30 years ago I felt that something else should have been done to accommodate me as testing especially using computers was very anxiety driven for me.

I didn't have a supervisor.

I didn't have an interest in providing therapy.

I didn't want to do therapy privately.

I do have an LCSW in MO. Since I no longer practice in KS, I may not get my LSCSW.

I do not desire to go through that process at this time of my career.

I do not feel like right now I have the time or dedication to work towards that license.

I do not need it for my line of work therefore I'm not pursuing it.

I do not plan to do therapy so I never attempted to get clinical license

I do not provide direct services. I chose the "less than five hours" answer on the previous questions since "not applicable" was not given as a choice.

I do not see clients for enough hours per week to accrue sufficient hours in the allotted timeframe.

I do not see the benefit. I do not believe the time and financial commitment it would take to get my LCSW would be reflected in salary. I do not believe my LCSW would be useful in my current role.

I do not want to do therapy for people.

I do not want to do therapy or be a therapist. There is no need for my career goals.

I do not want to do Therapy.

Appendix #5

I do not want to go into private practice. I am a school social worker.
I do not work directly with clients.
I don't currently desire to provide therapy
I don't have a clinical supervisor and can't afford to pay out of pocket
I don't have an interest in private practice so the license is not needed.
I don't have enough face to face hours to make it work. It would take too long.
I don't like how many hours you have to do and taking another test is holding me back
I don't need that credential for my current position and I'm close to retirement.
I don't feel that I want to do psychotherapy
I enjoy my case management role and not trying to do therapy/clinical practice.
I have a LCSW for almost 20 years. I looked into reciprocity some years ago, but the process appeared so confusing. I did ask for clarification and did not receive much help from the BSRB staff.
I have a LCSW license in Missouri
I have always worked in Hospital/Home Health settings and frankly, there is limited access to LSCSW supervision if any at all. Plus the pace of working in healthcare does not allow for the LSCSW to have time to supervise. (also, we do not do mental health work in acute care). Lastly, at age 63, I am winding down, with no expectation to benefit from the LSCSW. :-)
I have an LCSW in MO. I am waiting on the compact to come about so that I may register with multiple states at once.
I have been a CCSW (same as LSCSW) in IN since 1993, but a gap in practice kept me at the LMSW level in KS. I could have re-applied anytime but didn't. However, I may do so next year at my bi-annual renewal since I'm licensed in other states at the advanced level.
I have been approved to take the LSCSW exam, but I have not tested yet.
I have been considering it. Evaluating how I could manage the extra hour with a full time Directors position requiring over 40 hour a week.
I have been with a school district for over 24 years. 20years ago the SW facilitator insisted it was not necessary and I was not convinced the school setting was clinical enough to qualify for a clinical license. Not true anymore. Since then I did start the process...consistent supervision became an issue, along with time and the cost. Now 6years away from retiring I'm am not thinking it is necessary for me.
I have EXTREME test anxiety and have attempted the test EIGHT times...most of these misses have been by less than five points, three less than ONE point.
I have looked at getting my C many times however I do not move forward due to the amount of supervision hours needed and how difficult that would be to obtain in a educational setting.

Appendix #5

I have looked into getting my LCSW license. The reason I have not started filing out my training plan and taking active steps towards this is because my current supervisor will not offer me free supervision so I have to pay out of pocket for supervision hours. These cost of supervision hours I have found is anywhere from \$70-\$200 per hour. I don't make enough to pay for that. I also have heard that if I pursued this higher license that my salary would not increase much at all. It seems the only way I would have a solid return on my investment is if I went into private practice or if I go into management, which not everyone wants to do. Supervision should be offered for free, it is already in other states like NY.

I have my Clinical license in AZ and work for the Federal Government so they accept it. The reciprocal process is not straightforward in KS.

I have my hours and have not passed the Clinical test. I wish there was other options to be grand fathered in I have been a SW since 2006. I have worked in social services for 24 years.

I have my LSCSW in Texas. Kansas did not provide reciprocity when I was interested in practice. Now I've grown concerned about field direction. Went into a field to be accepting, respect and provide dignity. Seems a lot of social workers have taken liberal stance to extreme levels that dilutes our core values. I've also been trained on strength perspective and hand up. Movement has appeared to show more entitlement culture. I'm more teach someone to fish not just provide tem fish. Don't get me wrong disabled, older adults, those with mental illness and situational stressor impact are areas I see value yet have seen shifts in our fields approach. Even ceu programs have some bias and leftists influence.

I have no interest in attaining an LSCSW as I am content in my current position working at an MCO as a supervisor of Care Managers, some of whom are licensed social workers.

I have no interest in getting my clinical license or doing private practice

I have not been but am making a job change out of education and will begin working on LSCSW. When I first moved into education setting (16 years ago) I was told I couldn't work on it while in school setting and that I didn't need it anyways. I regret not doing it back then as I was working on it before moving into education.

I have recently started taking steps to attaining my LSCSW.

I have the hours failed the test by three questions. Never went back. A lot of places of work don't care about a higher license. Honestly I think clinical supervision is pointless

I haven't had the time

I hope to start the process next year. I'm 63 and just received my MSW in 2019. I would like to earn my LSCSW but not sure how it would benefit me in my current position. I would do it to advance my career and skills. I've hesitated due to the time required, cost, and taking another exam.

I just had a baby in October so I haven't finished the paperwork

I just haven't started yet

I looked into it 6 years ago and it was a complicated process. Was going to pursue obtaining in another state but ended up not doing it at all.

Appendix #5

I moved into an administrative role and figured I would never choose to practice independently
I need to find someone to supervise me. My job doesn't have that.
I no longer live in Kansas
I plan to complete my career working on the macro side for a local funder
I plan to retire in a year.
I plan to start my LCSW in the next year
I plan to start this within the next year. I am currently focused on macro work and not getting many direct hours with patients.
I submitted my plan just this month, 20 years after my first LMSW licensure. Cost has been a huge factor for me, paying \$125/supervision session, which occurs every 15 clinical hours has been a huge barrier.
I tried for years in Arizona and I couldn't keep a clinical supervisor for longer than 6 months. They got their license and then they left WYGC for greener pastures. Where I work in KS doesn't offer any more money for higher licensure, and I don't want to be a manager, so it's wasted effort to attempt to obtain one.
I wan 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 want to eventually work towards LSCSW, but the LMSW was very traumatic for me and is off putting.
I want to license in Kansas as an advanced generalist, but Kansas hasn't implemented that ASWB exam even though other states have.
I want to obtain my LSCSW but finding supervision is difficult and as well as having a fitting place to accrue hours.
I want to work towards my LSCSW and am currently thinking about how that could be achieved working in a school setting
I wanted to but too many hours required
I was not interested in working in private practice
I was supposed to take the test then covid hit. I had to wait a long time to take it and developed major test anxiety. I took it once to desensitize myself but didn't pass. Then I studied hard and took it again but didn't pass by 1 point! I then gave up.
I will be 78 years old August 2025
I will be starting steps to obtain in the next year.
I will eventually. Just started using lmsw at new job
I will in the future but don't have the financial resources currently.
I work for an insurance company and do not do direct practice
I work in Hospice and having an LSCSW would not benefit my career.
I would be the only LSCSW and I would be getting all of the Medicare clients, and I don't want that to be my majority of clients.
I would like one but got a new job that doesn't require it and I can't afford to pay for supervision hours

Appendix #5

I would like to be the process seems daunting and expensive. I also do not have a supervisor identified.
I would like to get my LSCSW. I have a lcsw
I would like to start but the hours required needs to be less.
I would like to, but I don't have the money or a supervisor.
I would love to work towards and LSCSW, but struggle doing so in the education setting as I cant diagnose officially
I would love to work towards getting my clinical license. The current opportunity that I have now doesn't allow for that. However, I'm actively trying to pursue joining the Air Force as a clinician to work towards my clinical hours.
I would love to, but I'm having trouble getting connected with a supervisor. I'm also concerned it would be too expensive to pay for supervision on my salary.
I would love to, this is truly my goal; however, financially, I am unable to afford the supervision. I have been practicing social work for 13+ years with the last 5+ years being in direct therapy services (that were billable). I have done both group and individual therapy as well as couples and family. It is discouraging that I am currently, and have been, providing the services but am unable to attain the next level due to the cost.
I would rather work in an educational setting.
I'm getting my LSCSW license in Missouri
I'm making plans to get full clinical in Washington.
I'm not interested in it.
I'm not right now because of the cost behind it.
I'm on the fence. It will require a lot of money for me to obtain (with no pay raise at work for obtaining it) and a lot of time away from my family while completing supervision hours (I can't do them during the work day) for several years.
I'm working towards reciprocity in MO the state I work primarily.
It does not help with my career path.
It feels too hard and unattainable with the supervision hours required.
It is not required for my position.
It is on my mind. Currently I work for Child welfare, but my 'retirement' part time plan would be to work in private practice and it would require obtaining my LSCSW
It is too difficult for me to do in-person hours. I, also, feel as though the number of hours (although recently reduced) is too high for me to attempt to obtain my LSCSW. It's just not feasible.
It was stressful taking the LMSW combined with a license is not required for my job.
it would be difficult to do in my current position, but I have considered it.
It's so extremely costly!
It's very expensive and hard to find supervision.
It's difficult to have a supervisor
It's on pause as I switched mental health providers
I've completed my training plan (several years ago) but never took the test. Covid delayed and then I just never redid the application. I still think about completing the process.

Appendix #5

Job security
Just finished my plan to submit for approval to start. I did not for years because I almost finished in Texas, but lost the supervision hours when we moved and I stayed home for twenty years raising my seven children.
Just passed the LSCSW clinical exam last week!
Lack of opportunity
LSCSW is not necessary for my position.
LSCSW It's not required for my position
Mostly the pay is no different from my LMSW to LSCSW when working for the school district
My age
My current position and organization does not require licensure or provide behavioral health services.
My employer requires one year of service prior to allowing clinical supervision.
My focus is on macro level issues, and I do not wish to provide clinical services.
My masters costs are all I can afford. I have student loans from BSW and MSW
<b>N/A (5 responses)</b>
Newly licensed LMSW I am trying to get some experience first before I do this.
<b>No (89 responses)</b>
No - due to the time commitment as I have young kids. I do not have access to clinical hours working in my current medical setting.
No - I obtained an administrative concentration, so clinical is not an interest to me
No- I was never interested in becoming a therapist.
No - it is not necessary for my work at this time.
No - it's not required and won't change my pay in the school, therefore the cost/benefit isn't there.
No - not required for my manager role. Do not want to do clinical/therapy type work. I work in a hospital.
No I have decided to go into Administration instead of clinical work.
No and daunting test.
No as I have been in management mainly
<b>No desire (2 responses)</b>
No desire to provide therapy
No difficult to find supervisor
No- don't need it to do what I want to do.
No due to my age
No have one in CA
No- I am self-employed as a trauma-informed consultant focused on program administration, not clinical client work, so it doesn't fit for me.
No- I can't find a supervisor and it's not affordable for me currently. Otherwise I would.
No- I did not choose that path -
No- I do not work in a setting where there would be covered supervision.
No interest in clinical practice.

Appendix #5

No- it was too costly and difficult to obtain
No my job will not allow it.
No need for a clinical level license as I provide administrative services
No- not sure how I would access a mentor in my area and within the school district I am part of.
No opportunity for clinical supervision
No since where I work it isn't needed
no time
No, additional cost and difficulty to attain while working my current Job
No, almost ready to retire
No, am able to do what I enjoy and want to with my current license
No, at this moment I do not plan to go into private practice so I do not feel the need.
No, because I am happy to stay in education
No, cost
No, currently am not working.
No, currently not working and it is difficult to find a clinical setting when you are not working
No, do not want to pursue the hours requirement.
No, due to the cost of supervision
No, happy doing what I am doing and clinical licensure is not required
No, have never considered it
No, I am a few months away from retirement.
No, I am currently working as a special education teacher and not a social worker.
No, I am not interested in therapy.
No, I am not pursuing an LSCSW license because it requires too many hours, supervision is difficult to find and afford, I don't want to take another expensive exam, and I have worked in school and medical settings, not as a private therapist, so I have not needed a C.
No, I am not working as a Social Worker now so I don't need my LSCSW
No, I am not. The process to become an LSCSW always seemed too overwhelming and difficult to do while working fulltime (and raising kids).
No, I am too old and will retire soon
No, I do not have the funds to pay for supervision nor do I have time to study for exam
No, I do not plan to obtain my clinical license due to time constraints and also costs.
No, I do not want to pursue a clinical license.
No, I do not want to work with clients. I may later on in my social work career, but currently find my area of interest in policy.
No, I don't need it in my work and I am close to retiring.
No, I don't want my LSCSW.
No, I don't need it for my job, and it won't make me any more money in the future.
No, I don't need it. I don't provide therapy.
No, I don't want to

Appendix #5

No, I don't want to provide therapy services so I feel content as an LMSW at this time. Supervision is costly and there is a lot of preparation for the test that I just don't have the time for right now.
No, I have almost 30 years experience in Health Social Work and case management in a hospital setting. Unfortunately Kansas has no recognized much of that work to be qualified to work towards LSCSW, unlike other states.
No, I have no interest in being a therapist or counselor
No, I have no interest in being an LSCSW.
No, I have tried previously and completed the hours but then was unable to test due to health of myself and then health and then death of spouse.
No, I not sure how to attain a LSCSW, working on different training and I plan to retire in 5 years.
No, I prefer macro practice
No, I started at the beginning of my career, stayed home with my kids for many years, lost all the hours I had accumulated. When I came back 15 years ago, it just felt daunting to start over. And now I'm in the last few years of my active career.
no, I want to, but there is no options in Topeka really. either you have to know someone or get hired and there is only two place fsgc and Valeo
No, I work in a medical setting. That does not qualify for a clinical license in KS
No, I work in a school setting and do not have the ability to work on my clinical license through my current scope of practice. I am also in my late 50s and not sure about obtaining further licensure?
No, I work in a school setting so difficult to get clinical hours.
No, I'm not actively working towards an LSCSW due to difficulties in finding a supervisor in a rural area, obtaining the hours required and supervision required, while maintaining my current position full time.
No, I'm not doing therapy
No, I've decided that I am not interested in providing therapy services at this time. I am happy with my role as a school social worker and find it rewarding.
No, it is a costly endeavor unless a job provides supervision. I also am not interested in providing therapy and many jobs don't offer a significant pay increase if you obtain an LCSW.
No, it is not required in the position that I currently serve in. I did start the process but I was not interested in providing therapy services. I know people that have utilized their LSCSW in other ways outside of doing clinical social work, but the only way to obtain that license is through completing clinical hours.
No, it seems daunting to complete so many hours to obtain LSCSW
No, it's not needed.
No, I've thought about pursuing my LSCSW but I haven't taken the steps to start that process. Factors keeping me from going back to school include the time school requires for classes and study, not having someone in mind to provide supervision, and my age.
No, just wanted my Masters
No, live out of state

Appendix #5

No, money and time
No, my current job doesn't require it
No, my job does not require me to have my clinical license. I would like to pursue it but the cost of paying for supervision since my employment doesn't have one is too expensive.
No, my job is in social services but does not require a license. I have been working here for over 15 years and do not see myself changing jobs
No, no ability to have supervision for clinical hours
No, nor interested in private practice, not needed in current position.
No, not doing clinical therapy work
no, not every SW position offer the opportunity to obtain an LCSW and I love what I'm doing
No, not interested at this time.
No, not interested.
No, not needed for current position and I don't know if my current position qualifies clinically. I may need to review current requirements.
No, not needed for my job and supervision is expensive
No, not needed for the career I have.
No, not sure how to and don't want to take classes. done with schooling
No, primary reason is my age.
No, see my current job role above.
No, taking a break from social work.
No, the cost to pay for supervision and time it would take is not conducive for my family at the time.
No, the expense of supervision and the hours needed wouldn't fit into my budget and work schedule.
No, there is no need at my job. I love my job and it would not advance me in any way.
No, too late in my career to make it work.
No, too much time and money, not currently providing direct care
No, too time consuming.
NO, unsure
No, very happy in my current position
No.
No. I have my clinical license.
No. Happy with position I am currently at. Also with family don't have time to pursue at this time.
No. I decided 25 years ago not to pursue this level as it was too complicated and required too much supervision, which I had to pay for.
No. I have a PhD so the clinical license is not needed for my work.
No. I'm not planning to do therapy. I was a hospital social worker.
No. My current role is mostly administrative and there's very little opportunity to accumulate hours toward a clinical license.
No. The cost of supervision is too high.

Appendix #5

No. Too many direct hours required and I am in a hospice SW position therefore providing no diagnostic services but performing all other aspects
No. Although my degree is in Clinical Social Work, I worked for decades in non-profit, and could not afford self-pay supervision. My work since 2014 has always been low-earning, because it's primarily with people with very limited financial resources. And now in 2025 I am now 70 years old.
No. Concerns regarding field-based stress, case overload, consistent client and agency crises, lack of clinical hiring options to obtain LSCSW, and time/hours needed given my current age of 54.
No. I am 70 now and ready to retire.
No. I am a full-time professor of social work and dedicate a significant portion of my time to teaching, research, and mentoring students. In addition, I am actively involved in community volunteer work. Due to these professional and service commitments, I have chosen not to pursue or maintain the LSCSW at this time, as my focus is on academic and community-based contributions to the field.
No. I am close to retiring.
No. I am not able to gain the appropriate clinical hours from my current position and would have to take on additional work.
No. I am not planning on providing private therapy and am able to work in the schools with an LMSW
No. I am not wanting to practice in a clinical setting.
No. I am not working toward a clinical license, as there is no pathway for clinical or advanced licensure for macro practitioners and educators.
No. I am semi retired and plan to retire in the next couple of years. I do not need my clinical license to meet my professional goals
No. I do Not want to be a therapist
No. I don't feel that I have the resources at this point to pay for supervision. I also don't want to work in private practice at this point. It also doesn't offer more pay in the areas I prefer to work (schools).
No. I don't have a desire to obtain an LSCSW
No. I don't want to do direct practice.
No. I don't work at the micro level.
No. I don't work in a setting that would give me the opportunity to do therapy with patients.
No. I failed the exam twice
No. I have enjoyed being a professional school social worker for almost 20 years now and plan to retire doing this work. I have never had a desire to get my clinical license. That may change over the next few years.
No. I have no desire to do mental health or therapy
No. I have no interest in a talk therapy position.
No. I have no interest in doing therapy in a clinical setting. I also do not want to spend the money or time getting my clinical license.
No. I just haven't had the time to begin the process yet.

Appendix #5

No. I looked into it but I didn't want to be a therapist. I worked as a hospital social worker and it brought no added income or benefit.
No. I plan to retire in 5 or less years
No. I prefer macro social work which doesn't typically require LSCSW license.
No. I prefer not to move into clinical practice, but to remain in mezzo/macro practice.
No. I was fine with my LMSW.
No. I work in a public elementary school and do not have access to social work supervision without paying for it personally. It's too expensive.
No. I work in child welfare and do not wish to pursue an LSCSW Lucero.
No. I would like to but am not sure how to make that possible without changing jobs and working as a therapist. It doesn't make sense financially at this time
No. I'm licensed under the administration path instead of clinical.
No. It is difficult for me to juggle the full time job and income I need and also to find the time and a place to obtain the hours and supervision for an LSCSW.
No. It is not necessary for my job.
No. It is too expensive when you work in the educational setting.
No. It is too expensive to get and my job does not offer that as part of my employment.
No. Many years ago, I was working on the clinical license. I had 88 weeks of supervision with 12 left and I left that job. When I was ready to pick it back up, the rules had changed and I was told that my previous hours wouldn't count and I'd have to start over. As an educator, I would have been able to work in a MH setting for 12 weeks over the summer to finish up, but I was not in a position where I could start over from zero. I have felt frustrated about that ever since.
No. My goal isn't to become a therapist; I'm fine doing what I do now (and have been for years). Unless being a therapist IS the goal, going through all the time and work to obtain a clinical license just isn't worth it.
No. My job does not require an LSCSW license and does not provide any additional benefits for obtaining it.
No. My job responsibilities do not require it and I am not interested in the clinical side of social work.
No. My plan changed upon raising a child with SPMI.
No. No interest in private practice
No. Not available to me at my workplace.
No. Not interested in therapy.
No. Not interested.
No. Not providing direct services.
No. Other states recognize my clinical licensure, and because I have been in leadership roles for nearly 25 years, it makes no sense for me to backtrack to go through the extensive process to obtain LSCSW in KS. I tried to when I moved from NY to the KC metro in 2006 and my clinical license was not recognized for reciprocity purposes largely because I was supervised by a Ph.D. clinical psychologist for 6 years which did not count. Very silly rules.
No. Retired.

Appendix #5

No. Sitting in an office all day, as a therapist would, is not the ideal working environment for me.
No. The process was difficult to get approved since I work in a school setting. I hit roadblocks on my application left and right because at the time the person didn't think schools provided enough opportunities then finally got approved but quit working on it because I felt I was under a microscope and my plan was overly criticized.
No. The required hours and a full time position is not feasible at this time.
No. Though I've been a social worker for 20 years and have done direct patient work as medical SW and hospice SW, BSRB and regulations will not allow me to apply for LSCSW because my practicum 20 years ago was not clinical. I would love to see this change due to my 20 years of experience in a LMSW role.
No. Too many hours for the practicum
No. Working in school social work, it would take years and years to get enough hours. Additionally, the supervision aspect of it would be hard to maintain.
No; I am moving out of state soon
No; I don't provide clinical services--and never have.
No; I work in crisis mental health, and do not have extended, routine contact with clients - I would not be able to capture the required hours in the set time frame.
No-I had previously thought about it but I would struggle to meet hours in current work position and trying to find someone to supervise has been difficult
Not able to find someone to supervise in my area and financially was taxing to pay a person to supervise.
not affordable
Not applicable to my current job.
Not at the moment but I've been looking into pursuing an LSCSW.
Not at the moment but would like to. I need to find a supervisor and come up with a plan. And figure out financial cost.
not at this time but I am looking into taking steps to achieve my llcsw right now I'm working in a school setting and my masters is what I need but I am looking forward to advance in my career I just was in school for such a long time 7 years straight before I earned my lmsw and the next thing is the price of supervision I am currently in the process of maybe working on my doctorate but I wish Kansas would have a doctorate and social work like at Washburn University where they focus on therapy
not at this time, I am ready to retire
Not at this time. A LSCSW is not required for my position.
Not currently as I am working on my DSW, but plan to pursue this in the coming months either in Kansas or Missouri (I work in Missouri).
Not currently interested in an area that requires it.
Not currently- partly due to the expense of supervision.
Not currently working towards this due to my work position right now. I am not able to because of a conflict.
Not currently. I do hope to but I'm a veterinary social worker and aid have to take on an additional job to meet the requirements for some aspects of the LSCSW requirements.

Appendix #5

Not currently. It's too expensive to pay for clinical hours and take the exam while working full time in the education setting. I'd have to do clinical hours outside of my full time job and pay someone for supervision which is too expensive
Not interested at this time.
Not interested in diagnostic or therapy work.
Not interested in doing so. Am satisfied with the flexibility of the LMSW.
Not interested in providing therapy
Not interested or necessary for my work in BIP. I do not want to pursue leadership/authority positions
Not necessary for education jobs
Not necessary for the medical SW I prefer doing
Not needed for the practice I'm doing and cost
Not practicing therapy
Not required, nor financially supported by my employer, no extra income for obtaining certification.
Not sure if I want to do therapy.
Not sure on the steps to obtain.
Not yet- started it years ago and will need to start over
Not yet, but hope to do so in the next 2 years.
Not yet, but I plan to do so...
Not yet, finding the time and supervisor can be difficult.
Not yet, I will be!
Not yet, too much required to obtain.
Not yet. I plan on pursuing it in the future. I am not sure of all the requirements and I don't know how to find a supervisor.
Not yet. I will be.
Not yet. Will be soon.
Not yet; no place in my town has supervision or options for this as I'm fairly rural so would have to drive 20-30 minutes away. Working full time, having young kids, keeping up on housework-it is too much to add any extra time plus studying for the test. I do plan on getting LSCSW when the kids are older and I have more time (also plan on staying at home within 6-12 months for 3-5 years for a break from work and to enjoy time with the kids while they are young and finally get caught up on never-ending housework/home projects)
No-too rigorous with current work standards and no additional pay opportunities
O
Obtaining a clinical license in Kansas is very difficult. I choose to get a dual license.
On the fence about starting the process.
Over the 20 years since I have been an LMSW the positions where I could possibly accumulate clinical hours and receive supervision were few and far between. When I looked into various arrangements to receive clinical supervision, they were cost prohibitive. I haven't ruled out getting my license, but it almost feels like it's unattainable.
Physical health issues

Appendix #5

Professional life is too far beyond this pursuit.
Reciprocity
Retired.
Retiring
Scheduled to test August 2025
Semi-retired; not able to accumulate sufficient supervision hours.
Still Thinking about it.
Busy life right now. Maybe in a few years.
take my LSCSW test on 7/17/2025 with hopes to pass and have active licensure
Test too hard, too many hours
The company I work with will not approve the supervision.
<b>The cost (2 responses)</b>
The cost for supervision is too high
This year, I discontinued my pursuit of the LSCSW credential. At 53 years old, I plan to retire within the next five years, and my current payers, KanCare/Kansas Medicaid, grant-funded programs, and Blue Cross & Blue Shield of Kansas, accept billing under my existing LMSW license with appropriate supervision. Given this limited timeframe, the substantial commitment of additional supervised hours, exam preparation, and licensure fees required for the LSCSW would not yield a meaningful return before my retirement.
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.
To many hours to complete since I am not working full time.
Too close to retirement
Too costly and time consuming at this stage in my life.
Too expensive and not the direction my career went.
Too expensive, do want to provide therapy services
Too long of a time commitment when I'm not sure what my next couple years will look like. I do not want to start the program and not be able to finish it. If there was a more obtainable way to receive this licensure, I would absolutely be working towards it.
Too many hours and not interested
Unable to find an affordable supervision clinician
Want to very badly, but having difficulty finding a supervisor in my area! Recommendations?!?
Want to work to my LSCSW but the requirements are prohibitive and details around what can be counted towards hours are obscure to me
Was not reciprocal when I initially received my license.
Was not required for the type of social work practice I was involved in.
When I transferred my LCSW from CO to MO and KS I was denied my LSCSW because I didn't qualify in KS. I just never changed my designation even though I'm qualified because I don't work as a therapist, but another position where a social work license is required-hospital or organ procurement organizations.

Appendix #5

Working in an educational setting is difficult to accrue the necessary hours and I am reluctant to pay out of pocket for the supervision, plus I don't think my job would pay me more for having it.
Working on clinical License in MO as this is my primary work setting but will be pursuing KS clinical license immediately after.
Working on clinical license in WI. I have relocated.
Working on it in Missouri but will apply for reciprocity in KS.
Working on LCSW in Missouri
Working through the process to start
Working toward LSCSW license
Working towards LCSW in MO
Would love to but the cost and I don't know how to do so.
Would love to work towards this but paying for supervision isn't an option at this time.
<b>Yes (192 responses)</b>
Yes - but I wasn't when I was solely a school social worker; since I have a private therapy practice, I am now pursuing LSCSW
<b>Yes I am (3 responses)</b>
Yes I am actively working on this and should complete it in May and then be ready to test.
Yes I am working toward LSCSW license in KS
Yes I am.
Yes I am. I have tested 4 times for the clinical license. I still want to test again but I'm scared.
Yes I am. I only have to take my licensure exam now.
Yes I have completed all my hours and am taking the required psychopathology course.
Yes I'm in supervision.
Yes seeking reciprocity
Yes working towards LSCSW
Yes working towards my clinical.
Yes!
Yes! Just completed with my hours and hope to wrap up application and take test ASAP!
Yes, actively working. I feel it is a competitive way to keep our profession valuable.
Yes, because it will allow me to advance in my current role and provide more opportunities
Yes, better opportunities
Yes, but I may change my mind in the next year if I can not pass the exam. I have tried a couple of times now. It is time consuming, stressful and expensive.
Yes, but in the beginning stages.
Yes, currently in clinical supervision
Yes, currently under supervision now for LSCSW.
yes, currently working toward clinical.

Appendix #5

Yes, hopefully will be able to sit for my exam early 2026
Yes, I actually completed my hours years ago and decided after the pandemic that there is a great need for experienced social workers to provide mental health services to youth and families. I believe that I can provide those services for individuals and families.
Yes, I am
Yes, I am actively obtaining hours towards the license at this time.
Yes, I am currently working toward my LSCSW.
Yes, I am currently working towards attaining an LSCSW
Yes, I am in the process of studying for the exam.
Yes, I am taking the test for the 4th time.
Yes, I am working on my LSCSW.
yes, I am working toward clinical licensure
Yes, I am working towards obtaining my LSCSW
<b>Yes, I am (3 responses)</b>
Yes, I have about 500 hours left but had to put it on pause due to life circumstances.
Yes, I made that decision to provide better pay and to allow myself more freedom when doing private practice.
Yes, I'm currently working towards my LSCSW in Kansas.
Yes, in process
Yes, MO
Yes, working toward LSCSW.
Yes, working towards attaining and LSCSW
Yes, working towards LSCSW
Yes. My goal has always been to advocate for mental health services and shame free treatment.
Yes. Working on my plan now
Yes. Completed hours, just need to take exam.
Yes. Currently working towards LSCSW.
Yes. I am working towards my LSCSW.
yes. I want to work independently of supervision and accept more insurances.
Yes. Just completed my supervision plan and submitted my application.
Yes. Just need to sit for exam. Have all supervision hours.
Yes. Just sitting to test.
Yes. More pay and less supervision. more job opportunities.
Yes. To make more money and practice independently

**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

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.

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 CEU tracking -Easier way to sync multiple licenses that use similar CEUs. Which alcoholic
Telework ethics
Telehealth and texting

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

<p>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.</p>
<p>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.</p>
<p>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.</p>
<p><b>Autism (2 responses)</b></p>
<p>Balancing financial crisis in current economy while also providing quality service.</p>
<p>Behaviors/ ODD strategies</p>
<p>Being trauma informed with practitioners working in the foster care system, like not understanding the impacts of decisions on children's long-term outcomes.</p>
<p>Being able to work across state-lines. Esp. here near MO/KS.</p>
<p>Benefits and risks of AI, Addressing political based mental health issues</p>
<p>Better leadership</p>
<p>Boundaries</p>
<p>boundaries &amp; presenting professionally</p>
<p>Boundaries and appropriate interactions with clients. Ethical issues &amp; the need for ongoing consultation and supervision by practicing social workers.</p>
<p>Boundaries and ethics</p>
<p>Boundaries with clients.</p>
<p>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.</p>
<p>Burn out in social workers</p>
<p>Can't think of anything</p>
<p>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.</p>
<p>CEUs on note taking, documentation, court reports, etc.</p>
<p>CEUs that actually give thorough information for diagnoses - not just one diagnosis.</p>
<p>Ceus on safety should be required across the board.</p>
<p>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.</p>

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

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.

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.

<p>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.</p> <p>I think it might also be good to offer something on how to navigate insurance requirements.</p>
<p>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.</p>
<p>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.</p>
<p>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."</p>
<p>I believe the decrease in msw practicum hours has lead to less prepared new grads in the work force.</p>
<p>I believe there needs to be more training in management and public policy</p>
<p>I can not think of any.</p>
<p>I cannot recall any specific instances within the last two years.</p>
<p>I could</p>
<p>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.</p>
<p>I feel it should be more affordable considering we don't make a lot of money!</p>
<p>I feel like the providers I work alongside are seeking out CEU's and webinars to better understand the changes of our field</p>
<p>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.</p>
<p>I feel like there is a shortage in social workers and the requirements needed to get a C is unobtainable in some cases.</p>
<p>I feel most of the areas of concern are surrounding boundaries</p>
<p>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.</p>
<p>I feel that too many practitioners do not have heart for social justice, and only care about what some random man in camo says.</p>
<p>I feel the profession is growing and that is a plus.</p>
<p>I feel we have way too much training by way of CEU's and the number of them .</p>

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.

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

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.

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.

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

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. 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

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.

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..

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 LCSW 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

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.

<p>Practicum supervisors needing background checks and more training in ethics. Likely, an interview process for pairing supervisors with student interns.</p>
<p>Practitioners could benefit from additional training in Documentation.</p>
<p>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 &amp; therapy services. I would also say practitioners need guidance on changes with gender affirming care and risk/legal guidance.</p>
<p>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.</p>
<p>Practitioners in child welfare and mental health</p>
<p>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.</p>
<p>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.</p>
<p>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.</p>
<p>Prenatal alcohol exposure and its impacts, research and its impact on the profession</p>
<p>Probably not</p>
<p>Probably Telehealth.</p>
<p>Professional ethics</p>
<p>Professionalism and understanding...working by the code of ethics. Also...dealing with their own personal mental health issues.</p>
<p>Projection, lack of self-care emotionally and physically, Transference</p>
<p>Providing and receiving supervision</p>
<p>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.</p>

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

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.

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 more harm than good.
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

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 Suicide and self harm awareness Competent advocacy/leading clients toward success

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.

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 line 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

<p>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.</p>
<p>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</p>
<p>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</p>
<p>As a social work educator, I continue to be concerned about levels of professionalism especially in areas of communication, confidentiality, and critical thinking.</p>
<p>Assessment. The basics. New social workers need more OJT then ever in my over 20 years of practice.</p>
<p>Assistance in accurately keeping up with changing terminology and jargon. Assistance with Meta, Chat GTP and the benefits and warnings with Mental Health Apps.</p>
<p>Autism support in the community, diagnosing and treatment specifically of youth and older adults.</p>
<p>Autism-more education needed</p>
<p>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!</p>
<p>Basic rapport building &amp; writing.</p>
<p>Basic social work professionalism. Obligations to report other social work to protect the profession.</p>

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

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 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>

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

-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.

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.

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.

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.

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 Currently, I supervise social workers for clinical license in Kansas in 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.

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.

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.

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

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

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.

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.

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?

<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>

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).

### **Supervision (2 responses)**

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

### **Telehealth (2 responses)**

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

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.
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.
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.
There is a great need for cultural competency. Many social workers do not speak another language and are not culturally knowledgeable.
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.
There is a need for better education around healthcare compliance in commercial and government plans.
There is a need for more trainings on appropriate and updated language (suicide, diagnoses, LGBTQ).
There is an immediate need for national licensure.
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.
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.
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.
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.
There's always room for more training on substance abuse diagnosis and treatment
These new social workers are a joke. Teach them how to be social workers, please.
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.

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.

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.

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

<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.

DRAFT

**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)**

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.

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

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.

I have been made aware of practitioners providing telehealth services while driving or on the phone while walking through public spaces.

I have conducted telehealth sessions over the past 2 years. More training about how to conduct telehealth sessions would be helpful.

I have coordinated training on the topic of telehealth ethics. I have received telehealth services myself. I haven't seen inappropriate use of telehealth.

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.

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.

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.

I have no provided telehealth except during covid and with dangerous winter weather conditions.

I have not been involved in telehealth.

I have not experienced this issue

I have not had an issues concerning Telehealth.

I have not personally dealt with this concern

I have not seen any issues. I do not use it at all.

I have not used telehealth in the past two years.

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.

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.

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.

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.

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.

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

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.
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

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.

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)**

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.

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.

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 I 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.

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.

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. 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

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

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.

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.

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

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.

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.

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

<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

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.

DRAFT

<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 LCSWs and even less who are willing to give supervision
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 LCSW
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 LCSW 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.

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.

<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.

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.

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.

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? 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.

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

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.

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

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.

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.

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.

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

<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)**

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.

**N/A (7 responses)**

NA, but no I would not!

**No (101 responses)**

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

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.

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.

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.

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

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

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.

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

<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

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 .

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

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.

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

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 were 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

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

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

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

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

**LBSW Q13. Based on your experience as a licensee in Kansas, do you have any recommendations on additional ways the BSRB could protect and serve consumers of services offered by BSRB licensees? (117 responses)**

A better way to audit someone's CEU's. Most things are online now and having to print and submit reading materials for an audit seems outdated, gets costly and is a waste of paper.

Advocate for social service positions be required to be licensed, not just a degree in a related field so there is an accountability to an entity such as the BSRB.

Allow LBSWs to grandfather in to job positions that require a master's degree by the years they have been a SW and if they have a good job record .

Based on my experience, I recommend the BSRB provide more education for consumers on what ethical services should look like, strengthen oversight for boundary violations, and offer clearer pathways for clients to report concerns safely and anonymously.

Clear way to understand self-reporting for CEUs when needed for a license

Constant education. The world is ever changing and evolving. We are ill prepared for the state of affairs that this world is currently in.

Don't require an exam for LBSW, loosen training requirements for LBSW. Those should be for clinical licenses.

Drop in visits to agencies.

How BSRB support LBSW care managers in the field

I am not sure how to answer this question. I feel the website could be a little more user friendly. There's almost too much information and it's overwhelming. My greatest fear was making an honest mistake paying a non-refundable fee and needing to fix it.

**I do not (2 responses)**

I think having CEU requirements should continue but you need to accept Non SW topics. For example I work in a hospital and need to keep up on Medicare and Medicaid regulations. I have had these ceus questioned as valid for my license in the past.

I think it would be nice to have a "mentor" or "friend" your first two years of licensure so you can have some to ask questions to that isn't necessarily your supervisor.

I think we need to develop another credential for persons who work on child welfare that are unable to obtain a license due to degrees in nonlicensable fields of study

In years past the SW students graduating were unable to pass the SW License test

It would be great to have a database or running list of high quality CEU's which all licensees could access. This would help consumers if the CEU's were relevant to the needs of Kansans.

It would be incredibly valuable if individuals could apply their work experience toward college credit or professional certifications. Recognizing real-world experience in this way would make education and career advancement more accessible and equitable.
It would be nice for the BSRB to share ways that Social Workers can advocate to government entities that make decisions about social issues.
Just understanding that the expectations on workers is very high and the state jobs are very stressful
Less paperwork and red tape so social work could actually be practiced. When I stopped working there was so much paperwork you had little time to devote to clients
Lessen the number of hours expected to remain licensed in Kansas. Instead of 40 every two years PLEASE consider reducing to 30 every two years.
lower the 40 hours every 2 years. When the agency you work for won't pay for CEU's and your income is way below other disciplines its hard to get CEU"s as you can't pay for them so you look for free CEU's
Make licensing cost less money and have significantly less fees
Make the renewal link more user friendly. I completed it but it wasn't received by the BSRB so my license expired
Mandatory internships and training for certain professions in the field with direct exp and training
More in person conferences
More website friendly with resources
<b>N/A (7 responses)</b>
<b>No (53 responses)</b>
No recommendations at this time
<b>None (6 responses)</b>
None at this time
None identified
Nope, no recommendations.
Not anymore than is already in place
Not at the moment
<b>Not at this time (2 responses)</b>
Not currently
Not right off
Offer more free CEU events/trainings.
Offer paid internships and require a variety of internship experiences so students can better figure out the area(s) they are most interested in or best suited for. Allow Associate degree holders to work entry level positions.
Offering more CEU opportunities in the above competencies .
Provide more financial support for the exam and funding for practicums.

Require all social workers to undergo regular background checks to ensure they have no history of misconduct or criminal activity. This can help maintain the integrity of the profession and protect consumers. Launch public awareness campaigns to educate consumers about their rights, the role of social workers, and how to seek help or file complaints. This can empower consumers to make informed decisions and feel more confident in the services they receive. Mandate cultural competence training for all social workers to ensure they are sensitive to the diverse needs of the populations they serve. This training should cover topics such as implicit bias, cultural humility, and working with specific cultural groups. Require additional training in mental health and trauma-informed care to help social workers better understand and address the complex needs of their clients. This can include recognizing signs of trauma, implementing trauma-sensitive practices, and understanding the impact of trauma on behavior and mental health. Provide resources and support for social workers to manage burnout and maintain their well-being. This can include access to mental health services, self-care training, and opportunities for peer support and supervision.

See above!

There has been a lot of media regarding lowering the standards for social workers and even discussion about whether social workers need a license. I do not believe that deregulating social workers would benefit the vulnerable populations we serve.

Title protection for social workers

Trainings/educations on confidentiality, HIPAA, and autonomy. I work in a long term care setting.

**Unsure (2 responses)**

Unsure at this time.

Yes, unlicensed professionals in the field of employment dealing with customer services should also need to meet the same standard of service.

**LMSW Q13. Based on your experience as a licensee in Kansas, do you have any recommendations on additional ways the BSRB could protect and serve consumers of services offered by BSRB licensees? (596 responses)**

1) Require a meaningful amount of training per renewal cycle about reducing suicide risk, with training that includes experiential practice and supervision, so that treatment behaviors change

2) Formally recognize Clinical Social Work degrees, and work experience that required mental health support, that does not require diagnosis

1. Enhance Public Education on Licensed Services. Many consumers are unaware of the differences between licensed providers and unregulated services. The BSRB could expand public outreach efforts to clarify what licensure means, the types of services consumers can expect, and how to verify credentials. 2. Acknowledge the Impact of the Political Environment on Access to Care

The political landscape—particularly decisions related to Medicaid expansion, workforce funding, and behavioral health policy—has a direct and profound impact on access to services for vulnerable Kansans. The BSRB can serve as a steady voice emphasizing the importance of professional licensure and consumer protections amidst shifting political priorities. Advocacy for stable, consistent policy support at the state level is critical to ensuring continuity and quality in mental health and addiction services. I appreciate the BSRB's dedication to both licensee accountability and consumer safety, and I welcome any future opportunities to support these efforts.

A strong presence in legislative bills introduce that conflict with social work ethics/values

Actually rescinding licenses for serious ethical violations

Add an advanced license level for macro social workers to help protect and make sustainable the organizations that social workers lead.

Additional required retesting for licensure renewal may be a way to ensure social workers are ready to best serve their clients. Perhaps every 10 years or so.

Additional supervision for LMSW candidates getting their LSCSW. It seems there are many LSCSW that are practicing without the needed expertise.

Advocate for better supervision in rural areas and better education in schools about what social workers do.

Advocate for higher pay and lower caseloads. Also community education on what social workers do. The majority of the American public only knows social workers as "those people who take kids away".

advocate for higher wages due to the nature of our jobs

Advocate for newly licensed social workers to begin clinical supervision as soon as possible.

Advocate for practice and policy change that help providers take care of themselves

Advocate for relevant social issues in KS (expanding Medicaid, right to choose, transgender rights, etc.)
Advocate hard for Medicaid expansion so people can be served. Advocate for all insurances to work with all licenses
Advocating for increased pay for licensees.
Allow exceptions for federal employees to work towards independent licensure under supervision while working outside of the state, for example employees working for the VA who hold LMSW in the state of Kansas using the same supervision plan they would if instate and allow the supervisor to apply for a temporary Kansas LCSW.
Allow in home testing for clinical.
Allow longstanding LMSW's with 20+ years of practice to sit for the LSCSW exam w/o supervision
Allow other states to easily get dual licenses because there aren't enough.
Apply for additional grants to support our role, we need higher pay, more PTO, and better benefits.
As stated above, it would be nice to have more direct contact with our school districts and the BSRB for more understanding of our role and having more therapeutic support.
Assisting school social workers become valued and have a voice. I'm leaving the school setting as are many others due to the inability to ethically complete our jobs and serve students well.
Be more friendly on licensure for those who have worked in specific area for a long time. Bring back grandfathering in process.
Being a military state, maybe get more aquatinted with out of state schools and requirements.
Being able to send out a CEU bulletin or a newsletter with CEU options for licensees to get a well rounded experiences. Think being able to provide education to general public about how to report, or even that purpose of having licensees and protection.
Better communication and check in with supervisors.
Bring back the 6 CEUs for diagnosis and treatment.
BSRB could offer profession-specific CEUs on ethics or BSRB specific areas Guidelines on use of AI and online profiles when professionals are specifically presenting as professionals online and posting content about diagnoses, treatment, modalities, etc.
BSRB making distinctions between professionals vs. non professionals working in child welfare. People commonly believe child welfare workers is the same as a social worker so when there are laws these workers break or unethical decisions it is associated with 'all social workers' do that.

Child Welfare certification would allow the public to hold non-licensed professionals accountable.
Child welfare workers need to be licensed social workers and need more education and training in the areas of
Clean website with information sectioned by usage/need
Computer training and employment assistance
Continue broadcasting board and advisory committee meetings on YouTube.
Continue to add service locations Continue improving services Build more resources for those who can't afford services
Continue to move forward with interstate compact licensure.
Continue to require licenses at the BSW, MSW and Clinical level to provide services. The licensure helps keep the quality of professional services up to minimal quality of standard.
Continue to speak out on how our ethical standards approach the things currently going on in the world and how we as social workers are guided to act.
Continue to support/encourage use of telehealth services to continue to remove barriers and help consumers receive the services they so greatly need.
Continued education for above standard practices and community education on professional social work services
Continuing to support and advocate for consumers and providers, we're all in this together.
Costs related to offering CEUs can be prohibitive. I work with agencies serving the homeless population and would love to offer low-cost CEUs but it's hard to make the math work
Could have case managers and clinicians trained on how to use a glucometer
Courses around supervision of others Courses around telehealth
Create a plan to make it easier for people of color and with lived experience to obtain the degree and subsequent credentialing to become clinicians
Creating an organized supervisee hours log for those tracking for their LSCSW. Streamlining and organizing the applications for taking the tests.
Cultural humility CEUs Patient centered care CEUs
Don't think so
Don't use a biased licensing exam
Educate other state agencies that utilize social workers like KSDE, so that they are more aware of social work roles.
Email the monthly online committee schedule or topics ahead of time. I'd love to learn more had I known it was happening. Will look for it going forward.
Encourage offering of more free trainings

Encourage persons to make reports based upon on "actuality" and not "frivolous" circumstances. And be fair to social workers in any investigations.
ethics training; consequences of ethical violations
Even as an LMSW myself in private practice, I question whether LMSWs should be allowed to practice independently in private practice. Thankfully I was able to do my practicum in PP, had a lot of prior experience to grad school as a later in life student, but so many brand new therapists are out here unregulated for the most part, and potentially doing unintentional harm.
Exam practice
Face to face is best no matter where
fight against the current administrations that is limiting or criminalizing access for LGBTQ+ folks.
Finalize compact agreements to license in neighboring states.
Financial options and options of licensure (LCSW) for low income social workers.
Fix the broken system. State Hospital situation sucks. Voluntary hospitalization is an ineffective joke.
Friendlier customer service at KSRB.
Give licensees more opportunities for free supervision through grants.
Given how low-effort CARF's inspections are, I find myself in the terrible position of recommending the JCAHO standards. I hate JCAHO, but a lot of what is acceptable under CARF would never fly with JCAHO.
Guidance on AI use as it will always be present
Have a way for consumers to verify a provider's experience or expertise with a modality. For example, a freshly licensed provider who says they have experience with several modalities and populations. I feel like there could be a set time providers have to wait prior to beginning their clinical training plan or obtaining their clinical license. For example, can't begin a plan until they are practicing for at least one year, two years, etc.
Have an ongoing list of accepted CEUs that is able to be located directly on the BSRB website
Having a bigger presence.
Help people such as myself find part time jobs as an LMSW. They don't seem to be available in my expertise as an LMSW that specializes in Alcohol and drug abuse.
Help with passing the social work license
Hold universities accountable that continue with issues of harassment, discrimination, retaliation; ensure students are actually being taught appropriate skills; etc.
hoping to get their license quicker
I am not familiar enough with current practices of BSRB other than licensing to speak to that question.

I appreciate the current licensing requirements in Kansas and hope they remain in place. On the Missouri side it is much easier to work as a "social worker" without being licensed and this has always concerned me.
I believe lowering the expectations for licensure could negatively impact social work. It lowers standards, which lowers quality of care of our clients.
I believe that BRSB is doing a good job.
I believe that it is not enough to addend the classes and turn in the number of hours completed. It could be required for the licensee to write answers to some questions about ethics, experiences that they have had with person-centered care, and about outcomes from the service they provide. This may not make a big difference, but one in two year, they would have to take a look at their practice and evaluate it. Maybe requirement of 2 hour CEUS of self-evaluation and examining their connection with their clients would be a good thing.
I believe that with the interstate compact coming everyone will then have to be finger printed. This will add another layer of protection. Oklahoma has required fingerprinting for years. When I got my license in OK. 4 years ago I had to be finger printed by an agency there that was connected to the state. I let my OK license lapse this year , due to the Interstate compact coming soon and I had not been using it.
I can not think of anything. The board has always done a great job protecting us as well as providing us opportunities.
I can't think of anything at this time.
I do have concern about the randomness of auditing at time of relicensure. I have been 'randomly' audited 4 xs with no concerns in the past 15 yrs. These seems beyond a random audit.
I do not
I do not agree with the recent change that fewer CEUs should be for treatment/diagnosis. I am not sure what other types of continuing education could possibly be helpful for anyone. Even in non-clinical roles, this type of education is foundational to effective collaboration and the best outcomes for every type of consumer we serve.
I do t think so
I do wish at times we could report other providers. Thankfully in my current job I haven't had this concern, but at my last one I certainly had concerns for the clients of one of my coworkers.
I don't know if this is available because I haven't looked into it. Once I have my LSCSW I would be very interested in attending some type of training or conference on the steps of having your own practice and real life stories from people's experiences so I can see the full picture and understand insurances or other things needed to be successful and have a good business and practice model.

I don't have any comments in this area.
I don't have any ideas at this time.
I don't really have any idea at the moment.
I don't think that hours and requirements should be reduced anymore for practicums, clinical licensure, etc.
I feel that there are a lot of barriers to obtaining social work licensure that do not positively impact social work practice. I understand that it's necessary to monitor who receives a license, but I feel the wrong things are focused on at times. I feel like character and quality of practice are more important than how many hours someone has (while respecting that experience is extremely important).
I feel the BSR B. could encourage educational institutions to help students understand the importance of keeping biases and political ideologies out of practice.
I have concerns that in recent years educational, CEU, and practicum hours have been reduced. It feels like a dumbing down of the profession. I have concern that unqualified social workers will get through to licensure. I am seeing graduates from Kansas City colleges who lack basic assessment and documentation skills. Neither one of them has been able to pass a licensure exam after taking them several times.
I have seen individuals that have identified as "conversationalists" and are essentially running their own private practice without education or governing statutes; to me, this is extremely frustrating as I am unable to with the appropriate education and experience.
I have way too many concerns about individuals working in corporations or for the state re: child welfare. The range of poor expertise or outright incompetence is angering. I served as a Guardian Ad Litem in NC for years. Coming to see how my social work colleagues, or persons with whatever degree they might have working in child welfare for KS was an alarming experience.
I like the CEU counter connected to the BSRB. I wish I could enter classes I take to keep track digitally without a subscription fee.
I personally think there should be better vetting of those pursuing a social work degree. It's unfortunate the amount of unethical people hold licenses and have their own personal struggles that negatively impact their clients and coworkers
I think focusing more on burnout and possibly implementing policies that would help the counselors. I have been in the mental health field for 4 years and that is the number one reason why people quit
I think having more networking events would be great and or free or low cost CEUs.
I think it is INCREDIBLY important that telehealth services be covered by insurance (including Medicaid) in order to reduce barriers for individuals seeking mental health services

<p>I think it would be in the best interest of the state of KS and the BSRB to make the licensing process less cost prohibitive. People will not want to stay in the field or advance if they are not going to be compensated appropriately/accordingly for the level of education and training they have obtained. There are many jobs that do not require masters degrees that pay more than some of the social worker jobs I have seen. There are social work roles that require a masters degree that pay close to the poverty line. No one wants to work for poverty wages after they obtained a masters degree. They want to be able to support themselves and do work for the community. But if they have to choose they are going to support themselves and their families first.</p>
<p>I think that the "C" needs less focus, as blue cross, blue shield allows LMSWs to practice...as a 8 year vet, I feel comfortable doing anything, especially with the amount of training we get with the certifications. Being certified should be the new standard to keep up the demand.</p>
<p>I think the BSRB and social workers can benefit from open communication with young social workers, because providing services and not knowing Licensure expectations can take a toll on clinicians and effect the services they provide.</p>
<p>I think there needs to be more accountability for mental health centers to provide every service their client needs.</p>
<p>I was highly frustrated by my college in moving people forward through the program who were not healthy enough for the role. I did not seem them seeking out, feeding into, or supporting those persons as I would think SW professionals would do. Not sure how the BSRB would combat that.</p>
<p>I wish I could count more continue education hours I get through the educational system.</p>
<p>I wish there was a universal license. I work so close to the state line I will always need to file for reciprocity.</p>
<p>I wish there was more value in the time we have spent in the profession when considering LCSW. I know other states consider this.</p>
<p>I would advocate for regional panels with a solid cross representation of all social workers in the area to determine how their clientele can best be served, then present those findings to the BSRB.</p>
<p>I would like to see continued protection of the social worker title, enforcement of those practicing or presenting oneself as a social worker without a license, and advocacy to continue to protect the scope of practice for social workers in our state.</p>
<p>I would love to have more education regarding ethical considerations and awareness of using AI both in the clinical and macro setting.</p>
<p>I'm becoming more concerned with social worker burnout these days. I think it's really impacting client care.</p>
<p>I'm note sure</p>

I'd like it to be the norm to require licensure for more positions. I don't like that a lot of people avoid getting licensed. Don't reduce the requirements, but reducing the fees would help. Also, I don't want us to stop requiring an exam, but I wouldn't mind looking at something other than ASWB. Especially at the BSW level, I'd be in favor of an exam that was focused just on the code of ethics.
Ideally it would be good if Social workers were protected from work place abuse, such as extended hours well past 40 a week and ridiculous On-Call hours where one has to drive all over the state.
Implementation of ways to make sure social workers observe confidentiality as expected by our code of ethics.
In community mental health. Insurance should be figured out before many services offered. So consumer is not left with bill.
In Lawrence Public Schools, students who are truant and attend the day school at the juvenile justice center are treated like criminals. Their rights are violated--they have no confidential interactions with social workers, their case workers from DCF or truancy officers.
In my years of being a social worker, I have not had any concerns regarding the BSRB protecting the public. I would have loved to see more work towards national reciprocity of all states with regards to licensing. Something more uniform and people could go anywhere in the US to work.
Increase public education on the importance of hiring and using only trained, licensed social workers who are bound to professional standards and ethics.
Information and guidelines on AI.
Instead of rebranding, focus on the human rights violations that are currently happening in our country.
Interdiction course on how the BSRB is a support to the social worker.
Interstate compact licenses, especially with Missouri
It is likely out of the BSRB hands but poor insurance coverage makes it very difficult for the middle class person to be able to afford consistent therapy. And I have found that many practitioners do not accept EAP's.
It would be great to see BSRB meetings held in other areas besides NE Kansas.
It's very expensive to become licensed. I'd love to see the barriers financially come down a bit.
It's under essential skills and traits for social workers. You have to have the desire and drive. Critical thinking, active listening, empathy, resource knowledge and development. It's the action plan from our foundation of knowledge appropriate to the practice setting. Commitment to do all that you can, within reason, for the best possible outcome. I see a generation where this is absent.
Keep telehealth, especially for rural consumers and others who have enough barriers that meeting over telehealth from home could make the difference between getting care or not receiving care.

Keeping and maintaining telehealth. It's an amazing opportunity to keep workers and allow us to provide quality work.
Continue to encourage/offer any and all free CEUs. Or lower/cost effective ones.
Less CEU's for LMSW's. 30 is enough!
Less costs
Let us support clients who are moving out of state. Especially if they are going to college out of state. It is inhumane to take away a clients rapport with their longstanding therapist once they make one of the biggest transitions of their life.
License SW and Not have to sit for LSCSW exam if you complete supervision hours and application process. This would allow more practicing clinical social workers.
Licensing while working in an education setting
Lobby for more mental health care funds and increases access
Lower the price for licensing and renewing license
Make forms web-based and able to be signed online. Difficult to get signatures when you and your supervisor are in different locations.
Make it easier for them to understand their rights. She requested a different practitioner.
Make it easier to get clinically licensed and update regulations around telehealth and AI.
Make it easier understand the live sing process and transitioning and setting up a private practice etc., working towards easier ability to provide these services
Make it more affordable to obtain and hold licensure.
Make it more realistic/attainable to get clinically licensed. Supervisors can charge whatever they want, often over \$150 hours for several years! I am unable to afford most people's rates, and that should not be a barrier to get clinically licensed.
Make materials to study for the exams! The study guides out there are not helpful and frame the questions differently
Make sure a member of the board is a consumer representative in each area of practice.
Make sure the public knows how they can look up a licensee's status and make a complaint if needed
Make training dollars available. Incentives the profession.
Maybe
Maybe a monthly newsletter about changes/or best practice ideas.
Maybe offer a supportive peer group
Maybe public education on what social workers do and how we can help (i.e., we don't just take people's kids from them). More importantly, legislative advocacy is an absolute must. In particular, the state of Kansas Medicaid is atrocious. There is no reason someone's spenddown should be 2/3 of their income.

<b>Mo (2 responses)</b>
More communication
More information to easily access how to report if needed and process of what it looks like if a report is made
More online trainings and resources
More opportunities for in person CEU trainings. More incentives for going for a clinical license
More oversight and requirements for unlicensed people supervising licensees professionals.
More promotion of KS networks involving our SW colleagues and supervision would be nice - maybe it's available and I just don't know about it.
More public messages as to the purpose of the BSRB
More required training to be a clinical supervisor. More training on best practice related to private practice, use of AI, billings, HIPAA, ect.
More requirements for clinical supervisors
More social workers on our supervisory committees and boards, not just attorneys
More thorough assessment of social work candidates. I have seen some classmates who are not fit to work with the public receive their license even after being "flagged".
Multi-state license process easier
My home State is MO and new to KS but I felt KS was easy and nice to use so no comments yet.
<b>N/A (40 responses)</b>
Need to invest in a 'helping' associate degree promoting as a career pathway for high school/middle school students. This can contribute to pursuing more professional BSRB licensing.
Ni
<b>No (233 responses)</b>
No comment at this time.
No I do not have recommendations.;
No other suggestions at this time.
No recommendations
No recommendations
No recommendations at this time
No, good work
No. Every time I have had to contact the BSRB my questions/concerns were always addressed and I was guided in the right direction.
No. I have had a pretty easy time contacting the BSRB when needed!
No. Except to insure broad access to services.
<b>None (13 responses)</b>
<b>None at this time (10 responses)</b>
None that are feasible.

None that I can think of.
None that would be appropriate for me to type here.
<b>None (3 responses)</b>
Not at this moment.
<b>Not at this time (32 responses)</b>
Not exactly but to remain relevant the BSRB must be toward thinking. It is good to solicit input from licensees but you must have forward thinkers as a part of your organization. You be aware of changes and incorporate those ideas that are considered "out of the box" and work to make them feasible in out practices.
Not really
Not right now
<b>Not sure (3 responses)</b>
Not sure what can be done, but there are a large number of new/inexperienced practitioners entering private practice. Seems unlikely that their work or life experience would have much influence on their competency, so what training and support can be provided to these budding social workers?
<b>Not sure (2 responses)</b>
Not sure. Other than stating what to look for when seeking a licensee. I am finding that there are online entities, misrepresenting mental health practices by promoting themselves as experts in the field of mental health when there are not appropriately licensed to do so.
Not that I can think of
Nothing to share
Offer a platform to track continuing education hours; lesson direct client contact hours for clinical licenses to reduce burnout (overscheduling to get direct client contact hours) and make it more attainable, heighten continuing education hours for LMSW if it is a concern of a lack of knowledge, require so many hours in any modality to ensure evidence based practice
Offer free remote CEU opportunities
Offer group malpractice insurance and free or low cost CEUs to help with cost of relicensure since social work pay is so low
Offer more free trainings for ceu
Offer more free trainings for CEUs so social workers can continue to develop their skills.
Offer some sort of program encouraging supervision discounts and participation for student
Offer trainings to school administrators on the role of school social workers. Have some sort of protection for social workers in the role, as school teachers have NEA to support them.

Offering an alternative to testing for a license. Possibly a presentation to outside licensed social workers. I've seen test anxiety hold great social workers back from being licensed and seen questionable social workers be great at test taking and become social workers
Offering of resources for free trainings in the state, particularly for safety, Ethics, and use of AI
Perhaps looking at the amount of years you have obtained a license and use that as another avenue to moving to a clinical license. I have worked in a school for over 10 years with my LMSW and have looked at moving to private practice and starting my own business but can not due to not holding a C.
Perhaps more notification and clarification of the Training Plan for government employees. This will enhance the supervision of Social Workers for LSCSW licensure as well as enhancing a comprehensive education for the candidates.
Periodic screening of professionals in the field
Please read the notes of field instructors. There are many in our field who do not represent us well.
Possibly a class on human rights - we are to advocate for our clients , However, things are changing.
Possibly add mandated reporting of colleagues who are violating code of ethics?
Possibly require more trauma informed care CEUS?
Practitioner Training and Continuing Education. Mandate Specialized Training: Require ongoing education in trauma-informed care, digital ethics, cultural competence, and mental health/substance use co-occurrence. Curriculum Updates: Periodically review and revise continuing education requirements to reflect changing laws, technology use in practice, and current consumer protection concerns. Transparency and Accountability: Publicize Disciplinary Actions: Continue and, if feasible, expand the scope of public disciplinary action disclosures, ensuring consumers have clear access to background information about practitioners
Promote in person meetings and sessions again for all services. Relationships are so important in our field and can't have good relationships without true contact with people
protect trans, immigrant, and other marginalized folks from the current administration's agenda in targeting them in the services they're able to receive
Protecting the title of social worker, as social service type workers use the title without the education or knowledge of those with licenses .
Protections for whistleblowers for bad admin behavior
Provide additional education/training on risk/legal guidance for gender affirming care given the current state of our country.
Provide anonymous reporting. For those social workers not abiding by standards of the profession

Provide better clarity about the differences between BSRB licensed professionals.
Provide education to consumers on self determination, self worth and advocacy
Provide email reminders to remember to get CEUs for the year or reminders of renewing licenses.
Provide examples of technology policies and best practices for BSRB licensees to use in their work.
Put your license application process totally online
Really I think by providing more free education to the licensees it would benefit the people who receive services so they can receive care from competent providers. Additionally, ensuring the field of social work remains protected by keeping exam and ceu requirements in place so we can regulate who calls themself a social worker and what level of knowledge and understanding they have
Recognizing more of us not in clinical work but defining community work and use of our skills at the macro level. I've not felt this recognition or ever able to clarify work I do and it's application to SW skills, ethics, and values.
Reduce number of required hours for re-licensure from 40 to 30.
Reducing the amount of fees related to applications and licensing. It's very expensive!
Re-evaluate reciprocity, align with other states, expedite interstate compact licensure
Require at least one CE hour every renewal cycle on evidence-based treatment for clients who have both mental health and substance-use disorders. And add an elective topic that covers screening and brief intervention for problematic internet use, now linked to ADHD-like symptoms in adolescents.
Require suicide or risk assessment as CEUs.
Requiring specific topics: I'm also licensed in Missouri, I think regular training in suicide prevention/intervention is critical. Ethics, crisis intervention, grief.
Same answer about Washburn.
So far BSRB seems to be doing their best to address issues and work on social work issues. Keep pushing at a state level for quality, cost savings, and keeping in mind not every social worker does mental health
Sometimes a second opinion would be a good thing when decisions by therapist influence court decisions.
South West Kansas I feel lacks support to LMSW
Stop decreasing CEUs required.
Stop having community health centers take advantage of the telehealth services as well as not being so judgmental to our clients. This is a disservice to those that are in need and does not build a rapport with any client that we serve.
Stop lowering the license renewal requirements

Strengthen the CE requirements. I would be glad to discuss my recommendations with someone from the Board. I believe I may have a unique perspective, as someone active in practice who also is an adjunct faculty member, and is continuing involvement with child welfare, family law, mental health, and criminal justice systems.

Subsidize social work supervision for social workers serving in public schools.

Substance use training. Making substance use education a requirement, not just having a LMSW.

Support your licensees with advocacy of appropriate pay scales, continuing education that is AFFORDABLE, and when calling into the office have staff not treat us like we are the perpetrators.

Supporting licensees in creating and distributing community resource lists for each county. Many people do not begin services because they don't know how to find service-providers in their immediate community.

SWs need more policy literacy.

Talk to the credentialed colleges more to make sure they are teaching what they should be. I honestly felt that my master's degree was worthless because I learned nothing during that time except from 2 classes. I also believe some people graduated and went into the field that should not be allowed to (like some showed ethical violations even in the classroom). There are classes that do not benefit us at all going into the field and classes that would greatly benefit that aren't offered or required. I honestly think the college I went to has no right being a master's level social work program.

Testing, I have taken the LSCSW and failed within 3 points. This does not reflect at all on my successful practice as a social worker and treating my clients with dignity and respect, ethical practices, and I do not believe the exam should be so rigid. Test anxiety is a true struggle for me personally.

The main thing I would say is having more community and financial resources

The only bit of feedback I can think of is I do not like how often we have to renew our license. I would prefer that we get a little more time to obtain our CEU's. This is already a really demanding job and to stress about whether or not we have our CEU's within the short time frame of two years is an added stressor that I feel could be alleviated if we had double the amount of time.

There are potential privacy concerns with utilizing AI based on early studies of AI behavior.

There could always be an improved mechanism for empowering consumers of services offered by BSRB licensees to fully UNDERSTAND their rights as a consumer of services being offered to / provided for them. It is not enough to hand someone a written document and ask them to sign it with only a few explanations, for the purpose of "expediency." I also think there needs to be more serious education done/required, for all levels of licensees, on the topic of HIPPA and Confidentiality issues.

Too many expensive fees

**Unsure (6 responses)**

We need more advocacy around funding programs. Social services are struggling across the board; we're trying to do so much with not enough. There are no good enough work arounds to such deeply insufficient funding and support in our state.

We need more frequent and improved communication with licensees via email, mail, and social media.

Weeks-long delays in licensing, upon application, serve as a barrier to service delivery for consumers in underserved areas and income barriers to professionals entering the field.

Where is work (prison) they replaced all social workers with correction counselors with little to no clinical experience.

While there is high support of people of different economic levels, races, sexual preferences, etc., support of differing religious beliefs is waning. Additionally, the support of differing political beliefs is lacking. The approach of truly supporting a person where they are at has eroded. New all inclusive training needs to be implemented as that is lacking in the State of Kansas.

With the regulatory changes re: the reduction in the number of clinical diagnosis/treatment hours required (as a percentage of the 40), I'd like to see some focus on the quality of those CEUs (since people will have a lot of flexibility about the content).

Yes have a separate board for just Social Workers versus all these other professions included in one board.

<b>LSCSW Q14. Based on your experience as a licensee in Kansas, do you have any recommendations on additional ways the BSRB could protect and serve consumers of services offered by BSRB licensees? (643 responses)</b>
1. Remove the two year temporary licenses; 2. Stop reducing hours to obtain clinical license; 3. Stop reducing requirements for re-licensure
1:1 must be preferred and AI limited
A CE requirement for technology and privacy as these change frequently. Even if a clinician uses paper, the clinician needs to be aware of devices in the room that may be eavesdropping and how to mitigate risk.
A more streamlined or easily identifiable process to become a clinical supervisor.
Advertise our services
Advocacy for consumers dependent upon insurance coverages for selection of service providers. Insurance companies drive away some providers and not all consumers can pay out of pocket. Limited # of providers for growing consumers #s and needs.
advocacy with low balling insurance providers like commercial Aetna, Ambetter and United paying a more competitive rate. It would be nice to serve clients via telehealth when they temporarily leave the state.
Advocate for additional resources
Advocate for change through the insurance commission. We have an ethics that says we should be paid for our work, but routinely are taken advantage of with multiple coverage cases- child welfare primary and secondary insurance triangulation, etc. we used to write off 35% and after COVID it ballooned to 55% and our practice closed. We can't charge Medicaid clients when Medicaid fails in processing or when we have a change in MCO providers and there is no path to claim resolution. The work is too hard to spend countless hours per claim per week to beg to get paid. The next generation is opting out of this field largely due to these issues. The board has a voice and access to legislators. My hope is the renewal fee and integrity of the license means you will support us.
Advocate for mental health care or transgender individuals of all ages
Advocate for national licensure so we are not bound by state boards.
Advocate to have the state include in the MCO contracts to require those who review for medical necessity to hold a clinical KS license. MCOs are allowing professionals outside of KS who are not familiar with KS Medicaid needs or services.
Advocate why hiring licensed SWs is critical, and benefits over other professions
Advocating for increased reimbursement rates from insurance companies
Affordable therapy for clients
Affordable trainings
Allow us as providers to negotiate collectively regarding reimbursement. If something is not done about this we will soon move away from insurance altogether.

<p>Allow us to practice in other states regardless of what state we are licensed in, if I have a client that is comfortable with me and moves to another state I can no longer see them-this is not what is best for me or them, only serves the state and it is all about the \$\$\$</p>
<p>Although CEUs are required to renew, there should be more education required to be a therapist just having a master's degree. I wasn't required to take any therapy classes except DSM so they can diagnose but have no idea what to actually do with clients</p>
<p>An online based website to submit forms, renewals and applications.</p>
<p>Any mental health organization that has a high employee turnover rate should be evaluated/investigated and recommendations or legal action should be taken.</p>
<p>Anyone supervising a team of clinicians should be required to hold clinical licensure.</p>
<p>Approve the inter state compact for social workers</p>
<p>Are in-person visits to Independent Practitioners possible.</p>
<p>Are we working on ways to have reciprocal licensure with surrounding states? There needs to be a movement toward some sort of national licensure or process that allows in a practical, less cumbersome way, for providers to be able to legally practice in multiple states</p>
<p>As a social work educator, I believe gatekeeping is an important aspect of my job. I think it would be wonderful to implement some type of praxis exam required for students entering the junior or senior year of a BSW program. My rationale for this suggestion is that universities are so focused on retaining students and student enrollment that instructors often feel obligated to lower grading standards in order to pass students who may not adequately demonstrate the skills and knowledge required by CSWE.</p>
<p>As consumers -you mean social workers? See below</p>
<p>Assist with compact licensing</p>
<p>at this moment I do not.</p>

Based on my experience as a licensee in Kansas, one key recommendation I have for the BSRB is to take a more proactive role in monitoring and ensuring the clinical competence of providers—particularly those in independent practice. At present, the bar for ongoing competency is relatively low, relying heavily on self-reporting and CEU accumulation, which doesn't necessarily translate into effective or ethical care. Creating a system for peer review, case consultation requirements, or periodic skills-based audits (even if voluntary or randomized) could significantly enhance consumer protection. Additionally, the BSRB could better serve consumers by improving transparency around disciplinary actions or license status. Many clients do not know how to look up a provider's licensure history or complaint record. A more user-friendly, searchable platform with plain-language summaries of disciplinary actions would empower consumers to make informed decisions. Finally, I'd advocate for more structured education around ethical marketing, use of social media, and scope-of-practice boundaries—particularly as more clinicians enter private practice or online therapy spaces. The rapid expansion of telehealth has outpaced regulation in many areas, and clients are sometimes left vulnerable to poorly informed or overextended practitioners. In short, a combination of clearer public-facing information, stronger clinical oversight, and updated ethical guidance for modern practice would go a long way in protecting the people we serve.

Be sure staffing ratios are monitored for students in the field doing their practicum so they and clients aren't put at unnecessary risk.

Because clinical social work in private practice settings has become a popular area of practice in the field, you may want to consider establishing a minimum number of years in the field before granting a supervision contract in a solo private practice setting.

Being active in policy change or notifying BSRB licensees of current legislation that may impact their work. Organized notification would be helpful and does not involve influence (unless you tell them to testify for/against something)

Better communication and responses to emails when reaching out. We are often dismissed or never responded too.

Better communication from BSRB if a report of a ethical violation is made. (i.e. confirmation of receipt of a report or complaint, and if an investigation is forthcoming, or if it has been closed).

Better help and guidance on how to protect ourselves. The code needs updated and needs to address this more directly.

Better screening processes/backgrounds check for individuals applying for licensure

Bring back ongoing supervision for newly licensed providers.

BSRB has always been responsive to my needs. I am concerned regarding the level of professionalism I have recently encountered with other licensees. Appreciate any / all continued efforts regarding providing services across state lines.
Build a community, openly engage and invite licensed for a lunch and networking hour monthly so people can learn and know each other. Plenty have done this.
By addressing what I wrote to question 10
by helping to advocate for appropriate reimbursements from insurance companies
Cannot think of a particular recommendation at this time.
Change policies which prohibit clinicians from being paneled under a group to bill commercial insurance.
Change the 3 diagnosis requirement back to 6 ceu hours.
Cheap/ free training to help us continue to grow as providers
communicate better w/ Missouri for reciprocity
Communication about continuing education for supervisors
Compact for other states
Compact for serving clients when they move to another state.
Concerns regarding deployment of services for families and children in child welfare and community mental health centers must do better at training their therapeutic staff on the modalities of treatment. They tend to be more cookie cutter and that it's not healthy for a majority of their clients because they are not trained to deploy cookie-cutter services for the benefit and welfare of their clients.
Consider a confidential client review of the therapist?
Consumers need protection against the use of AI in their clinical services and medical records.
Consumers need to be made aware that how much experience their clinician has before they are charged such high self-pay rates.
continue expecting licensee to obtain the CEUs including the mental health topics- do not start lessening the requirements- we are professionals.
Continue telehealth. Get Kansas license to work in other states
Continue to advocate on behalf of the SW profession
continue to require the ceu's that you currently make mandatory and add something around the addictions.
Continue to share plans via the emails you send. Thanks for all the work on the Compact plan.
Continue to uphold and stress ethics. I feel like people slide under the radar and get away with things until it gets very awful then reflects on the profession negatively.

Continued advocacy for the role of clinical social workers as they bring an insight to working with oppressed populations...an area that will likely increase based on our current national administration.
Continued development of counting hours as well as ways to bring large groups across the state to train and support one another.
continued lobbying and advocacy for support of mental health services and insurance reimbursement for mental health services, especially in the current political climate where clients are very anxious about possibly losing Medicare, Medicaid, and Social Security benefits
Continued support around ethics training regarding AI, concerns for issues related to political climate and provision of services, and navigation of tele-health services.
Continuing to offer information related to insurance specifically related to telehealth and cyber protection as it is increasingly growing and the hackers never rest. Also, something needs to be done to allow counseling compact. It seems unethical that I cannot support a client if they are in crisis while traveling to another state in which I'm not licensed.
Coordinate with KDADS on supervision requirements.
Creating an AI task force
Credentialing problems with insurance companies, reimbursement issues, makes it hard for accessing mental health services. How can we streamline the licensees process to be able to provide services and be paid properly. They cannot work for free and consumers need support!
Cultivate community within the practitioners themselves
Cultural competency/diversity training should be debated as a CEU requirement.
Dealing with insurance companies is a nightmare.
Defining Kansas laws with minors and healthcare rights
Do not assume a signature on a form is proof of the reg being followed. Due diligence remains key.
Don't continue to lower standards expected for social workers.
Don't reduce the requirements or licensure.
Due to the low salaries and high expectations, it would be wise to increase pay, benefits, and other incentives when it comes to trainings. Most of the time, SW cannot afford the memberships, CEU training, or they get burned out quickly.
Eliminate all of the promotion of unhealthy liberal agenda items - transgender/gender dysphoria, recommendations for child/adolescent disfigurement, drag queen services targeted at children
Encouraging networking, or providing ethical consultation when needed
Enforce social title protections! Too many CJ people think they are actual social workers. Define Your requirements for CEUs better. Offers links and resources to meet those CEUs. Offer ways to join or advise the board.

Ensure protection of telehealth coverage as equivalent to in-person services. Provide avenues for therapists to negotiate higher rates from insurance companies—this could lead to more therapists being able to stay on insurance panels, broadening access to care.
Ensure that licensed providers are identifying themselves by their credentials and confirming they are completing appropriate CEUs
Expand Medicaid. Join the interstate compact. Advocate for increased funding allocated to foster care, community mental health, and mental health in education.
Expedite your investigation and resolution of licensee complaints. Currently have one that is pending for 17 months! It's ridiculous that these complaints are not getting resolved sooner and causes a great deal of emotional distress and professional goals are often on hold including interstate licensing.
Feel BSRB does a good job.
Find more
Focus on provider self care and development and collaboration when in private practice.
for Caucasian social workers need more cultural awareness
From my experience, BSRB, appears to do a great job in this area.
Generally everything feels clear and easy to navigate. Although having updates on laws and changing policies could be helpful. I'm a member of NASW in Kansas and often hear of policies changing through them.
Get out and ahead of regulations pertaining to AI with consistent messaging and expectations to licensees.
Get rid of it. I have a MSW degree. Let the consumer ,be the Judge.
Have an easier way to file a complaint (e.g. anonymous online platform)
Having appropriate boundaries is always a good idea; this could be included as part of ethics training. Training for diagnosis should also be renewed every two years. I cannot think of anything else
Having had the experience of testifying in a case of very questionable practice, I was disappointed in the outcome in terms of accountability in the therapist's practice.
Help with the SW Compact. I believe Kansas is making a move to lower CEUs to 30 hours rather than 40 which is beneficial for people who hold more than one clinical license.
Helping provide more CEU opportunities that are easier to find for those in the rural areas. I prefer in-person because I retain more and can network but it has been difficult to find trainings at times that are not online.
Helping validate our expertise with the agencies we serve!

I am also licensed in the state of Missouri and cultural competency CEU's are also a requirement there for renewal. I could see 3 hours every two years as beneficial for staying current around cultural changes or reminding them of something they have forgotten back in school.
I am concerned the license across states, the compact, will be abused by practitioners.
I am in favor of multi-state licensing that allows practitioners to see clients in multiple states via telehealth.
I believe social workers are deeply committed to protecting and serving consumers; however, I respectfully urge the Board to consider implementing stronger protections for professionals within our field. The ongoing use of non-compete clauses in agency employment contracts places unnecessary restrictions on our ability to serve clients and maintain job security—often creating conflict with our ethical responsibility to prioritize client access and continuity of care.
I believe that being licensed in multiple states would allow my practice to expand or at least continue to provide services to college students, those that move related to work, or even allow me to travel and provide telehealth.
I believe the BSRB is doing a good job with the limited resources provided.
I can't think of any at this time.
I can't think of anything right now.
I certainly encourage continuing to offer telehealth/remote services to as wide a range of adults as possible.
I continue to be concerned about the public's view of the term "social worker. " It is often confused with caseworker and not seen as a profession requiring licensure. It would be good to train school guidance counselors and others regarding our profession.
I do not - I have had a good experience with Kansas licensure and response to any questions I have had.
I do not believe lowering hours needed to obtain license or lowering hours for consuming education fits then coming generation social workers. To maintain the respect for the profession and license I believe rigorous requirements for continued licensure and professional development are necessary.
I do not know why BSRB lowers the CEU requirements. Even when it was 60 hr every two years I always had far more hours than needed. Then the clinical hours were lowered. The need for knowledge is increasing and the ease and cost make them more assessable than ever before.
I do think that it's important to keep our CEU requirements and exam in place. While I don't necessarily agree a standardized test shows competency in social work practice, I also do not believe that someone having a temporary license for several years is effective in their learning and growth to become competent.

I don't
I don't right now.
I have always had great experiences with the support and guidance provided by BSRB
I have been practicing as a LCSW for 30+ yrs and tried to obtain licensure in another State. They wanted info on initial supervisors and hours and scoring of my exam. I was not able to provide nor had BSRB kept records. I was unable to get another state license due to lack of info. Love that the IC will be coming!!
I have found that most professionals know very little if anything about brain injury. However, I would say that likely every professional has worked with a client who has sustained a brain injury whether they knew about this or not.
I know it's a tall order, but I think new graduates should have to work in agencies, organizations etc. for at least a few more years for more experience.
I know the BSRB has many responsibilities and a small staff, so I appreciate your hard work. It would be nice to have a better response time when issues or concerns arise whether it has to do with the licensing process or a professional issue. However, I am grateful for the hard work of this team.
I love our BSRB team!
I no longer work in the child welfare arena. I did for 20 yrs. SW's working in this field provide support to the most vulnerable yet have the least access to quality trauma training. In addition lack of funding to receive high quality training and or certification. It has been five years since I left child welfare this may have changed is my hope. In addition the leadership in most child welfare agencies is significantly lacking in representation of the cultures they serve.
I personally think the BSRB is doing a great job of protecting consumers of services offered. I think licensing is important it shows more than competence it shows dedication and persistence when people put in the hard work to become licensed despite challenges. Dedicated professionals protect and properly serve consumers.
I provide services in Spanish as well as English. Several of my clients share that other providers who report they are fluent in Spanish, are not actually fluent. They may speak some of the language, but not enough to provide effective treatment.  I don't know if it is possible to manage, but it is too easy for providers to report they are fluent in other languages when they are not.
I recommend not continuing to lower the standard hours needed for clinical licensure. When I received mine the start was lowered 1 year later and now its being lowered again. We deal with difficult populations and the intensive training and supervision that is needed for clinical licensure is integral to the quality services we provide our clients.

I see a lot of neurodivergent individuals who have experienced harm from BSRB licensees, who most likely mean well and have good intentions, but are really lacking in neurodiversity affirming care which shows in the language they use, as well as the approaches they take with these individuals.
I start with my first Kansas client next week.
I think BSRB does a good job.
I think expectations of paper work needs to be made clear when they start the licensure process. The clinical expectations were met but the way the paperwork needed it set up was not as clear and caused issues for many in my cohort trying to get clinically licensed.
I think having clarity regarding what is and isn't a useful board complaint as an FAQ on the website would be helpful.
I think it does a great job
I think it would be helpful for the BSRB to have additional resources so they could respond to complaints and do investigations more quickly.
I think it's unnecessary that the BSRB has newly licensed clinical social workers wait two years before they can provide clinical supervision. In most cases, clinical social workers are under supervision at our practicing clinicians for anywhere between 2 to 6 years.
I think supporting the transparency of the potential benefits & limitations of the process for both parties could be helpful.
I think the BSRB could serve to be a better resource for practitioners re: providing guidance on the do's and don'ts of practice. For example, years ago I contacted the BSRB re: Questions I had regarding possibly taking on a supervisee. I was told by the person I spoke with at the BSRB that they could not answer my questions. If the BSRB as the regulating board is not able to respond to such questions then I am at a loss as to who to direct such questions to. As the regulating board, I would think the BSRB should be the expert/authority regarding any question governing practice in the state of Kansas.
I think the multistate license will be helpful.
I think there are ethical issues that arise in the billing of psychotherapy services, where if you do this independently it can feel like there is no one place to get questions answered. Examples of this are having a consistent fee for services; use of a sliding scale where you might also bill insurance.
I think they are doing great. However, I am in a rural area they may be issues in urban areas.
I think we are decreasing the educational criteria for new SW in Kansas and it's dangerous for the profession and consumers
I understand the need to shorten requirements to get more clinicians practicing due to shortages, but in my opinion, some is lost in shortening the total hours and having higher expectations to meet within those hours.

I was concerned by the recent changes in the clinical hour requirements. The number of required hours has been reduced compared to previous standards, and the same goes for the continuing education (CEU) requirements. At a time when people are facing increasingly complex mental health challenges, it's troubling to see the path to becoming a clinician being shortened. While I understand the need to increase the number of professionals in the field, I can't help but wonder if we're compromising quality in the process.

I was surprised to see the change from 6 Diagnosis CEUs to 3. While I can understand this change for the LBSW and LMSW licensure levels, I felt as though it was not a good idea for LSCSW licensure levels and think LSCSW should still have to get 6 Diagnosis CEU's.

I was unhappy to see a reduced diagnosis and treatment CEU requirement for LMSW and LSCSW

I wonder how or if BSRB could maybe be more visible to consumers? I'm imagining cases where some sort of blatant abuse of boundaries, etc., could be more readily reported by consumers.

I would like to see that the ability to practice in multiple states without having to apply to each individual state's licensing board move forward.

I would like to see the number of required supervision hours increased again (even though it is a complete pain!) in order to focus more on the quality than quantity of the overall social work profession.

I'd like BSRB to reconsider the position that only the client can make the complaint if they inform current therapist of another therapist having had sex with them or their partner. There may be good reason for the current policy but it is concerning. At one time I could call and get a consult on an ethical dilemma with someone in the social work dept of BSRB. I miss that resource.

If only there was a way to crack down on "coaches" that are not licensed mental health providers but try to work with clients that need mental health services.

If the BSRB genuinely wants to protect consumers and uphold professional integrity, the following reforms are essential:

- Create an anonymous mechanism for reporting therapist-to-therapist harm, especially in supervision, consultation, and personal therapy.
- Audit and hold religious or ideologically narrow educational institutions accountable for training deficits.
- Mandate CEUs on power, grooming, whiteness, colonization, and cultural humility--led by clinicians from marginalized communities.
- Redefine professionalism by involving a diverse panel to decenter emotional flatness and image management.
- Require clinician value transparency in licensure databases--especially orientation and educational background--to help clients make informed decisions.

If there is a way to increase implementation of Trauma Informed Care I believe this would improve services to consumers.

I'm not sure

I'm not sure, but I would be willing to participate in conversations about this.

I'm not sure. I have some concern with the amount of LMSWs I see on psychology today posting about being an independent private practice but receiving supervision and it worries me a little just because I've seen sometimes how insufficient supervision can be.

I'm not sure. I think this requires more time to consider than the few mins of taking this survey.

I'm sorry, I do not

Improve clinical training. Expect higher level of performance from students and new graduates.

Improve ease of insurance paneling and reimbursement, Medicaid specifically.

Increase the number of CEUs required, including hours on how to behave in the workplace with co-workers, also more hours on how to address on your own past trauma so it doesn't impact your clients, and maybe some sort of guidance for agencies/companies on how to report poor social workers to the Board when they fire them (I think they believe by firing them they are done).

Increased advocacy for Medicare/Medicaid recipients

<p><b>Increased Public Education and Outreach:</b>  Many consumers are unaware of what licensure means or how to verify a provider's credentials. The BSRB could enhance consumer protection by offering more accessible educational materials, social media campaigns, or public workshops to help individuals make informed choices when selecting behavioral health providers.</p> <p><b>Streamlined and Transparent Complaint Processes:</b>  Making the complaint process more user-friendly and transparent would empower consumers to report concerns without fear or confusion. This could include simplifying the online reporting system, providing clearer timelines, and offering follow-up communications on complaint progress.</p>
<p>Insurance offered used to be good. Now I am unable to get insurance at a decent rate.</p>
<p>Insurance us a concern, coverage if mental health services with cuts to ACA and Medicaid. Advocacy please.</p>
<p><b>Interstate compact (2 responses)</b></p>
<p>Interstate compact completed and keeping Clinical Social Workers informed about the progress.</p>
<p>Interstate compact will greatly enhance the scope of our practice across the country.</p>
<p>It can be very difficult to obtain a license in the state of Kansas, but when a clinician carries out various wrongs they are able to continue to practice.</p>
<p>It does seem like there is a shortage of good supervisors available for individuals seeking their clinical license. I was very fortunate to know people when I was working on mine, but it has been difficult for colleagues who are still working on theirs to find good supervisors.</p>
<p>It is a challenge to make people aware of this option. I wonder what internet searches would lead to the BSRB website?</p>
<p>It seems like the BSRB is lowering the standards for clinical supervision and licensure. It's concerning to me as I don't think future SWs will be well equipped to meet and maintain professional standards.</p>
<p>It seems that it is rare to actually lose your social work license and I think that should be mandatory for some acts.</p>
<p>It should be enforced that social workers must have a professional business with the state of Kansas to ensure that they have completed hours before they are alone working with clients without in-house clinical Director access, without colleagues that they can staff cases with in house, and without general access to Supervision when needed. Kansas needs high quality social workers more than more social workers.</p>

It would be great if schools of social work were required to provide some options for specific training for different therapeutic interventions, such as EMDR or DBT or whatever modality that fits with the population they will likely be working with.
It would be helpful to offer more information/training on the ethics when AI is encouraged in the workplace and how to handle in abuse cases. These could become discoverable, so who is the keeper of the records when AI is in place.
it would be nice to be able to discuss real ethical dilemmas and decision-making
It's the licensees that need better services and protections. Unless you jump the seemingly pointless hoops to clinical level and enter private practice, you're up the proverbial creek with a turd for a paddle.
It'd be helpful for the BSRB to provide training on ethics and laws so that providers can be reminded of best practices and what is appropriate. Sometimes it's hard for me to find the answer to some of my questions, such as--do both parents need to consent to a child's treatment, can a provider transport a child to/from therapy, and can a therapist provide case management or advocacy services (without it being a dual relationship).
Just continue to do the principled and accountable work that BSRB has been known to do. I have held a KS license since 1976, LSCSW since 1978, and have experienced BSRB to hold a consistent professional mission, high set of standards, and accountability for consumer protection over my career.
Kansas is one of most supportive boards that I have been exposed. Kansas board educates, supports and works to better the practice of social workers! They are available and answer the social worker.
Keep our standards high! I know you just reduced some criteria but I professionally don't agree with that
Letting people know that you will consult on difficult issues related to licensure to reduce fear related to the authority aspect of the Board.
Licensure portability to allow easier access to clinicians; free or reduced trainings on key issues, such as use of AI, and those related to ethics
LMSW's under clinical supervision for their LSCSW should work for an agency or institution for administrative supervision along with clinical supervision. They should NOT be allowed to be in private practice...period. Clients are being harmed by allowing this.
Lobby
Lower cost CEs around best practice in regard to treatment modalities and that can lead to credentialing as well
Maintain a standard of excellence for the profession that keeps us desires and valued
maintain the standards
Make it more clear what the BSRB does aside from approve and audit licensing.

Make licensure easier to complete initially but provide more follow up and support. More requirements on what types of CEUs qualify maybe some work place specific or crisis continuum of care specific.

Make submitting forms and everything easier and virtual. Having to mail in everything has been a nightmare

Make sure these private practices aren't out here treating clients like cattle. Requiring clinicians to sign legally binding documents that if once they decide to leave the group practice that a certain percentage of their income PER SESSION & PER CLIENT is due to the originally group practice is absurd. Additionally thorough checks that organizations are not burning clinicians out just to meet "numbers". Grant to the side, the service wouldn't be a service if the SW didn't exist.

Mandate trainings on personality disorders for all masters level practitioners.

Maybe have clients be given information on how to reach out to BSRB for information/concerns

Maybe provide information to consumers on how to find a therapist and questions they should ask. Help consumers understand the different types of licensure.

Maybe reminding others who are in clinical supervision in Private Practice ways the board can assist those with bullying of their supervisors who are afraid to report or find other supervisors.

More education around working with insurance requirements. Some way to assess if Social Workers are prepared for managing an independent practice.

More follow through on consequences for violations of code of ethics or statutes. Allow for anonymous reporting of violations.

More free legal support

More information, enlightenment and understanding of differences, complications, struggles in being a sole practitioner in rural western Kansas.

More information.

More oversight of clinicians in private practice who do not possess a clinical license - for example some required training on documentation, insurance, etc. Or supervisors need to be adequately prepared to assist in this area. The amount of information I learned in an agency setting was invaluable and I find clinicians who go straight into private practice are at a disadvantage due to this.

More prompt responses to questions.

<p>More public education on the importance of clinicians holding a license and the different types of licensees between disciplines might be important. The rise of influencers, life coaches and mental health podcasts makes any person seem like an expert if they are confident and have a wide enough reach. People are at risk of being misled or taken advantage of if they don't know to make sure someone has a license to practice. I have also informed several people personally and professionally about their ability to verify the license of another provider on the BSRB website, and to lodge a complaint with the board if they feel it is necessary. It seems like we in the field are the main folks looking at these things, the public needs to be more empowered through education.</p> <p>Similar but separate is the distinction between LSCSW, LMFT, LPC, etc. I explain what my license means and the perspective of my discipline to every new client and they are usually sort of surprised because they never really thought about those issues before.</p>
More readily visible when consumers need to know where to complain, raise concerns or find out about the profession. In other words, publicize existence to the general public.
More specialized training
More support for the licensee.
More support with accessing free CEUs
More training in providing evidenced based clinical services
More training on AI, more ethics. I understand the new CEU Dx requirement is decreased from 6 to 3 hours. Why decrease? SW -ers need to be competent, well trained and on par in quality with other licensed professionals. It appears that schools are producing MSWs in large numbers of social workers and sending them into the field. Wondering if they are prepared enough by their education.
More use of technology as applicable to reduce barriers and help clinicians be more efficient
More vetting for taking the board
Moving complaints through the oversight process MUCH quicker and being more thoughtful about what gets screened in or out. Requiring anyone without a clinical license to clearly list who is providing their supervision and in what form the supervision is taking place.
<b>N/A (34 responses)</b>
<b>No (230 responses)</b>
NO AI
No concerns at this time.
No ideas right now.
No recommendations
No recommendations
No suggestions
No, but you should crack down on unlicensed "troubled youth" facilities.

No, I am licensed in five different states and KS was one of the boards who is the easiest to get in contact with.
No, I find this board to be quite helpful and responsive. I am licensed in other states as well and BSRB has always impressed me. As evidenced even by this survey. Thank you.
No, I think you do a good job
No, not at this time.
No. I appreciate the BSRB making the effort to place value on how they are serving and protecting consumers and practitioners.
No. I feel like you all do a nice job.
None but see above
<b>None (19 responses)</b>
None at the moment
<b>None at this time (2 responses)</b>
None come to mind.
None pop to mind
<b>None that I can think of (2 responses)</b>
None to knowledge
None to note
Nono
Not at the moment
<b>Not at this time (25 responses)</b>
<b>Not currently (2 responses)</b>
Not license disciplines outside of social work.
Not now
Not particularly outside of what I answered above about being able to work with cross-systems, dual diagnosis clients AND the other agencies that serve them simultaneously. Knowing how to collaborate with other providers to make a truly integrated plan still alludes us.
<b>Not really (2 responses)</b>
Not right now
<b>Not sure (2 responses)</b>
Not that I can think of at this time.
Not that I can think of currently.
<b>Not that I can think of (3 responses)</b>
Not that I'm aware of.
Not to limit services to LGBTQ clients, to protect DEI in all areas of our education and work
Offer a multi-license
Offer more diagnostic specific related trainings. Ex-OCD. Also options on how to document effectively to cut down on insurance reimbursements.
Offer more free CEU opportunities

Offer more training on working with older adults
One thing that might be interesting would be to create a small group of people from the board, advisory committees, etc. that would be willing to go to universities around Kansas that offer social work degrees and offer a short 1-2 hour training about licensing and the field in general. Reach out to younger candidates before they are out of the educational system.
Ongoing training and clinical supervision is always important which is already part of the process and should be continued. Setting some guidelines around telehealth services would be beneficial if these aren't addressing current concerns.
oversights for newly licensed clinicians to have varying clinical/therapy experience. possibly setting a guideline for "private practice" process?
Perhaps clearer information on how social workers earn and maintain their licenses- help legitimize our efforts.
Possibly provide easy access to training on using telehealth effectively and realistically. There would be some ethical practices to be aware of such as other people entering their space or the clinicians. Even training on setting up a safe and ethical telehealth practice with age appropriate practices.
Protecting social workers from parents and constant threats to physical safety and threats against licenses for standing up for what is right would help us do stronger work.
Provide clear guidance as to licensure and training boundaries.
provide groups or trainings on the navigating the current political events as a professional and how licensees are personally affected.
Provide some sort of liability insurance
Provide, free of charge, brief, simple community education seminars on common topics of interest/service (mental health/diagnosis/accessing services/managing stress/living will/DPOA/housing/children's needs/parenting/money management/preparing for retirement, etc.)
Providing opportunities for structured mentoring, promoting the state associations that are affiliated with groups licensed through the BSRB, partnering with these associations
Proving national license
Question that I don't know the answer to - how much of a supervisor's recommendation does the Board take into account? Sometimes it seems there is a fear of being too punitive or cautious.
Quicker response times/decision turn around time for complaints
Quit lowering the standards for practice
rather than a short questionnaire maybe develop a short quiz to ensure that folks still have the required knowledge to practice ethically and responsibly

Real reciprocity is long overdue. Nursing and medicine has done this for decades, and the healthcare system in Kansas would vanish if this had not been the case. The "fence-building mentality of Kansas BSRB professions artificially creates shortages, and inflates the cost of services, and creates a "closed shop barrier" in a supposedly "right to work" state.
Reciprocal licensing
reciprocity with other states so services don't need to be needlessly terminated based on a client's moving out of state
Reduce costs
Reduced CEU fee rates as the fees to renew every two years and meet required training is expensive.
Reducing the cost associated with tests and licensure fees. SW's are typically underpaid and this is a big expense for many providers.
Remind consumers in writing what we as Social Workers are bound by law and oath to report certain facts.
Removal of DEI has impacted social work practice and how we conduct SW practice with our clients. There is currently a fine line between advocating and remaining silent right now that is unhinging.
Require a separate license for psychiatric social work compared to those who work in general social services.
Require CEUs be related to practice area Stop reducing CEU hours
Require CEUs that focus on cultural competency, diversity, equity and inclusion, including for LGBTQIA2S+ individuals.
Require record-keeping ceu's.
Require suicide assessment and screening as a CEU requirement for renewal like MO does.
Require training on continually "doing our own work" so we don't traumatize clients and bring our trauma onto others.
Required CEs for supervision.
Respect the needed SW college education expansion to central and western Kansas communities.
Return phone calls requesting information about specific topics would be helpful to navigate/know resources for information needs - especially regarding specific state and practice regulations
RPT should be standard practice if you are working with children. If you do not have a thorough knowledge of child development and differences in communication needs damage can be done.
Rural Kansas needs more access to providers. - This means reducing barriers for social workers in rural Kansas to obtain supervision, to offer telehealth services to residents, etc.
Same answer as question 9.

<b>See above (2 responses)</b>
See answer to question 10. I am also eager for the interstate compact license as keeping a license in multiple states is confusing (multiple dates for relicensure to keep track of as well as differing CEU requirements resulting in unnecessary time and money in my opinion) and costly in time of energy and resources. I am also eager for the interstate compact of be nationwide. Our training as a social worker is standardized on a national level as is the licensure testing we undergo, but then the various state laws and social work board policies vary a great deal, which ultimately limits services to clients to the point of months long waits for therapy at best or a total lack of provider at worst. We can do better as a society to make necessary mental health care and support available to our citizens.
Supervision in a CMHC where volume of clients seen is high is old history typical of my era, i.e., LSCSW received in 1987. I would recommend this over a new MSW grad in private practice with adequate supervision but typically low volume.
See previous responses
Set up part of the agency to help clients get their behavioral health services paid for by insurance companies.
Social workers are drilled in ethics. I am proud to be a of the profession.
Start sending out actual cards again.
Stop lowering the standards. This profession and license obtainment is hard for a reason. In the last 5 years, you've lowered the standards twice. It's insulting. Lowering the standards allows subpar clinicians through.
Stop watering down the requirements to be a social worker.
Students right out of college are being put in very stressful jobs with little experience. Now they can go right into private practice. This is scary.
Take reports of unethical behavior more seriously.
The biggest harm to consumers comes from insurance companies. Payments to providers are often slow, incorrect, or don't come at all. This hinders access to care. Tricare, VA, and UHC are all difficult to work with, which affects both licensees and consumers.
The board has worked very well on issues
The BSRB could help those of us in clinical practice by researching and recommended products and services to us that are useful in private practice. As it is, we have to make our best guess and when that fails, guess again. We can ask colleagues, of course, but sometimes they don't know, either. Also Square Up is the company I use to process payments and they charge me so much money to provide this service! It would be wonderful to learn of a service that won't break the bank.
The random audits at license renewal do not seem random when it's happened every time.

There is a huge gap in knowledge and service on how best to serve/treat Autistic/neurodivergent populations.
There is an extreme need for experienced trauma providers. Please start requiring CEU's for Social Workers in Trauma. Many SW'ers will provide trauma sessions with inadequate experience or training.
This is hard to answer. I believe that ethics education is probably stronger in healthcare than anywhere else in our culture; and vitally important. I wish there were more ethics training - everywhere.
To continue to advocate for laws that promote self determination
Train practitioners on what occurs if a client makes. complaint against them - - - and that BSRB's role is to protect the client - not the practitioner.
Trainings free of charge when possible. Better communication surrounding what each box is looking for on the application form for licensure. Questions on the application regarding practicum hours seems irrelevant if that was many years ago the wording could be phrased more appropriately to accommodate all professionals in their career states.
Universal license options
<b>Unknown (3 responses)</b>
Unsure
Unsure at this time
Unsure. Licensees may need to get education on countertransference and what it can look like or what to notice to be aware it's coming up. Sometimes it hits people out of nowhere and they can't tell they're experiencing it and it results in non-ethical behaviors.
We do a lot of trainings on what we can't do and following rules. Might want to focus a bit more on what we can do in a changing landscape of care, such as people using g AI for therapy
We seriously need a second online option for safety training. The training currently offered is the same one I completed in 2013 after I attained my masters
Work on a multistate compact for licensing
Work with legislators to help them become more compassionate, caring, and open-minded human beings.
Y'all need to make the test harder or something
Yes- please distinguish the importance of social work values and ethics. Specifically boundaries around ethical practices and public trust. Increasing the frequency of needing to provide completed CEU opportunities, yearly requirements with big early renewal fees. Social workers are the Swiss Army knife of helping professions. Our unique psychosocial and person on environment perspectives give us an edge in the helping practices that other helping professions are lacking. New licensees are not prepared for roles in environments provided crisis services, like mobile crisis, co response, or crisis intervention centers.

Yes, it would be helpful to identify best practices around notes - most specifically for therapy sessions. Any entrepreneurial courses/classes.

Yes, by taking complaints and violations seriously. I have made several complaints in which I have provided documentation to support the concern and the individuals continue to practice and have even been approved for their clinical license despite me not recommending them for licensure due to egregious misconduct. In addition the BSRB should not be taking over a year to investigate complaints, all while the social worker continues to practice and potentially do harm. The process should be completely redone to ensure it happens quicker, the person filing the complaint is interviewed, and a report of outcome is given.

Yes, speed up the interstate compact.

Yes. I had a recent negative experience with KS BSRB. I applied for a LCAC license with my completed "Attestations" in sealed envelopes. However, the LCAC personnel stated that they never received the sealed envelopes with written attestations that is required by BSRB to accompany the LCAC application. I emailed the BSRB licensure personnel in an email and 'CC'd the person(s) who had written my recommendation(s). This caused severe damage with my professional relationship(s) because they felt that I had highlighted them to the BSRB for possible retaliation against them. It is sad that someone cannot attest actions by the BSRB without fear of any retaliation by the BSRB and/or its employees. My recommendation is for the BSRB to modernize their "Recommendation(s)" procedures. In the application, have the individual write the names of those who will give recommendations to the board. Then, the BSRB emails the persons providing the recommendations with periodic updates to the individual. This can work. I have seen it work when applying for federal jobs on USA Jobs and going through the onboarding process with the federal government.

Yes. More parameters around newly graduated MSW providing therapy

Yes. Please stop decreasing regulations around expectations and experience-CEUS and hours for clinical license

You guys do pretty well. Appreciate asking for guidance.

**LBSW Q14. Do you have any other comments or feedback you think would be helpful for the members of the Advisory Committee to receive when evaluating possible recommendations for changes to the statutes and regulations for the social work profession? (106 responses)**

Advocacy on the value of having licensed social work. The legislature and employers need to understand the value of having a license.

Again, reality based practices. It has been frightening to see how little counseling young people with sex/gender confusion get before they start hormones. Many in the "trans" movement have become violent radicals. I'm concerned many of these people are taking hormones. Also, many social workers have their own issues or children with issues. They need to look at things objectively. I think it's good for social workers to engage in their own mental well-being & possibly seek therapy, but as I was talking to another fellow social worker, we are afraid because the profession has become so captured with a dangerous political ideology. We used to be able to disagree & still work together or with others. I always encourage people to really read the bios of the therapist because it can be dangerous if they pick the wrong person. I've seen TikToks of liberal, white women threaten to poison Trump supporters. Ya'll need to get a handle on it. Retraining on biases. Something.

Consider introducing more flexibility in the licensing requirements to accommodate different career paths and specializations within social work. For example, allowing for different levels of licensing (e.g., clinical, non-clinical) can better align with the diverse roles and responsibilities of social workers. Encourage and support interdisciplinary collaboration by including provisions that facilitate working with other healthcare professionals, such as psychologists, psychiatrists, and primary care providers. This can help ensure a more holistic approach to client care and improve outcomes. Advocate for mental health parity in insurance coverage to ensure that clients have equal access to mental health services as they do to physical health services. This can reduce financial barriers and improve the overall quality of care. Strengthen regulations around client confidentiality and data security, especially in the context of telehealth. This can include requiring the use of secure platforms, regular training on data protection, and clear guidelines on handling sensitive information. Develop and support formal supervision and mentorship programs, particularly for early career social workers. These programs can provide structured support, enhance professional development, and ensure that new practitioners are well-prepared to handle the challenges of the profession. Ensure that ethical standards are clearly defined and consistently enforced. This can include more robust mechanisms for reporting and addressing ethical violations, as well as regular updates to the ethical guidelines to reflect current best practices. Promote a culture of lifelong learning and professional development. This can include offering incentives for continuing education, such as reduced licensing fees or recognition programs, and ensuring that a wide range of training opportunities are available...

Appendix #21

...Provide additional support and resources for social workers in rural and underserved areas. This can include telehealth training, travel stipends for in-person training, and partnerships with local organizations to enhance service delivery. Address the mental health and well-being of social workers by including provisions for self-care and stress management. This can help reduce burnout and improve the quality of care provided to clients. Develop strategies to address burnout and improve retention rates among social workers. This can include offering mental health support, flexible work arrangements, and opportunities for career advancement. Ensure that the Advisory Committee has diverse representation, including social workers from various backgrounds, specialties, and geographic areas. This can help ensure that the regulations are inclusive and reflective of the needs of the entire profession.

Consider renewing license every 3 years changing the 40 vey hours to 60.

Education of social workers should be free.

I am concerned with the number of people working in the social welfare field that do not have a social work license.

I appreciated that the cost of licensure renewal went down. That was very helpful in this economy. Thank you

I believe there is a lack of SW moving into higher licensure due to bachelor level loans. I was informed while working in a non-profit in rural area that my loans would be forgiven after 10 years . That's not true. I was informed my loans don't qualify which made it frustrating to consider adding more debt when I felt deceived by the college, professors, financial aid office and loan providers. I haven't been able to find any local scholarship to help get Masters....

## Appendix #21

I believe there is a significant need for more local options for virtual CEU opportunities. Most of the online courses I've taken are offered by organizations based in states like California or New Jersey, with little relevance to the specific challenges and context of Kansas. Having training tailored to local issues would be far more practical and beneficial. I also strongly prefer virtual learning over in-person CEU sessions that require long travel times. In today's digital world, it's not always feasible—or realistic—for working professionals to take full days off to attend courses at a university hours away. Despite the shift to virtual formats in many sectors, social work training has been slow to adapt in meaningful, localized ways. Additionally, in my 15 years of experience in the field, I've found a striking lack of training, CEUs, or continuing education materials designed to support social workers in supervisory or leadership roles. This is a critical gap. As a result, I've often had to seek out leadership and management development opportunities outside the social work field, spending both time and money on business and leadership seminars geared toward other industries. More broadly—and I say this as someone deeply invested in the profession—I've observed that many social workers are not well-prepared for leadership roles. As a general trend, some of the most difficult supervisors and ineffective managers I've encountered have been social workers. Many struggle with peer conflict, especially when it comes to disciplinary actions or terminating underperforming employees. Others lack the business acumen needed to manage budgets or build financially sustainable programs and services. My own leadership journey was fast-tracked largely because I brought practical business experience into the field, which has helped me build a successful and impactful career. It's unfortunate that social work education continues to focus almost exclusively on client-facing skills, without also equipping professionals to lead organizations, manage teams, and make strategic decisions that ensure long-term service delivery. If we want social workers to be change-makers at every level, we need to intentionally prepare them to lead—not just serve.

### **I do not (2 responses)**

I do not. Thank you for sending out this survey--I'm excited to see how it will be used.

I have been an LBSW in Kansas for 26 years and I have been audited 3 times in my career yet I have friends who have also been a social worker that long or longer and have never been audited. It doesn't feel very "random". It also gets costly to have to obtain the reading materials if you do your CEU's online and then pay to mail all of those materials.

I just feel the LBSW is no longer respected when it's not required for most employment opportunities now. I'm not sure I'll continue to renew my license. There are only so many trainings to complete 40 hours every two years and it becomes repetitive to maintain over time. After a certain amount of time, licensure could be "grandfathered" without so many CEU's required.

I think it's sad that with over 25 years of working as a Social Worker as an LBSW, I can't get a job without MSW. I can't afford to not work for the hours needed for the internship

I would like to see the possibility of putting a license on hold while having a position not requiring a license.

It would be great if the universities would offer a class to help prepare students to take the MSW exam.

Appendix #21

Keep asking SWers for their ideas and consider implementing changes. Many of us are holding down jobs, raising families and being caregivers as well.
Keep social work a protected title. Make it easier for BSW to receive MSW such as counting years of experience towards MSW.
Keep the ethics requirements; in general with younger employees I see a lack of ethical standards.
LBSW licensure is too hard to obtain and way too expensive.
Love the ministry of Social Work and am very proud to serve others in this way.
Lower the 40 hours of CEU's to 30
<b>N/A (10 responses)</b>
NAPSA
Need more Affordable CEU's
<b>No (51 responses)</b>
No additional comments. Have worked 29 years in Kansas as a licensed bachelors level social worker. Always in child welfare. My main issue is that my agency no longer requires someone with a social work degree and license to do the job.
Not a recommendation for statues and regulations but I feel the website needs to be easier to navigate.
Not at the moment
<b>Not at this time (4 responses)</b>
Not currently
Offering affordable licensing for advanced SW with a more streamlined process. The biggest concern that I have is the cost to obtain an advanced license and the many steps you have to go through to obtain.
Probably later. I seem to always come up with questions later.
Really, I think maybe a course regarding how to supervise others when going through Masters level Social Worker or like Virginia Satir used to say, learn how to do 'people making'.
Reducing the continuing education hours for people who have been licensed for over 15 years would be appropriate.
Reimbursement for LBSW care coordination
Same answer as above create a program for other disciplines to allow for a code of ethics for unlicensed people doing the work
See #13
Social workers need to be trained. I don't believe you can throw someone with an English degree to do child welfare or CPS and expect it to work well
This may be outside of the scope of what the committee can enforce, but paid practicums should be mandatory.
To many people that are no social workers are working in child welfare and there is no board to hold them accountable
What about links to free continuing credit courses?
When a person is under investigation feedback when there is extensive delays causing unneeded stress would be helpful. While under investigation I waited almost 12 months for a response. During this time I strongly considered leaving the profession when, ultimately I would not have had to as nothing was found inappropriate.

**LMSW Q14. Do you have any other comments or feedback you think would be helpful for the members of the Advisory Committee to receive when evaluating possible recommendations for changes to the statutes and regulations for the social work profession? (531 responses)**

1. Modernize Supervision Requirements to Expand Access. Consider revising supervision rules to allow for greater use of secure tele-supervision, especially in rural or underserved areas where access to qualified supervisors can be limited. This change would maintain quality while improving the pipeline for licensure. 2. Clarify Scope of Practice Across Levels Greater - clarity in the distinctions between BSW, LMSW, and LSCSW scopes of practice—especially regarding therapy, assessment, and clinical documentation—would help employers, clients, and new professionals understand boundaries and expectations. 3. Address Workforce Shortages through Streamlined Licensing Pathways - Explore temporary licensure or provisional credentialing options for out-of-state licensees and new graduates waiting on exam completion, particularly during periods of workforce shortage. Streamlined reciprocity with surrounding states could also help address access issues.

A clinical license should also be made available to those in multi faceted LMSW positions and not only ones doing diagnostic work.

A licensed professional should not have to get additional licenses to work with “specialized” populations (for example LMAC when you already have a LMSW or LSCSW)

AI opportunities for documentation and being able to practice in another states.

AI training or CEU's pertaining to AI would be helpful.

Allow for greater modifications when testing for some of us who may require an alternate setting and have difficulty with functioning in a silent environment. Also with having to sit still that long and not having something to possibly fidget with for us neurodivergent folks.

Also require state schools to have a component educating clinicians on how to navigate the BSRB if they should have to have interactions based on complaints, or requests for exceptions, etc. The BSRB should feel approachable and supportive, not like a Superintendent with a big stick who only shows up to use it. Or maybe that could be a CEU offered. Get more Safety Training courses available. The only one I could find was not good quality and frankly did not make a lot of sense.

Although it’s a long shot, I do wish the hours toward clinical supervision could be decreased so I could sit for my clinical exam. If that were the case, I would likely be able to quit my current job and start practicing therapy again. I want to use my license, but it’s not quite feasible since the pay for a LMSW isn’t that great. Plus the cost of supervision.

Any ways to make regulations and statutes more clear, or a dedicated place to ask questions would be helpful.

Appendix #22

<p>As a newer person in the profession is very intimidating to find CEUs and complete processes due to having all the new roles/task to learn, having a bulletin or a place go post them on the website would be helpful. Also, maybe implementing a mentoring program or match can help new social workers get confidence and reduce burn out. Not all have a social worker or want to use a social worker at their agency to discuss things with.</p>
<p>As an employer, I wish there was more funding available to support internships in private nonprofits. DCF has funds and never fully spends them. Would be nice to have access to those funds!</p>
<p>As I mentioned in the supervision part, I think it would benefit the collective to be able to get half of the required hours from a clinician that is not a social worker. It makes getting licensed easier and it benefits the supervisor and supervisee by providing conversations with differing experiences.</p>
<p>Be above reproach and teach professionalism within our practice.</p>
<p>Be sure to really hear the thoughts of those that are out know the field practicing on a daily basis.</p>
<p>Being 65 soon- I would do counseling -I have obtained a few certificates in trauma and grief and loss- I would like to know more about remote telehealth and the challenges other have experienced</p>
<p>Better communication of continuing education and what is expected of the license holders.</p>
<p>Better communication. Most of us know there are less than 10 people actively working on licensure and investigation but some employees can be rude and this may be due to having a high volume, but than instead of being unpleasant or ignoring calls, respond with a clarification email and most of us will wait.</p>
<p>Better enforcement between colleagues on human dignity and worth of the person</p>
<p>Better support for social workers through the BSRB, NASW, ASWB. Better advocacy for higher pay and lower licensure fees.</p>
<p>Can we move the licensing process to some sort of online portal? Doing paper applications can be sometimes cumbersome.</p>
<p>Case loads are high and services (at least in rural areas) are low. I've experienced burnout and vicarious trauma. We are overworked and underpaid with the expectation to get a higher license. Lesson some of the pressure.</p>
<p>Change the practicum hours back. It was understandable during Covid however there should be no issues with students achieving their hours now.</p>
<p>Clear and concise guidelines for SSDs in all areas of social work.</p>
<p>Clinical licensure exams, I have heard that it is easier for other professions to obtain clinical licensure. (LMFT, LPCs) If someone already has an application on file, an easier way to reapply for approval to take the clinical exam vs completing everything all over again.</p>
<p>Clinical licensure needs to be adjusted and better organized to fit our changing society. There should be an option after so many years of verified practice to take the test even if hours are unmet.</p>
<p>Clinical supervision hours reducing from 4,000 to 3,000.</p>

Appendix #22

Concern 'dumbing down' to make it 'easier' will have long term effects. Similar to what happened in child welfare. Due to being desperate, the standards for qualifications of the helping profession was reduced, in thinking this would open more options, but instead, it watered down the profession and weakened the system. You would not expect to have a professional service (haircut, dentist, doctor) from someone not professional or trained to that standard. Don't be desperate -

Consider changes to the clinical licensure requirements.

Consider changing the process if you have to reapply to take the test. Where you don't need your supervisor redo a supervision form or 3 letters of recommendations.

Consider lowering the number of hours to complete clinical level. Lower the number of hours of supervision to complete clinical.

Continuing education is so important. What a blessing to have a love of learning, or to be in an environment where that love can and is fostered by professionals around you so that your growth is reflected in the lives of your clients and patients and students.

Cross state licensure access!

Curious about what is happening with reciprocity. Maybe a email brief even just once or twice a year to all licensees on important updates and issues.

Curious of the status of the SW compact w/ other states. Hoping that it will go through soon. Thank you!

Don't stop testing for initial license of any kind. Don't stop CE hours mandate

Don't capitulate to the discriminatory whims of the federal government. I fear that our state licensing bodies will change our continuing education requirements or ethical guides to meet the federal government's priorities. Help social workers protect and affirm vulnerable populations.

easier multi-state license.

Enhance Public Participation and Transparency

- Solicit Broad Input: Involve a wide spectrum of stakeholders—including consumers, practitioners, educators, and community representatives—when drafting or revising regulations.

Advance Ethics and Professional Standards

- Standardize Supervision: Develop clearer, statewide standards for clinical supervision to ensure consistency in quality and experience for emerging practitioners.

- Strengthen Ethics Education: Reinforce ongoing ethics training requirements to address evolving dilemmas, especially those tied to technology and diverse cultural settings.

facilitating social work license reciprocity with other states

For social workers to have some testing knowledge and capability within their scope would greatly improve diagnostic knowledge as well as reduce the wait-list/report burden on psychologists.

For social workers wanting to keep their license but not doing direct practice currently, the number of CEU hours seems excessive.

Have Kansas license be dual for the 4 surrounding states

Appendix #22

How will the board support those who rely on Medicaid for reimbursement if there are drastic cuts to Medicaid.
I am concerned with how certain state laws impact the ability of us to fulfill our duties as professionals. Case in point, SB 63 this year bans state-funded employees from "promoting social transition." What does this mean for school social workers? The law is vague; what protections do such people have? What does it mean when that law contradicts our ethics (i.e., respecting the autonomy of our clients)?
I am glad that the diagnosis ceu requirement has decreased
I am in support of the interstate social work compact.
I am thrilled at work being done on the reciprocity out of state license and plan to apply in the future.
I appreciate all that our KNASW and BSRB does.
I appreciate the support and desire to maintain the integrity of this amazing profession
I appreciate the support and guidance provided by BSRB.
I can't really think of anything at this time. You are highly regarded and respected already!
I can't think of anything
I definitely think as the aforementioned technological advances continue, such as telehealth, use of AI, etc., Kansas may need to add statutes specifically dealing with confidentiality in the digital age.
I do believe that supervisory hours are important towards obtaining a clinical license; however, I do not feel an exam is necessary to obtain upgrade a license - especially if one is already licensed through the state with an LMSW. please consider changing this as this could stand in the way of some very good social workers expanding their careers.
I do feel a change in the field has occurred. I do hope balance and core values can be retained. I would love to see clarification on categories of service -- administration, education, non profit program staff, executive directors. Substance abuse jobs, criminal areas - jail, corrections, probation. Parole, children/youth programming . Thanks for listening.
<b>I do not (2 responses)</b>
I don't have any feedback at the moment.
I don't have anything to add except to say that the changes in the past years since the pandemic have been beneficial in trying to move forward within the profession. It's still difficult to move forward but seems a little bit more possible.
I feel extremely proud to be a part of the social work profession. If there is some kind of way to encourage or require a provider to mentor a newly licensed provider their first year. (More than a 1 hour weekly supervision) I feel that would be helpful to the mentee but also a learning experience for the social worker providing guidance
I feel like our professional fees in private practice are not competitive with insurance rates and companies.

Appendix #22

I have moved out of state and have maintained my Kansas license because I am Kansas proud. I am looking forward to the continued work on the interstate compact. In the event I would later like to pursue a clinical license while living out of state, I would love for Kansas to find a pathway through the interstate compact for me to progress to the clinical license without needing to license in my new state, as the new state currently does not have reciprocity with any state.

I keep letting my membership lapse because I am not seeing the benefit. I have heard others due this. What is the cost/benefit to having a membership?

I like changes made to decreasing CEU requirements for diagnostics.

I personally think that an individual providing clinical supervision should not also be a licensee's boss.

I see concerns with unlicensed individuals whom have no board oversight - DCF was recommended to implement a certification program which has not been done

I think as a practiced as of over 20 years 40 hrs. of educations is high but I understand there are standards! I appreciate that we have a license as a LMSW as I think it bring integrity to our work!

I think hospice and other medical social workers should be eligible for clinical hours towards LSCSW licensure

I think in person trainings for maybe 1 or 2 classes would be helpful in networking. I think connections are being lost, but I understand why.

I think it could be nice for licensees to receive emails with the board agenda and links about the statutes. Finding and learning and reviewing statutes and regulations is not something that is always learned in school and it is so important. These surveys are helpful and a good idea. Thank you

I think it is crucial that the BSRB advocate for the rights of transgender youth to access gender affirming mental health care in both public and private settings

I think it will important to look at ethics for telehealth in the future, as well as AI use.

I think I've covered everything that has been of concern to the Social Workers I work with. I very much appreciate being asked about ways Social Workers in all settings can be protected.

I think over all the work Social Workers do is so pivotal in today's society and regardless of my few negative experiences, I am proud to be a Social Worker, as everyday provide me an opportunity to make a different in someone's life. For that I thank you all for the opportunity to Help.

I think providing ways to pay the exam would be helpful.

I think requirements for CEU's need to stay the same and not be lowered.

I think that the term "social worker" should apply to anyone with a social work degree, regardless of if they have their license or not. I do not believe it is right for someone to get disciplined for calling themselves a social worker, while they were working in a social work-related job but did not have the license. If the policy remains, I believe this should be required to teach in the social work classes.

I think the licensing exam should be reviewed as many other standardized tests that may be culturally biased (subjective) and difficult for all cultures to pass at an equitable rate.

Appendix #22

I think the state of KS should recognize that the social workers will leave. They will move to other professions and the statistics show that. The profession has a poor retention rate because the providers are treated poorly and they aren't paid well.

I think there could be multiple paths to obtaining independent clinical licensure. I have 40+ years of experience in child welfare, Healthcare, and social work education.

I think there should be an ability to expunge a record.

I think work experience, supervision hours, and the supervision contract, should be enough for a social worker to obtain their clinical license once completed. An exam is not only expensive, but the time it takes to dedicate to that takes away from our clients who we have been serving for years at that point, under supervision. Especially if we are serving clients in a private practice setting - it is literally what we do full time at that point. If nothing else, being able to take shortened versions of the exam proctored by our supervisor and not a testing center would be extremely helpful for all of us social workers who are committed to serving our community, not hypothetical scenarios that are not even close to what we do every day.

I understand that you do not provide advocacy specific to wages or affordable CEU however, you have the ability to review the current statute and regulations that could help direct some of it.

I understand the need to obtain clinical hours, but I do think 3,000 hours to obtain a clinical license is just too much, especially given that we are working in the field daily and, also, have graduated from accredited programs at the undergraduate and graduate level.

I wish I had helpful feedback, but I can't think of any.

I wish there was more advocacy for the profession, including for better wages and benefits, protecting the boundaries and importance of the profession.

I wish there were more free options for education refreshers especially since we spent so much time and money getting our degrees and licenses already. I feel real life experience is where you really learn things. if they had a option to tell us we had to go back to school after practicing few a few years I feel more would be able to better apply what we use in the real world. I feel sometimes the forced structure of a school setting can be hard but beneficial.

I would be interested in knowing why the board has made moves to reduce and/or change continuing education requirements such as reducing the hours required for DSM training.

I would like it if it were easier, less costly, to get licensed clinically.

I would like to be a part of this in some small way. You may reach me via email

I would like to better understand the reasoning for LCSW/LSCSW hours differences between Kansas & Missouri, especially for those of us who live right on the border or practice in both.

I would love to see more updates on the interstate collaboration. I'm very excited for that. Thank you so much for the opportunity to give feedback.

Appendix #22

I would strongly recommend looking at years of services for individuals trying to get their clinical verses another exam. I would also recommend extending CEU's to every 3 years verses every 2 years.

I'm licensed in 3 other states. They all only require 30 hours every 2 years.

If an LMSW doesn't pass the LSCSW by 1 or 2 pints, please make another option available. Esp older social workers like myself. I can show you what I know in a paper or presentation rather than a test

If there is an encouragement for social workers to get a higher license, it would be nice to have an alternative avenue to a LSCSW besides focusing heavily on diagnosis work.

I'm concerned so much of my information is available online - I was REQUIRED by BSRB to include my maiden name when I never practiced SW under my maiden name, I think privacy is a huge concern in the community and online and I don't like clients having one more way to find me outside regular means.

I'm concerned that the number of hours related to diagnosis was decreased. I think historically Kansas has had high standards and I'm concerned that this lowers the standards.

I'm glad you have reduced the hours for diagnosis and treatment.

I'm not sure about statutes and regulations, but I appreciate how simple it is to obtain CEUs (Missouri's used to be a nightmare). On another note, though, please stop selling my contact information or at a minimum, give me the option of what kind of organizations can have my contact information. I'm tired of the emails, especially for jobs I don't want.

I'm not sure where we are in pursuing reciprocal licenses in other states, but that's a valuable trajectory.

Improve feasibility for being licensed in neighboring states.

Improve the process for finding a clinical supervisor and consider capping the fees. Some practitioners are charging rates they would charge for therapy sessions. Many whom are seeking clinical supervision, may not have the funds to responsibly afford those sessions and could potentially deter many from even trying.

Improve website and make regulations and statues more reader friendly.

In general I think social work programs should require more diagnostic requirements and focus on different therapeutic interventions. I have had to learn a lot in my current job.

In my opinion, Kansas is premier for education of social workers. Social workers are desperately needed in Indian Country also. The Training Plan for federal government employees in need of or who desire licensure needs to be made more public especially for the federal government. Recently, Social Worker positions were announced for ONLY clinically Social Workers only. Just FYI, this preference counters the IHS Health Professions Scholarship program for recruitment of Social Workers in that IHS can/will fund the education for Social Work at the Masters level and will require a pay-back to IHS. Yet, the degreed Social Worker will have to attain licensure elsewhere due these types of announcement selective qualifications.

Appendix #22

In my work, I struggle to find licensed professionals willing to work in community mental health due to the work load and minimal pay. It's difficult to find QMHPs willing to do community based services which is a majority of our population. Community CMHCs need more funding for retaining and maintaining quality therapists.
Information regarding disciplinary actions should be readily accessible to the public upon request from the BSRB. Disciplinary documents should NOT be posted to the internet where they are easily searchable by Google as a way to publicly shame social workers. This discourages persons from entering the profession and is contrary to our social work values.
Interesting survey. Keep on getting feedback from BSW's, MSW's and Clinical Social Workers.
Is not at this time keep up the good work!
It would be great if there could be some a push to State entities of the benefits of hiring licensed social workers. It's an overwhelming issue that people in related jobs are not bound by any code of ethics or have any knowledge of professional/client boundaries.
It would be helpful if BSRB could take into consideration that licenses are sometimes required for SW roles even if clients aren't being seen.
It would be helpful if our requirements coincided with other states such as Missouri. Keeping track of different licensing requirements can be challenging. I'm a rule follower and want to make sure I have all the specific requirement for both licenses.
It would be nice to be able to submit CEUs online in stead of mailing them in when you are selected for an audit.
It'd be nice to rework what counts as individual hours. My current position doesn't provide therapy services. But I still work 1-on-1 with clients in a non-therapeutic setting. My supervisor informed me that my work won't count towards my clinical license. So finding a way to make those count towards clinical hours would be nice.
I've appreciated the changes you guys have been making to make it a little easier to keep up with CEU's and reciprocity.
I've been a social worker for 20 years and have done direct patient work as medical SW and hospice SW, BSRB and regulations will not allow me to apply for LSCSW because my practicum 20 years ago was not clinical. I would love to see this change due to my 20 years of experience in a LMSW role.
Just be mindful of how things hinge, evolve, and progress with time as well as the factors that influence those changes. As we revolve we must evolve.
Just echoing the importance of retaining and supporting/encouraging virtual therapy sessions for consumers (and therapists!!).
Just wish it were easier to get licensed in other states especially when you have over 5-10 years experience.
Kansas is a strong Social Work state. I feel it is important for the integrity of the profession and our state to maintain high professional and educational standards.
Keep up the good work.
Less CEU hours every 2 years, or less frequent renewal
Less hours for clinical. Advocating for higher pay for social workers

Appendix #22

Less required hours of supervision and cost of additional testing after clinical hours are completed
License SW and Not have to sit for LSCSW exam if you complete supervision hours. This would allow more practicing clinical social workers.
Lighten up on the high demands for obtaining clinical licensure in Kansas.
Lower the amount of hours to obtain the LSCSW and possibly no test for this or could the test be combined when you get your LMSW so you don't have to pay for 2 tests or take 2 separate ones
Lower the costs of the licenses
LSCSW exam in paper form
Make CEUs more affordable, accessible, and require less than 40 hours as it can get very expensive. It's unfair as we already spent money going to school for our degrees in the first place
Make license renewal fees cheaper. Social Workers are already poorly paid so we cannot afford large fees.
Make the licensing process cheaper. Make ceu hours and costs on par with other professional licenses.
Maybe a requirement involving laws that apply to our clientele such as the juvenile justice system, probation requirements, mandated mental health and substance use services
Maybe have an actual interview process with those who have practiced for many years and possibly allowing some of what they have done--count toward some of the clinical requirements. Develop a point system that would give credit for different types of service provided. Maybe I am just to idealistic. Thanks for asking these questions.
Maybe just better communication about what is being seen as challenges or concerns that some of us just are not aware of. With me being the only social worker in my school I hear very little about other areas.
Missouri requires a suicide CEUs as well as diversity CEUs... that might be of use.
More ways to become involved.
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
My only feedback would be that before anyone goes changing things, put the changes to the test in the field. Time and time again I see regulations and/or changes coming to the social workers in the field that have no merit whatsoever. Just because it looks good on paper doesn't mean it will work out in the field. Thank you.
My recommendations would be to become stronger, not weaker, but it doesn't seem that is the direction the profession is going.
My struggle and desire was to have a clinical license. I settled for LMSW.
<b>N/A (49 responses)</b>
Ni
<b>No (215 responses)</b>
No but thanks for asking

Appendix #22

No comment
No I do not.
No I have moved to Alaska for work so I will be transferring my license here
No I think the BSRB has been great in answering any questions and being very supportive of me. I'm taking it one step at a time and not getting too ahead of myself, but I look forward to getting more experience and learning from others.
No recommendations at this time.
No, thank you for all you do for us!
No. Thank you.
<b>None (23 responses)</b>
<b>None at this time (3 responses)</b>
None at this time thank you
None at this time.
None at this time. Thank you for surveying the SW in the community to give their feedback.
None come to mind.
None that are feasible.
Nope! Thanks for the survey!
Not a fan of the DSM V
Not at the current time
<b>Not at this moment (2 responses)</b>
<b>Not at this time (21 responses)</b>
Not at this time, thank you for your attention to this survey.
Not having to take the licensing exam for the LSCSW after completing the requirements. It's already a lot of money to pay for supervision, and after two years of supervision it shouldn't come down to taking a test to receive your license as for some people test taking is hard and shouldn't determine if you get a license or not after all the hard work and time put in for clinical hours and supervision.
Not need to test for the Clinical License as long as hours are met and reference letters are good.
Not now
Not really
Not sure how to address it, but getting more males involved in the profession. When I was in sophomore year of college (1998, University of Texas BSW) I had no understanding of professional. I imagine this is still the case. I figured it was all either school counselors and DCF folks checking for child abuse
Not sure since I am not sure what they do. I would say having a good representation of the profession on the committee not just one black person or one rural person, do you have a Catholic on the committee, do you have a senior citizen on the committee, have you worked the extra mile to engage the profession in providing input and most importantly do you really listen and discuss or do you do polite listening and then plan according to what the committee feels is best.
Nothing at this time.
O

Appendix #22

Other states allow to test for higher licenses in home. I have literally done EVERYTHING to pass this test from different practice modalities, tutors and Kansas BSRB does not appear to be as supportive as other states in allowing at in home testing. People have different needs to pass standardized testing.

Our local Compass Behavioral Health center has experienced such high turnover among therapists and administration that local people are seeking private practitioners. Sadly, those private practitioners have come from Compass Behavioral Health, where they experienced higher-than-normal workloads with less time in between clients for the necessary paperwork. What I understand is that they will have back-to-back clients with little time in between to log what services were provided. It almost seems like to keep the doors open, they had to be able to bill the insurance companies for covered services. So the more clients you get through doors, the more services you can bill for. Like quantity over quality. As I am in the schools (23 years) and have been a social worker so long, I have seen at least 8 changes of office administration/supervision at our local CBH. The individuals who seem to stay the same are the case managers and client liaisons.

Payment of social worker student practicums. Most agencies depend on free student labor and several in the field overwork themselves and get burnt out before even starting due to most practicums not being paid. Or having to reduce work pay down to part time and the other part time being "interning". I just don't think it is ethical. At least a stipend or something.

**PLEASE DO NOT WATER DOWN OUR ETHICS AND COMPETENCIES TO TRY AND MATCH OTHER PROFESSIONS!!!**

Please go back to requiring 6 hours or even more diagnosis and treatment continuing Ed hours for masters plus degrees. There are so many more people with mental health issues, especially severe Anxiety now cause kids aren't receiving needed problem solving and coping skills and the level of anxiety that's caused by phones/social media anymore so the level of need for good therapists has greatly increased. Please require well educated professionals for social work services.  
hours

Please hold more free classes and CEUs for Social Workers preferably on the weekends when the majority of social workers have off.

Please look into Andover Family Counseling and Lindsay Sanner (LSCSW, RPT-S). There are some wildly unethical, problematic and predatory practices taking place with her and that practice that are directly impacting students and new social workers.

Please make the test and licensing process more affordable. Having such steep costs limit who is able to become licensed.

Please update your license renewal verbiage to include intellectually disabled term that has changed in the DSM-5. It has two spots under working codes numbers 27 & 38, that need updated. Thank you!

Quarterly newsletters would be helpful. More information on links to watch meetings and reminders, along with training resources.

Appendix #22

<p>Recognize the clinical nature of Hospital Social Work by allowing hours to count toward the independent clinical license. There are behavioral health complexities that have to be addressed to have successful outcomes for patients. It requires a focused therapeutic intervention that is goal oriented. Many times evidenced based short therapeutic interventions are utilized.</p>
<p>Reduce the fees and CEUs</p>
<p>Reduce the renewal hours for social workers t 30.</p>
<p>Require at least one CE hour every renewal cycle on evidence-based treatment for clients who have both mental health and substance-use disorders. And add an elective topic that covers screening and brief intervention for problematic internet use, now linked to ADHD-like symptoms in adolescents.</p>
<p>Salary should match experience and certification/education level. If this is not possible, requirements should be lessened/dropped.</p>
<p>Same answer about Washburn.</p>
<p>see #13 - there are less of us, nurses, doctors out there, there will be a massive gap in services in 5 to 10 year...especially with the "big beautiful bill" and the changes to student loans</p>
<p>See 13.</p>
<p>See above</p>
<p>share more info on compact licenses as well as changing CE requirements. I moved from NY and they require less hours and have a 3 year renewal structure- NY is very strict with CEs and the amount and timeframe to obtain them for KS is too much. I work for the state and there are some licensed folks in DCF in social work, but not a ton. I am the only one in my office, and I think in my region (KC). I had to pay to join an online provider to get enough CEs this last time.</p>
<p>Stop allowing private practices to have egregious contracts specifically relating to non competes and allowing private practices to charge clinicians for their clients if they choose to leave. Seeing that the majority of our work stems from the relationship we form with our clients and then allowing these practices to do that to clinicians goes against our moral ethics in my opinion. Start with the largest and most corrupt private practice in Kansas. It's called Soma in Wichita.</p>
<p>Stop pushing beliefs, values, politics, etc. Focus on standards of competency and practice.</p>
<p>Supervisors need to be at minimum an LBSW, even if they have a license in another area, in roles where they are supervising client case management.</p>
<p>Systems changes that promote provider well being and trauma informed staff development/supervision.</p>
<p>Take a look at the necessity of licensing exams. I understand the state of Illinois no longer requires exams for social workers due to learning that the exams were biased in terms of marginalized populations is not passing them at the rate that white social workers were. If you have a degree, you should get a license. If you do the clinical hours you should get a license.</p>
<p>Thank you for allowing the opportunity to provide feedback, I appreciate that of the BSRB Advisory Committee.</p>

Appendix #22

Thank you for asking for our feedback.
Thank you for checking on us!
Thank you for putting out this survey!
Thank you for this questionnaire
Thanks for taking to time to get feedback!
The amount of CEU's is excessive!
The BSRB office is not responsive to questions or concerns from social workers. I have called and sent emails months ago regarding a specific question with no response. There needs to be more stringent oversight regarding individuals portraying themselves as social workers when, in fact, they do not have the education or license.
The clinical exam is challenging and difficult to target which areas to focus on. The 20 questions that are not counted are unfair to the test takers and need to be removed in my personal experience.
The hours required for LSCSW should be 3000 the same as MO
The licensure test for a clinical license is awful. I would have my C already but I suck at testing. Others struggle with the same thing and I can't get jobs I want based on the fact I can't pass the test.
The needs are huge, please keep considering how to keep social work services accessible
There is a significant need to recruit new clinicians to the profession and make it easier for clinicians to get adequately trained and licensed. Explore ways to offer reciprocity and expedite the multi-state license

Appendix #22

To avoid burnout make sure each social worker/licensee is being treated appropriately within the work place. For instance, if they are only supposed to have a maximum of 12 clients on their caseload-make sure these therapists/workers aren't being taken advantage of and have close to 40-50 clients on the caseload. Consider what one client consists of depending on the type of therapy. For example, if they are FFT family therapy, then that one client becomes anywhere from three clients to most likely closer to ten on one case, bc of all the family members involved. So 12 cases that are court mandated because the teenager was on intensive supervised probation (ISP) becomes close to 100+ people. Then add the 30-40 additional cases they add on top that you have to work with and some that are on waiting lists that you MUST make contact with every single day which turns into hours of talking because they are so frustrated and just want help, while the actual client on ISP want nothing to do with you, it all becomes nearly impossible to bear and actually keep up with. People are calling literally 24/7 with emergencies and horror stories that I as the therapist am expected to fix. And to be very honest if I don't answer or try to help, people would have died. There were many times I was the only one who made a difference between life and death. I hope that makes sense; that it can become extremely overwhelming and make you feel like you are drowning. Especially with very little support and systems in place where you and your mental health don't matter, just positive outcomes. Also, offering more options for licensees who are disabled. I believe there is a large population that could benefit so many people greatly with their training and hearts. However, there are limited options for these people. Id love to be able to find more ways for those who have unfortunate scenarios or are physically impaired to make a difference in the world!

Try to get a wide variety of advanced, new and retired professionals.

We need some guidance on AI and telehealth. Right now there is none.

We would benefit from Tarasoff legislation. Most of the universities in KS teach it as being the law in KS, but it's not.

When I was renewing my license in January of this year. There was an employee of the BSRB that helped me greatly.

Typically, I know the BSR is very busy, but she took a lot of extra time to help me when your application systems were glitching. Renewing my license was a little bit stressful for the first time and she took a little bit of ease out of it with the help that she gave me.

While not directly related to statutes and regulations, I'd like to see the BSRB expand CEU options to include advocacy work or serving in elected office.

With current legislation, therapists need to be protected. Transcripts provide proof.

Working for multiple interstate agreements regarding licensing, especially with telehealth

Would recommend revamping regulations regarding the amount of clinical hours needed for independent/clinical licensure. The financial strain and the time commitment could be condensed to still receive quality supervision in less time. Possibly consider the amount of time a LMSW has been working in the field as a direct staff and consider being able to apply hours toward clinical licensure.

**Appendix #22**

Yes, reach suggest that people color are not passing the LCSW test at the same rate as others, there KS should consider alternatives.

Yes. There is not a good way to transfer supervision hours. The BSRB allows reciprocity but they don't have a standard set for when someone is in the middle of supervision. Also, in Missouri, you can test when you have a certain portion of your hours, you can't do that here.

Your website is terrible and finding information about requirements is difficult and not straightforward at all. Also, we need more people licensed in Kansas. Stop making policy advocacy choices that put the BSRB at odds with helping people practice in this state. We should make KS a place that is as desirable for social workers as our neighboring states. Where is the multi-state license?

**LSCSW Q15. Do you have any other comments or feedback you think would be helpful for the members of the Advisory Committee to receive when evaluating possible recommendations for changes to the statutes and regulations for the social work profession? (578 responses)**

1 Mandatory training for social workers who provide clinical supervision; 2 Increased oversight for clinicians in private practice - I am not opposed to this for clinically licensed clinicians as well; 3. Increased education about burnout. I see a high correlation of people seeing 30+ hours to increase revenue however this increases the likelihood of burnout, secondary trauma and decreased quality of services. As a seasoned clinician this is still a difficult balance and I am learning about how to advocate for higher rates - but this is an area which I had no formal education and guidance; and 4. Increased guidance and education with incorporating AI in our practice. Ethical do's and don'ts

40 hrs. of CEUs is a lot!

A clearer investigative policy with specific timelines for complaint resolution should be instituted.

Action, we need actions. Also the dumbing down of the education so students can pass needs to stop. Stupid SW s are entering a very challenging workforce and jeopardizing my profession.

Advertise supervision trainings. I'd like to begin that but cannot find trainings.

Again, I think appropriate business practices and how that should be practiced within the state for social workers.

Age restrictions or requirements should be considered for particular Social Work assignments. I have a hard time with someone under the age of 25 making decisions that have huge implications for individuals and families.

AI is coming for our jobs, especially clinical jobs. We will have to step up training for clinical social workers so that it is clear that we offer something that no bot can offer: a transformative human relationship.

allow us to practice in other states regardless of what state we are licensed in, if I have a client that is comfortable with me and moves to another state I can no longer see them-this is not what is best for me or them, only serves the state and it is all about the \$\$\$

Already noted

An interstate compact. Trying to get my clinical license in Kansas after already having it in Missouri was such a headache. Just have one license that serves at least Kansas and Missouri.

An understandable manual available for supervision, licensing/relicensing, etc.

Appreciate the communication

As a SW myself I have been grateful for all my interactions with the BSRB staff. We are supposed to maintain a strengths perspective practice which seems evident in the statutes and regulations that I am aware of. So maybe make sure these are easy reads with common sense reasoning behind them?

Appendix #23

As I consider retirement, how could I keep my license for the possibility of helping as a volunteer in a crisis, such as after tornadoes. Also, this survey doesn't have choices of zero in some questions.

As someone licensed in Illinois who applied for licensure in Kansas I will say that the process was much much smoother here. I found that using email and online communication made the process much quicker. I also found staff to be responsive and helpful throughout the process. Thank you!

As we move towards a multistage license please, please help us navigate with insurers with reimbursement. I fear that insurers are colluding to keep costs low. This along with company's like better help are moving lscsw's to insolvency or at least out of private practice. Kansas has been very fair in reimbursements. If this changes I personally will look to cease accepting insurance at all.

As you consider changes to statues/regs, please limit the need for any additional paperwork burden. The amount of signatures and information we currently convey and collect can be overwhelming for clients----clients who already are burdened by issues bringing them to our office.

Be cautious in regs when it comes to our rural areas. We are serving an underserved population and the more requirements and travel the less likely we can continue to provide services

Be helpful to have proportional representation by social workers on the BSRB

Because of the unique work that social worker do, it is important that they are highly educated and well trained. When you reduce requirements for social workers, you maybe reducing the quality of social workers.

Clarity if someone takes pauses in their supervision or lacks client load when initially starting. Even with one client a month they are required two supervision meetings a month and that can get expensive when a social worker is paying out-of-pocket for supervision.

Clear information on providing clinical supervision on the website.

Communicate to licensees on BSRB updates via email, including advisory committee hearings.

Communication about what statutes and regulations you want to change would have been more effective than this survey.

Compact

Compact has been a good idea and helpful.

Compact would be super helpful!

Consider what I said about AI. Too many therapists look for ways to ease their workload without knowing or considering the terrible implications.

Continue to pursue interstate/multistate licensing, especially due to telehealth and people in our area of the state, SW KS, living just over the borders in CO, OK, and NE.

Appendix #23

Continued movement towards interstate compact in the US to help provide services. Kansas is my third licensing experience due to moving for my spouse's career and although it went well, no matter how quickly I try to get the paperwork into the individual states, there is always a delay meaning that I am unable to earn income until the state approves. By joining the interstate compact, hopefully the process can be streamlined and made efficient to allow people like me to start working as quickly as possible.

Continuing to push approval of interstate compact.

Could the number of required CEUs be reduced for those of us who have practiced 25+ years, or more?

Could the statutes be put in a more searchable database? I have a hard time finding things and end up emailing for assistance more than I would like to (thanks again, Joan! )

Decrease CEUs from 40 down to 30. Approve interstate compact license for social workers with no test requirements and at a regional price for the license.

Diversify the advisory board

Do follow up on those that wrote recommendation letters.

End licensing at BSW level and open those jobs up. Focus on MSW level practice.

ensuring NASW Code of Ethics are upheld while also ensuring compliance with federal guidelines from SAMHSA and DHHS

False allegations made by consumers without evidence can trigger prolonged investigations that significantly impact a clinician's career, reputation, and mental health. The duration and lack of due process in these investigations are concerning. We need the Board to advocate for fair and timely review processes and to safeguard the profession from punitive measures that lack substantiation.

Finalize Interstate Compact

For clinical social workers, the perception of being at the top of their profession is having their own practice. This is very concerning. It takes many years of experience to achieve the necessary level of competence to serve in that capacity. I fear that with the tremendous demand for mental health professionals, we will/are compromise competence and quality for bodies in chairs. This will result in harm to clients, negative experiences, and ultimately a poor reputation of the profession.

General support. This is a very, very difficult profession at this time and while it's very rewarding, too, people, including ourselves are in deep psychological pain about the state of the country and the world. We need support groups! I could find one but I don't have time to assemble one. Thank you!

Get some people on the board who actually care about "services to the people" of this state who have health, mental health, or substance use disorder problems. The fence-building is out of hand. The fence building has wrecked the child welfare system in this state.

Glad to help with a committee.

Handling and managing insurance is difficult and often has no rhyme or reason. Maybe some trainings in this area would be helpful

Appendix #23

Help to promote the inter state compact to make it easier for social workers to provide services across state lines.

Hmm, I have had a few clients who expected to do therapy while they are driving. I've explained that I don't do that because it is a distraction. Mostly they understand that. But a few do not. Should that be regulated? It's not for me to say. But for me, it is a safety issue; I could never live with a bad outcome. I suppose people often do business calls while driving, and those can be complex. I think this will probably fall into the realm of personal choice.

Hoping the state reciprocity network will ease challenges with multi-state practices.

I am continually disappointed with the skill set and insight of marriage and family therapists. I routinely work with clients who have seen a LMFT in the past with negative results. There seems to be an overall lack of solution-focused interventions leading to long term ineffective therapy and often a lack of trust. I'm concerned MFT programs lack ethical and educational rigor.

I am in favor of multi-state licensing that allows practitioners to see clients in multiple states via telehealth.

I am licensed in 3 states, the other 2 require 30 hrs. of CE's. The LCSW's that I know are diligent about continuing to learn, and not just for CE's - so I 'm wondering, especially with the compact in mind if Kansas would consider going to 30 CE's to be compatible with other states. Although I must admit I have not looked into all the other states requirements.

I am licensed in Kansas but reside in Arkansas. I will say that as a 28 year social worker, I do find it unnecessary to have not only 40 CEU hours, but to mandate they be in certain areas/topics. I respect the CEU process and I believe they are important. I do not believe a board should dictate what hours I pursue however.

Appendix #23

I am offering this feedback as someone who believes deeply in the healing potential of our profession--and who wants to see it evolve into a space where integrity, humility, and justice are not just discussed, but practiced. As a 26-year-old clinician, I should still be looking up to the more experienced professionals in this field--seeking mentorship, community, and inspiration. Instead, I find myself increasingly appalled by the conduct of many older therapists in Kansas. These are the individuals who often hold the most power in practice ownership, supervision, and community leadership--and yet they consistently model rigid hierarchy, emotional inaccessibility, ideological bias, and judgment disguised as professionalism. They are the first to preach about trauma-informed care and relational authenticity, and the first to punish it when it's actually practiced. I did not expect to enter this field only to be alienated by those who built it. And honestly, I don't even know how much longer I will last in this profession--not because of a lack of skill or commitment, but because of the lack of relational and moral sustainability in the professional culture around me. I know I am very likely addressing some of the very professionals who are immersed in these systems and may not yet recognize how they perpetuate harm. And I also understand that for some readers, this feedback may feel too harsh, too personal, or like it doesn't reflect your experience of the profession. If that's your first reaction, I invite you to pause and ask: Whose experiences get validated in this field--and whose don't? Who gets to speak openly, and who is taught--implicitly or explicitly--that it's safer to stay silent? The discomfort in reading this is not a sign that it's off-base. It's a sign that the system has become so normalized in its harms that naming them feels inappropriate. That's exactly the problem.

I am very appreciative of the work of the Board and Advisory Committee.

I appreciate the CEU tracker, but I am licensed in multiple states and the other states aren't on there. I know that's out of your control but the NASW offers a CEU tracker for all states.

I believe in maintaining licensure for the BSW and MSW levels. I was able to complete my clinical supervision via virtual meetings with my supervisor and other supervises. I am very grateful this was an option and think it should remain an option. It allowed me to make connection with and learn from social workers in other parts of the state that I likely wouldn't have met otherwise.

I do not but I appreciate the opportunity. Thank you

I do think consistent and definitely widely given opportunities for suicide prevention clinical skill improvement would be something to encourage/build up.

I don't know if this is possible, but I would really like the committee to consider a statute or regulation change around the ability to temporarily serve clients who go to another state for a short amount of time, or clarity on the circumstances for which we can continue working with those clients. I work with many students who go home for the summer or to another state for an internship for a short amount of time and, even if they are on and off or actively suicidal (if I reading our regulations correctly), I cannot continue to serve them temporarily meaning I have to interrupt our work just because they are fulfilling an educational opportunity or educational geographic change.

Appendix #23

I encourage BSRB to continue allowing CEUs for licensure renewals to be completed through online courses so that licensees in rural and underserved areas are supported in their Continuing Education with easy to access and affordable resources.

I encourage the BSRB to re-examine the practice of issuing public citations in instances where consumer safety is not in question, or where concerns may be a stretch. If the goal is to protect the public, then it's worth considering whether public posting is always necessary, especially in cases that reflect professional missteps rather than a clear risk to safety. Ethical violations and professional missteps, while important to address, do not always equate to a threat to public safety. Treating all infractions as equally severe may dilute the impact of serious concerns while creating undue harm for licensees navigating less critical and raw human issues. Additionally, current policies that prevent individuals with any historical infractions from serving on the Advisory Committee Board directly contradicts the peer support and lived experience values our profession upholds. Transparency is important, but so is proportionality. A more restorative, trauma-informed approach to regulation could reduce unnecessary stigma, support learning, and foster long-term professional development. Trauma-informed systems recognize that shame is not a driver of accountability; safety, connection, and fairness are. I would also recommend establishing a clearer pathway for expungement or restoration of one's public record after corrective action has been completed. Doing so could reinforce equity and renew trust between licensees and the communities they serve. As it stands, the current system often highlights only the negative, overlooking the everyday ways licensees promote healing and resilience. In a human-centered profession rooted in supporting the recovery of others, our regulatory body should reflect those same values. I am not calling for leniency, just a call to align our practices to reflect the core principles of our field - dignity, accountability, and the belief that growth is possible.

I enjoy the email updates that help me keep abreast of the ideas, and knowledge surrounding licensure and the individuals we serve. I also like the fact that I am included in surveys, and asked for my opinion.

I feel better informed and supported because of all the people working at the Kansas regulatory board of social workers THANK YOU!!!!

I find that the telehealth option has been a wonderful asset for my people with agoraphobia and other issues, travel that I am able to help them and they don't fall between the cracks. They have said how much they appreciate this option.

I focus on serving my clients and I have not had the need to ask for help. Although I know I can benefit from being more in the known of the ins and outs of our board, for professional growth.

I have been a social worker for over 30 years and am always disappointed but the lack of support and respect we show one another. If we don't have one another's backs then how can we expect others to!

I have been on the committee and understand that everyone is doing their best to provide guidance for our profession during difficult times. I appreciate this survey. It is good to get input from the profession. Thank you!

Appendix #23

I have been totally happy with my career of LCSW over the last 20 years, however due to age I plan to retire sometime in August or September and will not renew my license.

I have found the efforts to include Kansas in interstate groups for broader licensing and outreach to individuals in need of services interesting. The need for social and mental health services is clearly growing not declining.

I have had trouble finding appropriate consultation or legal support. Even through NASW- who only had one of two legal and ethical support roles filled. It would be nice if we had back up or services offered to us similarly from our own board. I would like to see the board go to bat for clinicians who are suffering under the power of big insurance in terms of underpayment, limiting access for clients and clinicians, and contributing to burnout. I feel the board can and should do more to keep social workers in its profession.

I have none at this time, but appreciate your work!

I have noticed a decrease in the willingness of social workers to become licensed because it's not a universal need based upon where they are working, which I think is negative impact to the profession. I work in a cancer center setting that does not require its social workers to hold a license even as a BSW. I think that without a license there is no accountability to maintain continuing education to improve their knowledge.

I have noticed students from some SW schools in KS lack basic skills and abilities compared to their peers schools. So much so that certain programs grads get a more thorough examination based on the low quality of past grads. I have noticed some trouble in getting new licensee's approved in a timely manner after graduation/confirmation from schools. The CE bank thing offered by the BSRB for tracking CE hours is cumbersome and useless. I hope you didn't pay for it.

I haven't looked things over recently, so not sure. Appreciated that they reduced the diagnostic CE requirement to 3 hours.

I know some changes stem from workforce shortage issues and making it easier to invite people into the social work profession, I just don't think our structures, values or regulations should be less to do so.

I know this is in progress but I am excited for the compact to start. What a great way to provide a continuity of care and be able to serve those folks who are traveling nurses, over the road truck drivers, etc. who struggle with getting care due to their mobility.

I like the interstate compact for licenses. Great innovation!

I look forward to continuing my membership as a retiree

I may be unaware of this, but I would like to see once a year where providers throughout Kansas are able to meet the committee and have direct Q&A.

I renewed my yearly license today and I was reminded of the reduction of renewal fees and it was a nice moment.

Appendix #23

I served on the SW Advisory Board two different times when meetings were only in person in Topeka. Thank you for your time and commitment. We should expect more, not less, from professionals. I take pride in my profession and my training/ongoing education.

I simply want to thank the Committee for sending out this survey to request honest feedback.

I still think you should contact Lis. Social Workers via email and mail . Not just one other. Or compromise and contact via email and text to check your email box. Support and Advocate for US Too

I think 40 hours of CEU's is to many. Maybe consider 30 hours instead.

I think advocating against the push to reduce Medicaid and Medicare services.

I think CEUs are readily available and have even become more affordable with all the online and webinar availability. It has helped improve my practice, certainly don't think that there should be any reduction in total hours. Nondiagnosing social workers might benefit from the reduction of diagnosing hours, but diagnosing practitioners should keep up the previous standard.

I think continuing to reach out to professionals and consumers for feedback makes sure everyone's needs are being properly met.

I think group supervision is the most helpful approach as there is more accountability and opportunity of learning from multiple sources.

I think it would be great if LMSWs had to work in community agencies for 2 years before being allowed to go into private practice. The learning would be tremendous and it would help with the shortage of mental health providers in CCBHCs and FQHCs.

I think it would be helpful for the BSRB to have educational material available on starting a private practice, there are so many private practice settings, different levels of licensure, fee scales and it feels like everyone just looks to private practice agencies or solo clinicians for guidance.

I think it would be very helpful if we had could be licensed nationwide. If we all have to take the same exam, it needs to be a national license so we can serve in the more remote hard to reach areas.

I think the continual and astronomical cost of applying for licenses, paying for tests, and fees to process paperwork is unethical. It creates a hardship for social workers who are trying to better themselves and provide services to their clients, especially because many of us are already under a large financial strain. The cost of supervision, the binding contracts many of us are forced to sign by agencies who abuse their power over us when we have to have supervision anyway, in addition to the cost of additional licensure requirements, is unjust and unfairly targets people who already face social hardships or discrimination. I also believe tele-health should be protected by the BSRB as it brings access to therapy services in rural areas. Many of my clients would not have access to services if they were unable to find a provider who offered virtual services.

I think the diagnosis and treatment CEU requirement is too basic. I'd rather see a course on trauma interventions be required.

Appendix #23

<p>I think there should be a requirement for training to include specific adaptations &amp; interventions to use when working with individuals on the autism spectrum.</p>
<p>I think we should go back to 4000 hours instead of 3000 for LSCSW. The quality of new LSCSWs seems to be lacking in ethics and ability to think critically. I think there needs to be frequent training specifically for people who are supervising clinical hours (min. 3 hours per CEU cycle).</p>
<p>I was disappointed to see diagnosis hours cut from six to three hours</p>
<p>I wish there was different requirements on CEUs for those who have spent years in practice and find themselves going to the same workshops over and over again. Might those in long time practice have fewer CEU requirements and have them focused on things that are ever changing, i.e. pharmacology, review of ethics, treatment of the geriatric population and an overview of all services available in the mental health field specifically in Kansas.</p>
<p>I work in an inpatient psychiatric setting as a clinical social worker. At this time, AI has been shown to be a significant negative problem. Patients will utilize AI for social support and at times refer to it as their therapist. When they describe these interactions, they do not appear to be therapeutic, oftentimes with the AI agent agreeing with things that might be detrimental to the patients improvement in terms of their mental health diagnoses. Regulating the use, marketing, and oversight of AI, which is explicitly for social support and or therapeutic benefit will be quite important in the years to come</p>
<p>I would just like to see the multi-state license completed soon.</p>
<p>I would like more updates about the Social Work Compact, I know it's still a ways out from being implemented but I'd like to know what steps are being taken and how it will be implemented in Kansas.</p>
<p>I would like to be able to see clients who move to other states, now that telehealth is available and accepted.</p>
<p>I would like to see the social work license to be applicable through all 50 states without needing to apply for reciprocity.</p>
<p>I would love for SW as a whole to be more proactive in the trends. I know Kansas is working on the interstate compact but we are so behind the Psychologists who are licensed and practicing in 40+states. I feel like sometimes we over analyze things that could be beneficial to the care of our constituents.</p>
<p>I would love these recommendations to be standard across professions</p>
<p>I would recommend looking at other state licensing boards to see what is being done in other states. Also, if you don't have a training for safety in the field already being held, then it is not appropriate to mandate it for social workers. We do not have unlimited resources to spend on figuring out what the board means and to spend money on things that might not be approved by the board for the continuing education.</p>
<p>I'd like to hear more about the social work compact with other states.</p>
<p>I'd like to see more alignment of requirements across behavioral health disciplines. It can be hard to navigate when one is in a large agency in a management role. Thanks for all you do.</p>

Appendix #23

<p>I'd like to see the ability to practice across states without getting licensed in each state. I will tell you I love being a LCSW and LCAC. I am grateful for the BSRB. Have a great day!</p>
<p>I'd like to see the multi-state compact operating and with more states, mainly for clients who travel a lot for work or move interstate.</p>
<p>If possible, fast track the interstate compact for mental health professionals.</p>
<p>If someone has been approved to take the LCSW test in the past, but is also currently definitely NOT recommended for licensure, the board needs to investigate rather than just rubber-stamping their license.</p>
<p>If there was time to create a "cheat sheet" or reference sheet that has the general rules people are often looking for such as who can supervise you for what license, how many hours needed, who is eligible to supervise, etc. would be super helpful.</p>
<p>I'll be happy to utilize the interstate compact. I would really appreciate emails notifying me of legal updates or any other mandatory issues that arise. Or information on an app to provide notifications.</p>
<p>I'm not sure if this is the appropriate place for this, but social workers need to have more career options in terms of being paid a livable and stable wage, a healthy work environments (where burnout isn't the status quo) while still serving populations that are underserved. To my knowledge, this crossover has yet to exist. Also, in private practice, social workers need more support on the business side of the practice.</p>
<p>Implement cross state licensure</p>
<p>In person trainings cost too much for the amount of hours received, and the amount of revenue lost.</p>
<p>Include a diverse social work body in the decision making process to ensure real world application is included and taken into consideration for any proposed changes to statutes and regulations.</p>
<p>Increase clinical hours for diagnosis to 6 CEU's again especially for those that have clinical licenses.</p>
<p>Increase requirements for child welfare workers. Make it a specialty. Require certain ethics courses maybe.</p>
<p>Interview anyone applying to be a LCSW. I have worked with too many clients who have experienced harm caused by a licensed provider that I feel we should held to the same standard as Police and others responsible for the safety and wellbeing of people; either by an interview with the BSRB in person or a psychological evaluation to ensure mentally well individuals are able to pass through the process to taking the exam and mentally/emotionally unwell individuals are not able to sit for the exam and obtain a clinical license. The standards have been drastically reduced over the last 10 years and I feel this is a disservice to the safety of our clients. If you want to require less practice hours to ensure therapists can apply sooner for their exam, also consider another layer of ensuring only the most ethical, healthy and competent providers are able to obtain the highest level of licensure. I worry the quality is watered down for quantity.</p>

Appendix #23

It is expensive and a hassle to hold multiple licenses along with professional memberships etc. Each state has different CEU topics. For more experienced practitioners, how many ethics workshops does one need in a lifetime?

It surprises me the required number of CEU's for diagnosis training was reduced when it is an important part of what I do as a clinical mental health therapist.

It was very confusing as a clinician under supervision years ago to be called on the carpet for using the title of clinical social worker/LMSW. Every part of the practice was clinical, but I was not allowed to be called a clinical social worker until after the LSCSW license. Too confusing. Tell clinical social workers under supervision what title is acceptable.

It would be advantageous for a nationwide license to be established. Sometimes I get referrals from out of state and have to refer them back. I also get clients who travel for a living and being able to serve clients in other states would assist those clients too.

It would be helpful if social workers who are dually licensed (LSCSW and LCAC) could have licenses renewed simultaneously and if more hours could carry over for both licenses.

It would be interesting to look at extending the license renewal process to a longer time frame once you have a certain number of years under the license. IE, if you have held an LSCSW for 10 years, then you can renew every 3 years???

It would be nice for these committees to have a newsletter or something that gave information on what is being done or worked on. Maybe a quarterly newsletter to license holders.

it's concerning to me how many new graduates right out of school are going into private practice vs gaining experience working for another organization that may provide rich supervision experiences.

It's interesting to observe that LMSWs are able to operate private practices independently, despite licensure regulations suggesting the need for appropriate supervision. I've noticed a growing number of LMSWs in my area running private practices without oversight. In my own private/group practice, we offer extensive support and resources for LMSWs to practice ethically and within the scope of their licensure. However, it's becoming increasingly disheartening—what's the incentive to follow the rules when so many clinicians appear to be practicing outside of legal and ethical boundaries, with no oversight?

It's quite difficult to see how one can get involved with Advisory Committees. I received one solicitation via e-mail almost 9 years ago looking for members to something that I know nothing about. I believe an ongoing e-mail campaign to both educate the professional community and solicit involvement for advisory committees may be helpful.

Join as many compacts with other states as possible!

Just a caution... remember that SWers can be disabled too. I am visually impaired and had a guide dog until a year ago. I thank Covid for remote opportunities and for many areas transportation is awful. I miss working in NP sector. In rural areas we need to push for adequate internet and affordable cell coverage

Appendix #23

Just setting up a website that we can use to update and submit information safely and efficiently. Improved instructions around application process.
Keep doing the great work that you do
Keep up the good work.
Lake, the diagnostic criteria of continuing education, easier to understand. Lots of trainings appear to meet that requirement, but it remains ambiguous to me.
Less ceu trainings through articles approved
Like every other dept in the state, we are worried about budget cuts. I know you are a small office and have limited capacity. I hope this year the feedback results in change to support us. Thanks for the effort.
Look closely at those supervising in the clinical realm. Ask for more feedback from those being supervised. If one supervisee has issues with a supervisor then there are probably others that are scared or feel intimidated to report that supervisor.
Looking forward to seeing how the social work compact will aide in providing services within and out of state.
maintain the standards
Make sure to join the PACT agreement so we can practice in more states without having to get a license in each state. I volunteer for Red Cross and it would've been nice to be able to provide counselling to victims in other states.
Make the statutes and regulations crystal clear so that supervisors and supervisees aren't having to use precious time to send emails asking for clarification.
Meet more often or do more work. In over a decade of experience in providing social work services in KS, I have become increasingly concerned about the low-bar set for individuals to practice in KS and the potential damage this is doing to both consumers and providers. Many providers experience the BSRB as purely a punitive agency.
Mo
More available options to acquire the required extra areas of training for free such as safety training.
More education on how to use AI.
More free continuing education opportunities!
More reciprocity regarding licensure in other states
More robust clinical/diagnostic focus for MSWs focusing on therapeutic work coming out of school.
More training about the process of becoming a supervisor.
Multi state Compact license will be helpful to avoid issues with serving in areas with close state lines, including Kansas City.

Appendix #23

My big push is for more education on evidence based therapy modalities. There are several new treatment modalities that social workers are spending thousands of dollars to get certified in that have no empirically supported data to back them up. It worries me that social work schools are even encouraging these alternative treatments without fully disclosing their lack of research. I'm surprised when I take on a practicum student who has little knowledge in this area and I find myself as their site supervisor teaching them about academic research which is something their school should be doing. Please add language into the statutes to differentiate evidence based from alternative treatment models.

My only hope is that virtual therapy continues as I have seen within my own practice and colleagues the benefits to consumers

**N/A (30 responses)**

NASW added self-care to the ethics code, and it would be helpful to make a statement about the importance of self-care and social worker impairment in the statutes.

Need a way that I can provide continuity of care and appropriate transition/follow up to clients move out of state, since the compact does not seem to be progressing

Need more social workers on the board. we far outnumber other professions and still have what 1 seat? 2 seats?

Need reciprocal licenses to meet out of state demand for services.

Nice to have flexibility to do CEUs all virtually, if necessary.

**No (218 responses)**

No - as I see the current state of the country - I'm proud of my profession and the value it provides.

No. Thanks

No comments at this time.

No thank you

No, aside from sharing those proposed changes with licensees

No. Thank you for the good work you do.

**None (25 responses)**

None at the moment

None at this point. Thanks for including our input.

**None at this time (7 responses)**

None come to mind.

None currently. I appreciate the work the advisory committee members provide.

None that I can think of at this time.

None that I can think of right now. thanks.

**None (3 responses)**

Not a this time

Not at present

**Not at the moment (2 responses)**

Not at the time.

Not at this moment.

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<b>Not at this time (24 responses)</b>
Not at this time, thank you.
Not currently
Not really.
Not really. think about as good of a job as we can that we are doing.
Not that I can think of, but appreciate the opportunity to participate in the survey
Not that I can think of.
Not that I can think of. Thanks
Nothing that I can think of at this time. The only feedback I would be able to provide is the experience with the BSRB itself.
Now
Number of CEU's required to be taken to renew every 2 yrs needs to be reduced. 40 is excessive.
On the other states that I have worked and gotten supervises there was a list of people in the state that do supervise students which would help to get more students to supervise like a register. Thank you.
One of the comments in the outline for this survey is why do we think that more individuals are not seeking out their LSCSW and I believe that it is in due part because in several practice locations (including most all schools) there is no pay increase for being an LSCSW vs. a LMSW. I worked at a school for 10 years and none of the social workers that had a higher license were getting paid more for having an increased credential.
Only to keep working on a compact. I know that's not just up to KS but we need to keep pushing for it.
Overall, doing a very good job of regulating the social work profession.
Overall, helping providers navigate licensure and the business side are where I see the most need. New social workers that do not have supervisors that help them through the licensing process leave students searching for answers on their own. Often reaching out numerous times to the board for answers and often not provided all the information.
Perhaps closer coordination/collaboration with schools/universities in terms of coursework offerings and curriculum to ensure higher rigor and academic training. More emphasis on quantitative approaches and training, more courses/ trainings in data analytics, fewer "reflection" assignments. More PhDs in SW are needed; adjuncts don't often provide academic rigor. Elevating the profession!
Please continue to prioritize having clinicians trained to serve diverse populations.
Please continue to support implementation of licensing compact.
Please don't reduce the quantity, quality, and comprehensive CEUs social worker need for recertification. It's creating subpar social workers.
Please help with getting a multi-state licensing pact agreement in place. I see a lot of military spouses that would benefit from continued services when they have to move to new bases.
Please let us know what's happening with the multi state licensing compact!

Appendix #23

Please make interstate licensing compacts to happen!
Please make the renewal process more straight forward. I shouldn't have to hunt down the paperwork and read through things to find the CEUs needed. Easy rubric or spreadsheet for CEUs. Quick email with a link to renew. It's too cumbersome and stressful.
Please promote improvements with training requirements around d ethics, safety, evolving issues in practice as technology becomes more integrated into our practice. The importance of collaboration and communication, social work jobs are not solo, individually driven careers.
Please put more emphasis on how to get behavioral health services for clients paid for by insurance company.
Please work to put safeguards back in place for the MSW clinical practicum experience.
Please work with ASWB, NASW, CSWE on regulations to uphold our professional standards and ensure next generation is prepared for direct practice.
Please, please get some oversight for the process of licensure. It is absolutely absurd how long it takes to receive answers from the BSRB. Submitting your packet, time passes, you reach out via email, phone call and nothing. It is so frustrating to not get answers or support from a board that credentials you. For example, after 2 months of waiting, I finally received an answer to my question and there were significant discrepancies between what the website says and what the BSRB representative did. It's hard to trust the BSRB with supporting patients when they can't support social workers themselves.
Please, please modernize your Attestations / Recommendations process for applicants to the BSRB.
Please, please work towards interstate agreements for nationwide mental health Care options. In telehealth (especially post-pandemic) my clients have become much more mobile and often switch residences due to jobs or providing care to family. Even my own family circumstances have taken me out of state to Provide care and thus, losing income, despite being willing and capable of continuing care.
Portability to serve clients across state lines using telehealth
Quit reducing number of required CEU hours or clinical training hours. Why are we lowering standards for social workers?
Reciprocity for all states
Reciprocity should be considered with Missouri
Reciprocity with all other states so we can practice all over the country, especially for telehealth
Recommend requiring training specific to suicidal ideation and safety.
Reduce NASW membership fees - every year I spend time deliberating if I want to renew...fee is just too expensive!!!
Reduce number of CEUs needed or allow SWs to change when their CEUs are due to align with other states. It is hard to keep track of CEUs in 2 states that are 1 year apart on when they are due.

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<p>Reevaluate the test. There are good social workers out there that have decent clinical skills but are terrible test takers. However, I want us to continue to be level with psychologists, and have the education to be seen as a peer. There are areas that LSCSWs can be a viable option where psychologists typically have been.</p>
<p>Regulations regarding AI use.</p>
<p>Regulations regarding billing for therapy</p>
<p>Require suicide assessment and screening as a CEU requirement for renewal like MO does.</p>
<p>Same as above</p>
<p>Same as above. Social work and related professions are devalued enough by assumptions. So not allow the quality and expectations of the professions to decrease as that validates excellence. Rather, gather more support and resources for excellence.</p>
<p>Same concern reported in my previous comment</p>
<p><b>See above (2 responses)</b></p>
<p>See above re: compact legislation that would benefit provision of telehealth services.</p>
<p>See answers to question 14.</p>
<p>See response to #9.</p>
<p>Set case load limits!!!!!! Lowering requirements and educational requirements only lowers the bar for professionalism and drives people out of the profession. The problem isn't stringent licensing requirements, it's poor pay, unrealistic case loads, high liability, and increasing constraint of decision-making and discretion. Therapeutic decisions are being driven by insurance companies and regulators rather than by clinicians.</p>
<p>Should not be as easy as it is for a new grad to start doing private practice, providing therapy to individuals on a full time basis in a private practice setting.</p>
<p>Social work should be highly recognized profession but instead it is viewed as an easy educational track. Bring back the high standards.</p>
<p>Social workers practicing in an educational setting often have to comply with CEU requirements and additional Masters+ hours to move up on the salary schedule in the school district. It would be incredibly helpful for social workers in an educational setting to count the Masters+ (Masters level coded classes often through a university) classes as CEU credits if possible. Widening the definition/scope of CEU would benefit social workers in all agency settings.</p>
<p>Some of clinical exam questions do not fully reflect practice. A therapy setting is not linear. Some of the "what would you do first questions are not realistic." In a session you will do many things. I suggest question improvement. Obviously safety is the prime need.</p>
<p>Sorry, but I do not.</p>
<p>Speak up regarding human rights and traditional social work values.</p>
<p>Strong language that prevents social workers putting hands on students when the student is out of control in the school setting, often, this occurs when the teacher is not credentialed.</p>
<p>Thank you for all that you do!</p>

Appendix #23

Thank you for all you are doing on behalf of the social work profession.
Thank you for all you do! I hope to continue to work towards being a supervisor in the next year or so.
Thank you for all you do! You are greatly appreciated!
Thank you for protecting our needs and rights!
Thank you for requesting this input
Thank you for seeking this information!
Thank you for supporting the growth of social workers.
thank you for your oversight
Thank you for your willingness to serve on the Advisory Committee!
Thank you for your work.
Thank you.
Thanks for all you do
thanks for asking our opinions
The "random" audits that are happening almost every time some renew are causing clinicians to think about no longer practicing. Is that the goal? Especially in areas of the state there is a shortage of LSCSW's. Seems this system needs looked at closely.
The BSRB has always been fair and treated me well while obtaining my licenses. I also receive responses promptly, and support. I am grateful for the board to help us be accountable and professional.
The counseling profession is only required to obtain 30 hours of CEU's every two years while all other behavioral science professions are required to obtain 40 hours. I think that all behavioral science professions should have to obtain the same amount of CEU's every 2 years. I applaud the recent decision to decrease the number of hours of diagnosis hours for social work as this creates greater flexibility in obtaining education in areas of practice that will most benefit a clinician. Every clinician's specializations are different. It's not a one size fits all. Greater flexibility in the type of training one can obtain CEU's in is definitely helpful.
The interstate compact would be greatly beneficial. I have had many kids who have gone to college out of state and they have difficulties with starting over and finding another therapist. Now that Telehealth is widely used, this is more doable than ever.
The most recent changes; decreased CEUs for dx, decreased total CEUs to 40 for two year period and decreased total supervision hours for LSCSW are fair and adequate for good standards. I'm not sure that group supervision needs to be required for clinical supervision. It's a good option for some but others, especially in remote or rural areas, find it difficult to access. It does not seem to be a necessary requirement for diagnostics or clinical licensure. Thank-you for the opportunity to provide feedback.
There need to be some guidelines or rules around religious counseling that are more defined.
There should not be a decrease in CEU's. There should be more regular review of the code of ethics. We should require more practical hours for students.
These kids might need another year of practicum before graduation and licensure. It's bad.

Appendix #23

This survey is clearly intended to identify problems, which is understandable, but does not seem to want to assess strengths and what is working well in the profession in the last two years- helpful use of technology that enhances the profession vs problems, improvements in accessibility for supervision, and services, improvements in salaries for social workers, more options for professional development and training...and cultural shift that recognizes the importance of mental health.

This was a good survey, glad I completed it.

Through the previous 35 years as a licensed social worker, with 21 of those years practicing as a clinical social worker, I have enjoyed the support, wisdom, knowledge, and information the BSRB has provided me. Thank you for all of your hard work.

To continue to advocate for school based insurance reimbursement for mental health services. This is critical.

Transparency into practice.

Unsure. Would like the social work compact to go through but unsure of the progress of that.

We need more frank discussions as a profession on the ethics of mandated reporting intersecting with the potential for police violence and/or trauma from involuntary hospitalization. I have heard too many stories of people getting a wellness check for suicidal ideation who end up murdered by the police. I discuss mandated reporting with my clients and several have told me directly (in theory, not in a moment of crisis) they would conceal information from me rather than risk having the police called on them. We are not properly emphasizing the space between ideation and intent, and how each requires different interventions. Involuntary hospitalization has been similarly traumatizing for several clients- they make a (poorly worded) comment in a different setting that is interpreted as suicidal intent, and then come out of the hospital in worse shape than when they went in because they feel so vividly that hospital staff and other involved parties didn't really care about their well-being, they were just checking a liability box. The ethical issues here are significant and erode client trust- we aren't talking about that at all as a profession, to my knowledge.

We should continue to preserve the respect earned by SW clinicians. Possibly look at another level of licensure for those not pursuing clinical therapeutic services that involve diagnosing etc.

When I renewed my KS license recently, it was a smooth and timely process.

When I transitioned to a LSCSW, the CEs I had done after my LMSW renewal now do not count because I was told they would be expired before my next renewal LSCSW. I had to renew my LMSW seven months prior to receiving my LSCSW. What is hard is that I had several CE hours in that 7 months, some were diagnosis CEs that I had paid for. Now, those don't count toward my LSCSW renewal. I hope these types of situations can be reviewed so that others don't have to have the same thing happen to them.

Working with BSRB's counterparts in other state's to streamline licensing would be phenomenal. With reaches of telehealth and professionals moving states more frequently, having that streamlined would be phenomenal. Especially given social worker pay and licensing expenses.

**Appendix #23**

Yes - given the immense power that social workers have over their clients, why would they LOWER the requirement for diagnosis and treatment CEUs when many social workers need MORE training in this area?

Yes, I did not know there was a BSRB YouTube Channel. This would be very helpful, and other channels like it. I would be interested in knowing what other ways I could connect to the BSRB.