SCHOOL OF MEDICINE
BOWEN CENTER FOR HEALTH
WORKFORCE RESEARCH & POLICY

2024 Behavioral Health Board License Renewal Information Fields

Administered to: Bachelor Social Workers, Social Workers, Clinical Social Workers, Marriage and Family Therapist Associates, Marriage and Family Therapists, Mental Health Counselor Associates, Mental Health Counselors, Addiction Counselor, Addiction Counselor Associate, Clinical Addiction Counselor Clinical Addiction Counselor Associate

1. Sex
   DROP DOWN
   a. Female
   b. Male

2. Are you of Hispanic, Latina/o, or Spanish origin?
   RADIO BUTTONS
   a. Yes
   b. No

3. What is your race? Mark one or more boxes.
   MULTI CHECK BOX
   a. American Indian or Alaska Native
   b. Asian
   c. Black or African American
   d. Native Hawaiian/Pacific Islander
   e. White
   f. Some Other Race

4. What type of degree/credential qualified you for your first U.S. counselor license?
   DROP DOWN LIST
   a. High school diploma/GED - counseling or related field
   b. High school diploma/GED – other
   c. Vocational/Practical certificate – counseling or related field
   d. Vocational/Practical certificate – other
   e. Associate degree – counseling or related field
   f. Associate degree – other
   g. Bachelor's degree – counseling or related field
   h. Bachelor's degree – other
   i. Master's degree – counseling or related field
   j. Master's degree – other
   k. Post-graduate certificate – counseling or related field
   l. Post-graduate certificate – other
   m. Doctoral degree – counseling or related field
   n. Doctoral degree – other

5. Where did you complete the degree that first qualified you for your license?
   DROP DOWN LIST
   a. Indiana
   b. Michigan

c. Illinois
d. Kentucky
e. Ohio
f. Another State (not listed)
g. Another Country (not U.S.)

6. What is your highest level of education?
   DROP-DOWN LIST OR RADIO BUTTONS
   a. High school diploma/GED - counseling or related field
   b. High school diploma/GED – other
   c. Vocational/Practical certificate – counseling or related field
   d. Vocational/Practical certificate – other
   e. Associate degree – counseling or related field
   f. Associate degree – other
   g. Bachelor's degree – counseling or related field
   h. Bachelor's degree – other
   i. Master's degree – counseling or related field
   j. Master's degree – other
   k. Post-graduate certificate – counseling or related field
   l. Post-graduate certificate – other
   m. Doctoral degree – counseling or related field
   n. Doctoral degree – other

7. What is your employment status?
   DROP-DOWN LIST OR RADIO BUTTONS
   a. Actively working in a position that requires this license
   b. Actively working in a related position that does not require this license
   c. Actively working in a field not related to this license
   d. Not currently working
   e. Retired

8. What best describes your employment plans for the next 12 months?
   DROP DOWN LIST
   a. Increase hours
   b. Decrease hours
   c. Transition to a non-direct service role
   d. Leave my current role to complete further training
   e. Leave my current role for family reasons/commitments
   f. Leave my current role due to physical demands
   g. Leave my current role due to stress/burnout
   h. Retire
   i. Continue as you are

Note: If an individual selects "a-d" on Q7 and "a-h" on Q8. In other words, if an individual selects BOTH "e. Retired" on Q8 AND "i. Continue as you are" on Q9, no additional questions would be displayed.

9. If you hold more than one license that is overseen by the Behavioral Health and Human Services Licensing Board, under which license do you primarily practice? If this does not apply, please select "not applicable."

RADIO BUTTON

a. Bachelor Social Worker
b. Social Worker
c. Clinical Social Worker
d. Marriage and Family Therapist Associate
e. Marriage and Family Therapist
f. Mental Health Counselor Associate
g. Mental Health Counselor
h. Addiction Counselor Associate
i. Addiction Counselor
j. Clinical Addiction Counselor Associate
k. Clinical Addiction Counselor
l. Not applicable

10. Do you use telehealth to deliver services to patients located in Indiana (as defined in IC 25-1-9.5-6; "telehealth" means the delivery of health care services using interactive electronic communications and information technology, in compliance with the federal Health Insurance Portability and Accountability Act (HIPAA), including: (1) secure videoconferencing; (2) store and forward technology; or (3) remote patient monitoring technology; between a provider in one (1) location and a patient in another location)?)
    RADIO BUTTONS
    a. Yes
    b. No

11. Please indicate which of the following services you routinely provide as a part of your practice: (Note: The purposes of this services list is to gather information on key health issues in Indiana) Please check all that apply.
    CHECKBOXES
    a. Addiction counseling
    b. Case management
    c. Crisis counseling
    d. Dementia/Alzheimer's care
    e. General Counseling/Therapy
    f. Mental health diagnosis (as authorized under IC 25-23.6-1-5.6)
    g. School counseling
    h. Services via telehealth to patients/clients outside of Indiana
    i. None of the above

12. *(For non-associate licenses only – LSW, LCSW, LMHC, LAC, LCAC, LMFT)* Over the past 12 months, have you served as a field supervisor to **current behavioral health students (pre-graduation)** in field placements, internships, or practicums?
    MULTIPLE CHOICE
    a. Yes
        - For which types of students do you provide field supervision (field placements, internships or practicums)?
          CHECKBOXES
          i. Bachelor in Social Work
          ii. Masters in Social Work
          iii. Doctorate in Social Work
          iv. Masters in Marriage and Family Therapy
          v. Masters in Counseling

vi. Masters in School Psychology
vii. Masters in Child/Human Development
viii. Masters in Psychology
ix. Doctorate in Psychology
x. Bachelors in Addiction Counseling
xi. Masters in Clinical Addiction Counseling
xii. Other
1. OPEN TEXT BOX

- What, if any, incentive do you receive to provide field supervision ((field placements, internships or practicums) to current behavioral health students?
  CHECK BOXES
  i. Financial stipend/payment from student/school
  ii. Financial stipend/payment from employer
  iii. Financial stipend/payment from other source
  iv. Adjunct faculty title or similar designation at student's/learner's academic program
  v. Trainer title or similar designation from my employer
  vi. I count this time toward my continuing education requirements associated with my license renewal.
  vii. Other
  a. OPEN TEXT BOX
  viii. None of the above

- What challenges have you experienced in serving as a field supervisor for current behavioral health students?
  CHECK BOXES
  i. Lack of understanding of my expectations from the student's academic program
  ii. Negative impact to my workflow and/or productivity
  iii. Lack of communication with the academic institution
  iv. Lack of space to provide proper supervision
  v. Lack of employer support
  vi. Lack of adequate financial compensation for time/effort
  vii. Other
  a. OPEN TEXT BOX
  viii. None of the above

b. No

13. *(For non-associate licenses only – LSW, LCSW, LMHC, LAC, LCAC, LMFT)* In the past 12 months, have you served as a clinical experience supervisor to **post-graduate (non-student) associate-level licensees** (or LSWs) who are working to qualify for full licensure?
MULTIPLE CHOICE
a. Yes
- For which types of associate-level licensees (or LSWs) do you provide clinical experience supervision?

CHECKBOXES
i. Social Worker

ii. Marriage and Family Therapist Associate
iii. Mental Health Counselor Associate
iv. Addiction Counselor Associate
v. Clinical Addiction Counselor Associate

- What, if any, incentive do you receive to provide clinical experience supervision to associate-level licensees (or LSWs)?
  CHECK BOXES
  i. Financial stipend/payment
  ii. Adjunct faculty title or similar designation from the trainee's academic program
  iii. Trainer title or similar designation from my employer
  iv. I count this time toward my continuing education requirements associated with my license renewal.
  v. Other
    a. OPEN TEXT BOX
  vi. None of the above

- What challenges have you experienced in serving as a clinical experience supervisor to associate-level licensees (or LSWs)?
  CHECK BOXES
  i. Lack of understanding of my expectations to support the trainee in qualifying for full licensure
  ii. Negative impact to my workflow and/or productivity
  iii. Lack of communication with the associate-level licensee (or LSW)
  iv. Lack of space to provide proper supervision
  v. Lack of employer support
  vi. Lack of adequate financial compensation for time/effort
  vii. Other
    a. OPEN TEXT BOX
  viii. None of the above

b. No

14. Please indicate the population groups to which you provide services:
    CHECKBOXES
    a. Newborns
    b. Children (ages 2-10)
    c. Adolescents (ages 11-19)
    d. Adults
    e. Geriatrics (ages 65+)
    f. Pregnant women
    g. Individuals who are incarcerated
    h. Individuals with disabilities
    i. Individuals in recovery
    j. Veterans/individuals who have served in the military
    k. None of the above

15. In what state is your primary practice location? Please indicate state using 2-letter postal abbreviation. If this does not apply, please select "N/A"
    DROP-DOWN LIST

Please include all states' 2-letter postal abbreviation along with an option for N/A

16. Please provide the following information regarding your primary practice location. If this does not apply, please indicate N/A
    Street Address: [Free text]
    City: [Free text]
    Zip Code: [Free text]

17. How many hours do you spend in direct patient care at your principal practice location? If this does not apply, please select "not applicable."
    DROP-DOWN LIST OR RADIO BUTTONS
    a. 0 hours per week
    b. 1 – 4 hours per week
    c. 5 – 8 hours per week
    d. 9 – 12 hours per week
    e. 13 – 16 hours per week
    f. 17 – 20 hours per week
    g. 21 – 24 hours per week
    h. 25 – 28 hours per week
    i. 29 – 32 hours per week
    j. 33 – 36 hours per week
    k. 37 – 40 hours per week
    l. 41 or more hours per week
    m. Not applicable

18. Which best describes the type of setting that most closely corresponds to your principal direct patient care practice location(s). If this does not apply, please select "not applicable.":
    DROP DOWN LIST
    a. Child Welfare
    b. Community Health Center (RHC, FQHC, Look-alike)
    c. Community Mental Health Center (CMHC)
    d. Mental Health Clinic (Not a CMHC)
    e. Criminal Justice
    f. Detox
    g. Faith-Based Setting
    h. Federal Government Hospital
    i. In-Home Setting
    j. Methadone Clinic
    k. Non-Federal Hospital: General Medicine
    l. Non-Federal Hospital: Inpatient
    m. Non-Federal Hospital: Other- e.g. nursing home unit
    n. Non-Federal Hospital: Psychiatric
    o. Primary or Specialist Medical Care (Non-behavioral health setting)
    p. Private Practice
    q. Recovery Support Services
    r. Rehabilitation
    s. Residential Setting
    t. School Health Service
    u. Specialized Substance Abuse Outpatient Treatment Facility
    v. Telehealth
    w. Other

    a. If you selected “other,” please describe the setting in which you practice.
       OPEN TEXT BOX
x. Not applicable

19. Which best describes the field of practice for your principal practice location? If this does not apply, please select “not applicable.”
    RADIO BUTTONS
    a. Addictions
    b. Administration
    c. Community Development
    d. Developmental and Other Disabilities
    e. Family and Children Services
    f. Gerontological Services
    g. Health and Rehabilitation
    h. Income Maintenance
    i. Information and Retrieval
    j. Juvenile and/or Adult Corrections
    k. Mental Health
    l. Occupational
    m. Violence and Abuse Services
    n. Other
        a. If you selected “other,” please describe the field in which you practice.
        b. OPEN TEXT BOX
    o. Not applicable

20. In what state is your secondary practice location? Please indicate state using 2-letter postal abbreviation. If this does not apply, please select “N/A”
    DROP-DOWN LIST
    Please include all states’ 2-letter postal abbreviation along with an option for N/A

21. Please provide the following information regarding your secondary practice location. If this does not apply, please indicate N/A
    Street Address: [Free text]
    City: [Free text]
    Zip Code: [Free text]

22. How many hours do you spend in direct patient care per week at your secondary practice location? If this does not apply, please select “not applicable.”
    DROP-DOWN LIST OR RADIO BUTTONS
    a. 0 hours per week
    b. 1 – 4 hours per week
    c. 5 – 8 hours per week
    d. 9 – 12 hours per week
    e. 13 – 16 hours per week
    f. 17 – 20 hours per week
    g. 21 – 24 hours per week
    h. 25 – 28 hours per week
    i. 29 – 32 hours per week

j. 33 – 36 hours per week
k. 37 – 40 hours per week
l. 41 or more hours per week
m. Not applicable

23. Which best describes the type of setting that most closely corresponds to your secondary direct patient care practice location(s): If this does not apply, please select "not applicable."
DROP-DOWN LIST OR RADIO BUTTONS
    a. Child Welfare
    b. Community Health Center (RHC, FQHC, Look-alike)
    c. Community Mental Health Center (CMHC)
    d. Mental Health Clinic (Not a CMHC)
    e. Criminal Justice
    f. Detox
    g. Faith-Based Setting
    h. Federal Government Hospital
    i. In-Home Setting
    j. Methadone Clinic
    k. Non-Federal Hospital: General Medicine
    l. Non-Federal Hospital: Inpatient
    m. Non-Federal Hospital: Other- e.g. nursing home unit
    n. Non-Federal Hospital: Psychiatric
    o. Primary or Specialist Medical Care (Non-behavioral health setting)
    p. Private Practice
    q. Recovery Support Services
    r. Rehabilitation
    s. Residential Setting
    t. School Health Service
    u. Specialized Substance Abuse Outpatient Treatment Facility
    v. Telehealth
    w. Other
        a. If you selected "other," please describe the setting in which you practice.
        OPEN TEXT BOX
    x. Not applicable

24. Which best describes the field of practice for your secondary practice location? If this does not apply, please select "not applicable."
RADIO BUTTONS
    a. Addictions
    b. Administration
    c. Community Development
    d. Developmental and Other Disabilities
    e. Family and Children Services
    f. Gerontological Services
    g. Health and Rehabilitation
    h. Income Maintenance
    i. Information and Retrieval
    j. Juvenile and/or Adult Corrections
    k. Mental Health

l. Occupational
m. Violence and Abuse Services
n. Other
    i. If you selected “other,” please describe the field in which you practice.
    ii. OPEN TEXT BOX
o. Not applicable

25. *(For non-associate licenses only – LCSW, LMHC, LAC, LCAC, LMFT)* In recalling the time when you were working as a graduate/associate and working toward obtaining your full independent license - What, if any, challenges did you experience during your supervised clinical experience period? CHECK BOXES
    a. Understanding the process for licensure after graduation
    b. Finding a position during my associate period with adequate pay
    c. Finding a position during my associate period with appropriate clinical experiences
    d. Finding a qualified supervisor for my associate period
    e. Finding supervision within my community, or a reasonable distance from my home
    f. Finding supervision in a preferred setting
    g. Affording my supervision experience
    h. Other
        i. OPEN TEXT BOX