

Behavioral Sciences Regulatory Board

Survey of Master's Level Psychologists

February 2025

DRAFT

Introduction

This report is part of a series of reports studying survey results in the spring 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 the master's level psychology profession. As of February 2025, Kansas offers two levels of permanent licensure for the master's level psychology profession: (1) an independent level of license called a Licensed Clinical Psychotherapist (LCP) license and (2) a non-independent Licensed Master's Level Psychologist (LMLP) license. LMLPs must practice under supervision or direction of a supervisor in Kansas. 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 for that profession.

In 2024, members of the Master's Level Psychology 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 master's level psychology 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 January 13, 2025, the total number of licensees in the master's level psychology profession in Kansas totaled 626, including practitioners with a Licensed Master's Level Psychology (LMLP) license (352) and practitioners with a Licensed Clinical Psychotherapist (LCP) license (274). From January 24, 2025, to February 23, 2025, all LMLPs and LCPs 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.

Over the 31 days that the survey was open for responses, 236 individuals completed the survey, for an overall response rate of 37.7 percent. For the LMLP level of license, 113 individuals completed the survey, for a response rate of 32.1 percent, and for the LCP level of license, 123 individuals completed the survey, for a response rate of 44.9 percent.

Note: While the results of the 2025 survey are included on the following pages, most specific language is found in the appendices. Identical responses were grouped, edits were made for spelling and grammar, and references to self-identifying information about licensees was removed, but otherwise language in this report reflects responses as they were provided in the survey.

Question 1 (LMLP and LCP). In what Kansas county/counties do you practice the profession of master's level psychology?

111 LMLPs answered question 1.

Full responses are included in Appendix #1 on page 22.

Several licensees referenced combinations of counties, but the most commonly referenced single counties included:

- Sedgwick (18 responses);
- Johnson (9 responses);
- None (8 responses);
- Ellis (6 responses); and
- Wyandotte (5 responses).

123 LCPs answered question 1.

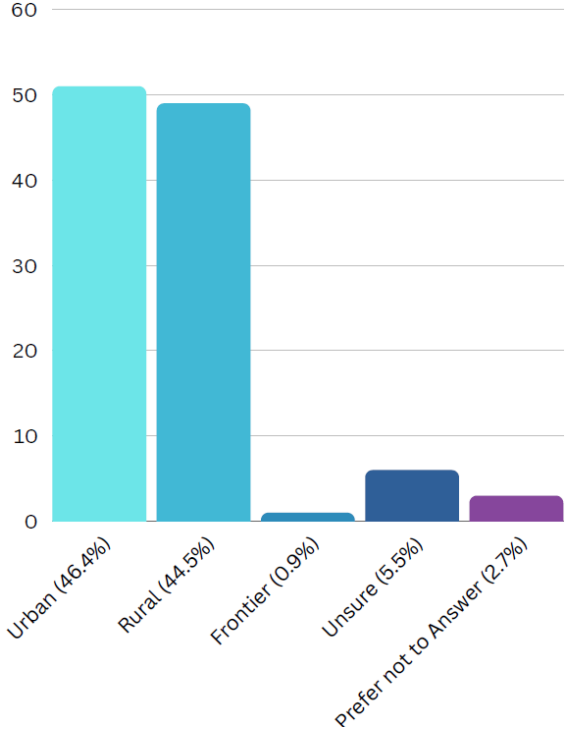
Full responses are included in Appendix #2 on page 24.

Several licenses referenced combinations of counties, but the most commonly referenced single counties included:

- Johnson (23 responses);
- Sedgwick (19 responses); and
- Shawnee (6 responses).

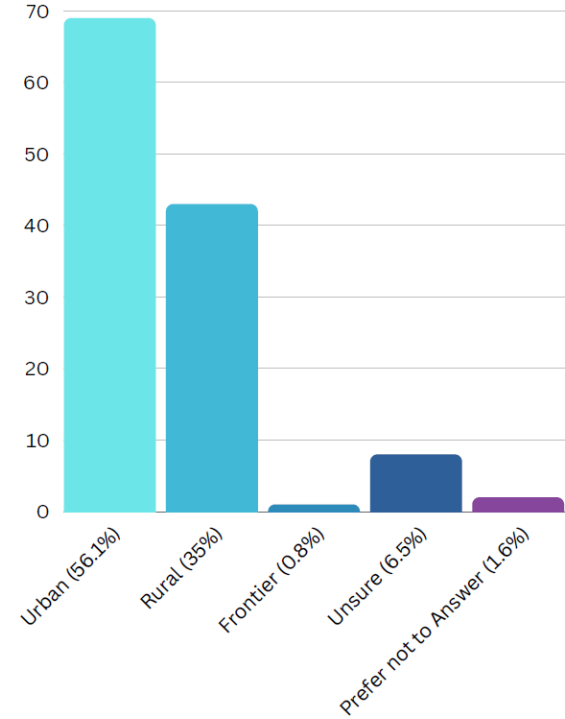
Question 2 (LMLP and LCP). Do you practice in a predominantly urban area, rural area, or frontier area?

LMLP Responses



Of the 110 LMLPs that answered question 2, about half (46%) reported living in an urban area, followed by licensees living in a rural area (44%). All other responses were less than 6%. According to the 2020 US Census, about 57% of Kansans live in urban counties, so the results from the survey are consistent with demographics from the most recent census.

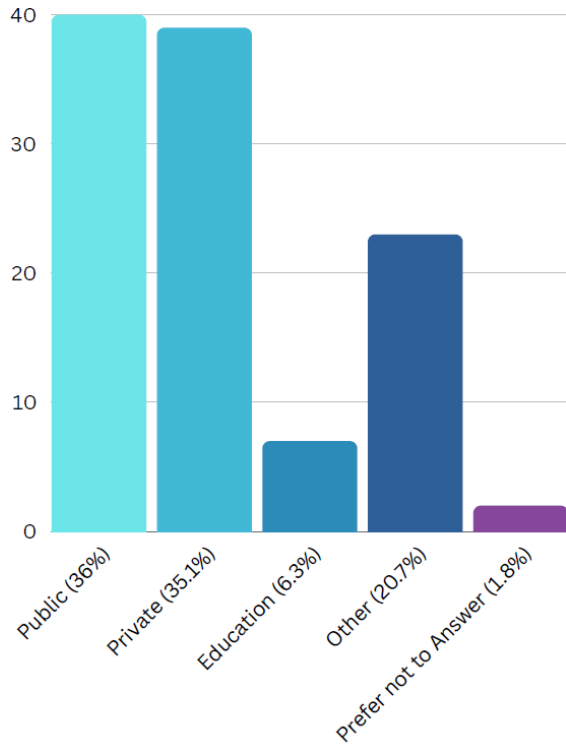
LCP Responses



Of the 123 LCPs that answered question 2, the largest amount (56%) reported living in an urban area followed by individuals living in a rural area (35%). According to the 2020 US Census, about 57% of Kansas live in urban counties, so the results of the survey reflect that while a higher percentage of LCPs live in urban areas compared to LMLPs, the overall the survey results are consistent with the census.

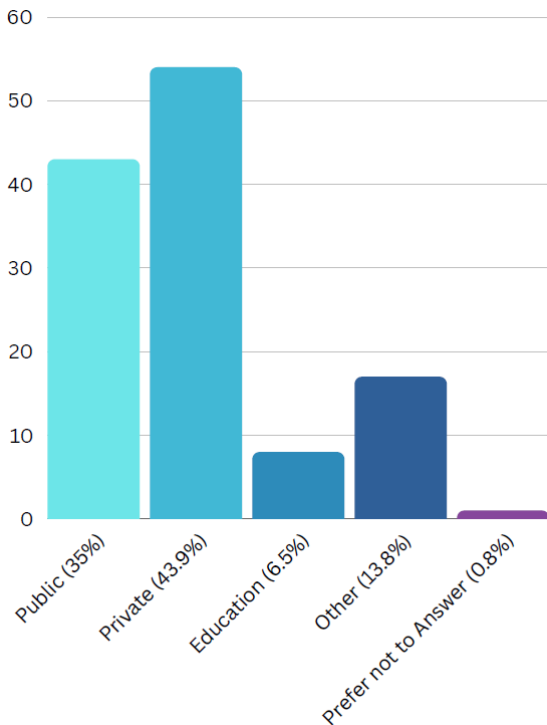
Question 3 (LMLP and LCP). Do you primarily work in a public practice, private practice, educational setting, or another setting?

LMLP Responses



Of the 111 LMLPs that answered question 3, about a third (36%) working in public practice, while nearly as many (35%) noted working in private practice, followed by individuals in other fields (20.7%). All other responses were less than 7%.

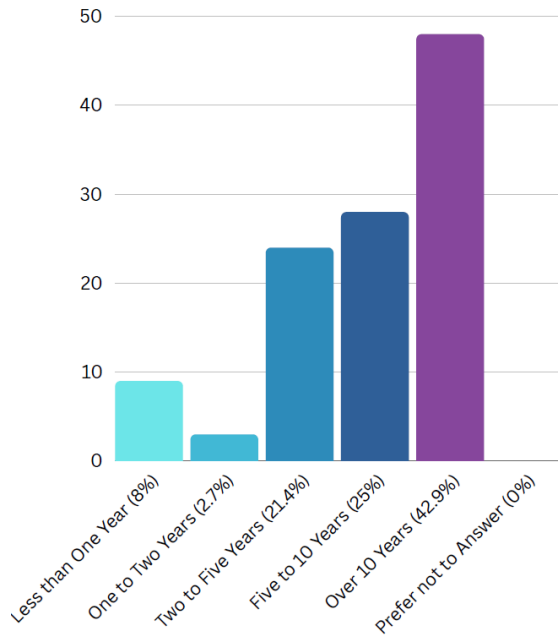
LCP Responses



Of the 123 LCPs that answered question 3, it is notable that the most popular response was private practice (44%), followed by individuals working in public practice (35%), then individuals working in another field (14%). All other responses were under 7%.

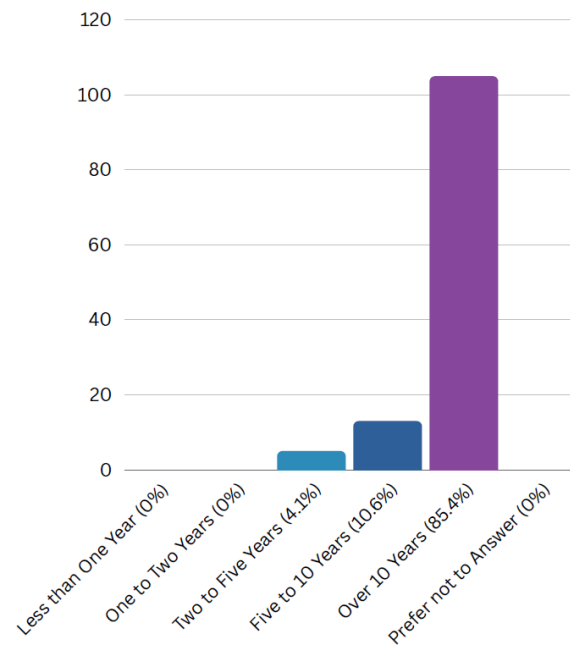
Question 4 (LMLP and LCP). How many years have you practiced the master's level psychology profession (if applicable, you may include years practicing master's level psychology in other states)?

LMLP Responses



Of the 112 LMLPs that answered question 4, when individuals were asked how many years they had been practicing master's level psychology, the most popular response was over 10 years (43%), five to ten years (25%), then two to five years (21%). All other responses were under 9%.

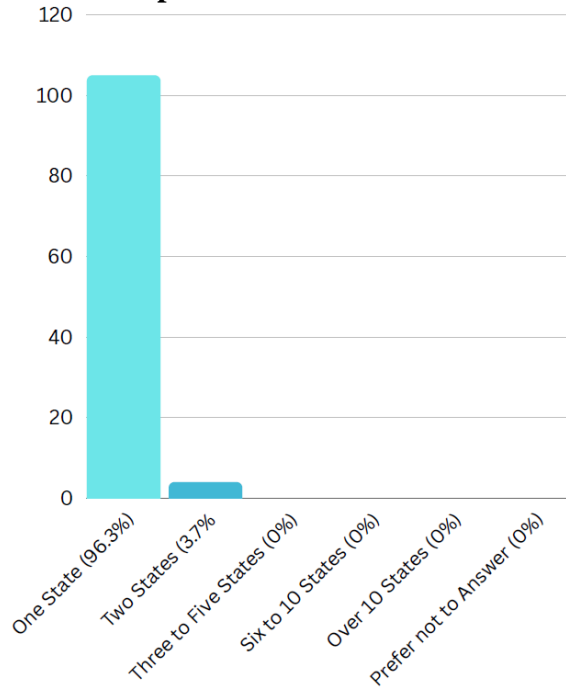
LCP Responses



Of the 123 LCPs who answered question 4, the biggest group of respondents by far (85%) reported practicing master's level psychology over ten years, followed by individuals practicing five to 10 years (11%). All other responses were under 5%. This data shows that the vast majority of LCPs are long-time practitioners.

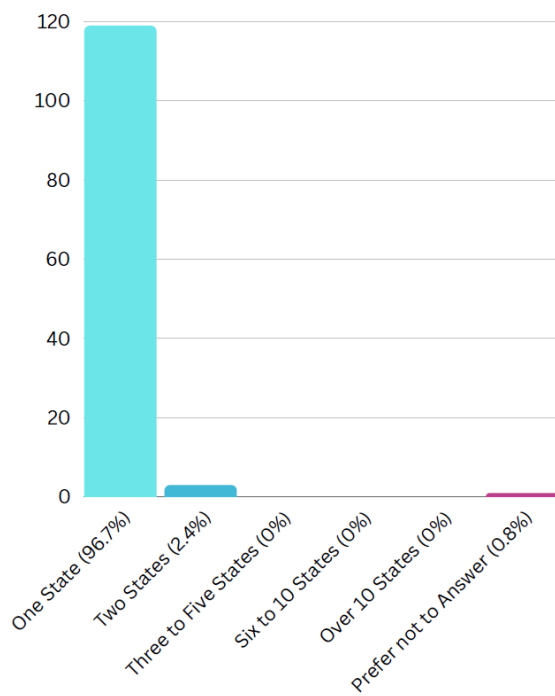
Question 5 (LMLP and LCP). Including Kansas, in how many states are you licensed as a master's level psychologist/in the master's level psychology profession?

LMLP Responses



Of the 109 LMLPs who answered question 5, the vast majority of licensees (96%) report being licensed to practice master's level psychology in only one state, though a small number of licensees report being licensed in two states (4%).

LCP Responses



Of the 123 LCPs who answered question 5, the most popular response by far (97%) was from individuals only licensed to practice in one state, however a small number of licensees noted they were licensed in two states (2%).

Question 6 (LMLP and LCP). Do you maintain an active license, but no longer work as a master's level psychology? If so, please explain why you are not providing services currently.

LMLP Responses

Eighty-two LMLPs answered this question. (Responses for all licensees can be found in Appendix #3 on Page 28)

The most frequent survey response (sixty-two responses) was that this did not apply to respondents. Twenty respondents, however, are not providing services despite maintaining an active license. The most common reasons for this (three responses each) included providing services not being a required part of job responsibilities and that providing services is not required but maintaining an active license is.

Two respondents indicated that they practice under a different license (i.e., LCPC, LSCSW, etc.) due to higher billing potential in other professions. Two respondents identified pay being better in other fields.

LCP Responses

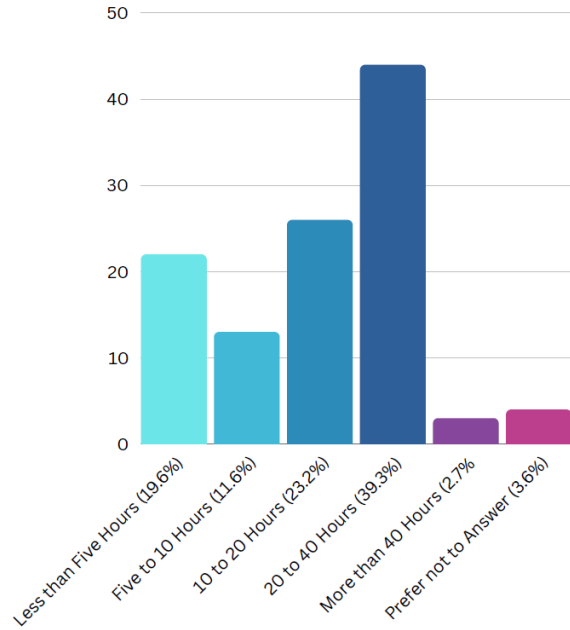
Eighty-three LCPs answered this question. (Responses for all licensees can be found in Appendix #4 on Page 30)

The most frequent survey response (61 responses) was that this did not apply to respondents. Three respondents indicated that, while they are retired, they continue to maintain an active license. 19 respondents indicated maintaining an active license but not providing services. Of these 19 responses, the most common reason why was because it is not required for individuals' current jobs. Examples of these jobs that do not require a license include school psychologists, university faculty, and other positions in the behavioral health setting.

While less frequently reported as the reason noted above, other licensees pointed out that they maintain an active license but do not provide services because they practice under a different license or in a different state, and that they provide supervision but not services.

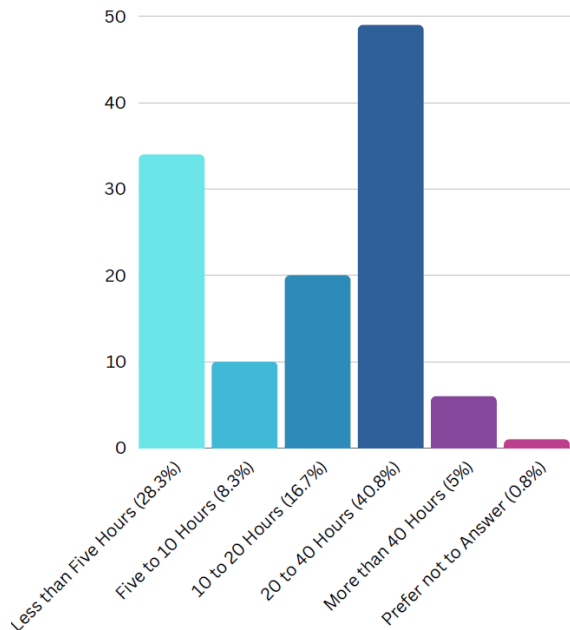
Question 7 (LMLP and LCP). In a typical week, how many hours do you provide in-person services to clients?

LMLP Responses



Of the 112 LMLPs who answered question 7, the most popular response was between 20 to 40 hours (39%), followed by 10 to 20 hours (23%), then less than five hours (20%), then between five and 10 hours (12%). All other answers were under 4%.

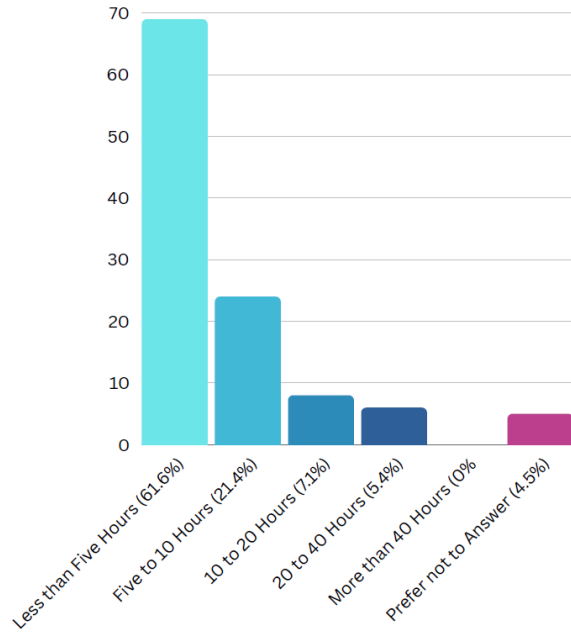
LCP Responses



Of the 123 LCPs who answered question 7, the most popular response was between 20 to 40 hours (34%), followed by between 10 hours and 20 hours (28%), then less than five hours (22%). All other responses were lower than 10%.

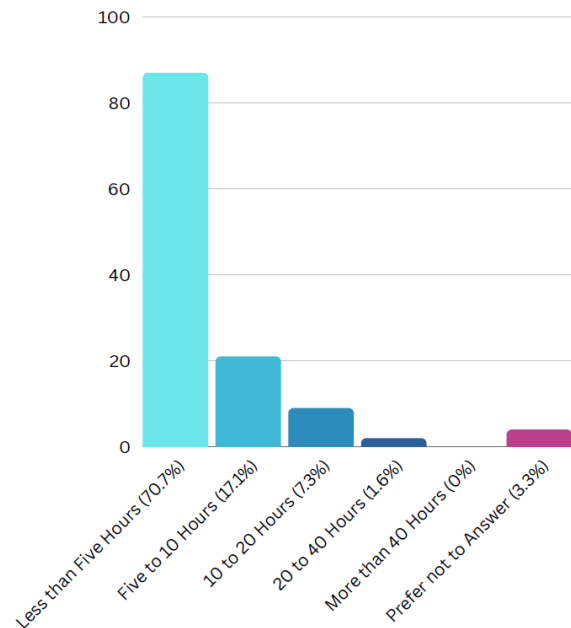
Question 8 (LMLP and LCP). In a typical week, how many hours do you provide telehealth/remote services to clients?

LMLP Responses



Of the 112 LMLPs who answered question 8, the most common response by far was less than five hours per week (62%), followed by five to 10 hours per week (21%). All other responses were less than 8%.

LCP Responses



Of the 123 LCPs who answered question 8, the most common response was less than five hours per week (71%), followed by five to 10 hours per week (17%), then 10 to 20 hours per week (7%). All other responses were less than 4%.

Question 9 (LMLP). *Are you currently working towards attaining a Licensed Clinical Psychotherapist (LCP) license in Kansas? If you are not taking steps to receive an LCP license, please explain why you made that decision:*

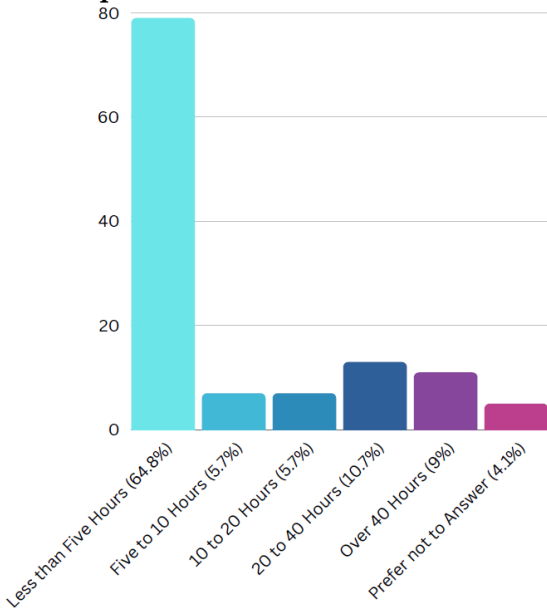
LMLP Responses

One hundred and nine LMLPs answered this question. (Responses for all licensees can be found in Appendix #5 on Page 32)

Some respondents noted they already hold an LCP, which is attributable to the BSRB permitting individuals to hold both an active LMLP license and LCP license if they qualify for both licenses. Other individuals noted they were working towards a Licensed Psychologist (LP) license, that their current employment positions do not require them to hold an LCP license, or that they need to take and/or pass the EPPP licensing examination at the correct number.

Question 9 (LCP). *In a typical week, how many hours are you responsible for supervising, managing, or overseeing the work of others?*

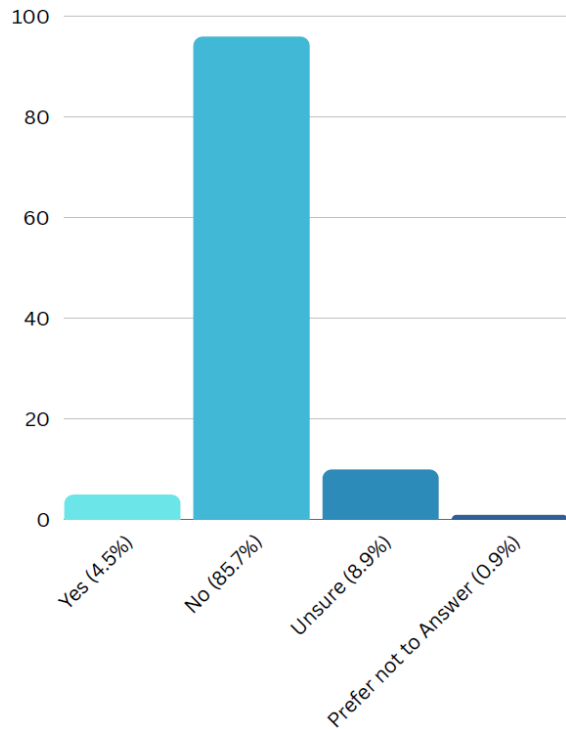
LCP Responses



Of the 122 LCPs who answered question 9, the vast majority of responses were less than five hours per week (65%), followed by respondents noting between 20 to 40 hours per week, then over 40 hours. All other responses were less than 6%.

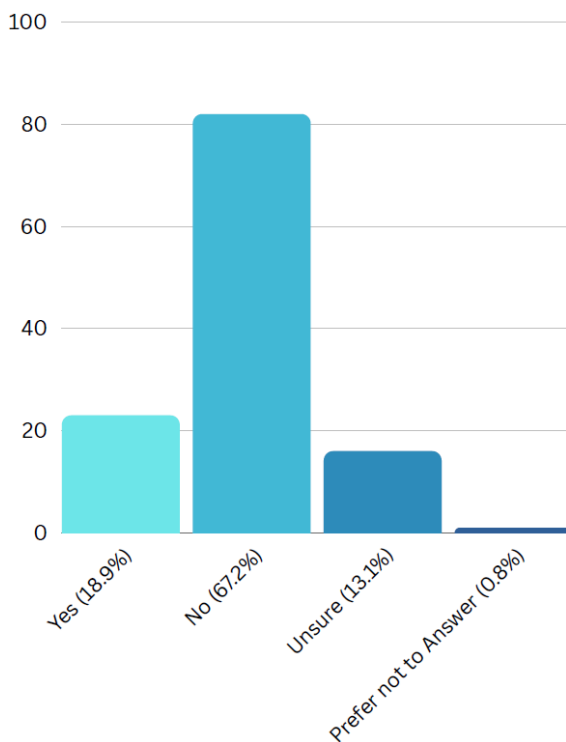
Question 10 (LMLP and LCP). Do you anticipate retiring from the master's level psychology profession in the next five years?

LMLP Responses



Of the 112 LMLPs who answered question 10, the most common response was “no” (86%). All other responses were under 9%.

LCP Responses



Of the 122 LCPs who answered question 10, the most common response was “no” (67%), followed by licensees answering “yes” (19%), then “unsure” (13%). All other responses were under 1%.

Question 11 (LMLP and LCP). Currently, no multi-state compact exists for the master's level psychology profession. If a multi-state compact was created under a model that would allow individuals to practice in other compact states by changing from a single-state license to a multi-state license for an additional cost, would you be interested in obtaining a multi-state license under such a compact? Please explain.

LMLP Responses

One-hundred and eleven LMLPs answered this question, providing insight into attitudes toward a potential multi-state compact in the future. Responses for all licensees can be found in Appendix #6 on page #**.

The most frequent survey response (eighty-six responses) was yes, individuals would be interested in obtaining a multi-state license under a multi-state compact. Of these responses, the most frequent reason (twelve responses) was that they lived near a border state and a multi-state compact would broaden who Kansas licensees could provide services to. These respondents indicated having to frequently turn down clients who live in the other state. The second most common reason (eleven responses) was that it would allow people to move out of state, which they have not done because of lacking reciprocal licenses in other states. Furthermore, nine responses spoke to being able to continue care with patients that are either out of state temporarily or that move out of state, and eight responses indicated that obtaining a multi-state license would open up more career opportunities.

While less frequently identified as the reasons above, other common reasons why respondents would be interested in obtaining a multi-state license include being able to help more people, having more widespread services, being able to work in multiple states, and gaining more telehealth clients. Two respondents noted that they would be willing to pay the additional cost and obtain their LCP for the sole purpose of participating in a multi-state compact.

Fourteen responses indicated that individuals might be interested, but it would depend on factors such as the additional cost and what other states were part of the compact. Seven respondents stated that they would not join the compact. The most frequent reason why (three responses) was due to the individual being too close to retirement. Furthermore, four respondents stated that they would not be interested at this time but may be in the future if it aligns with their family and home goals.

LCP Responses

The most frequent survey response (ninety-six responses) was that yes, licensees would be interested in obtaining a multi-state license under a multi-state compact. The following list contains reasons why licensees support a multi-state compact:

- A multi-state compact would make working close to a border state easier (thirteen responses);
- A multi-state compact would make services accessible to more people (eight responses);
- A multi-state compact would allow for smoother continuity of care when clients move out of state or temporarily leave the state (eight responses);
- A multi-state compact would make the master's level psychology profession more recognizable to other states (four responses);

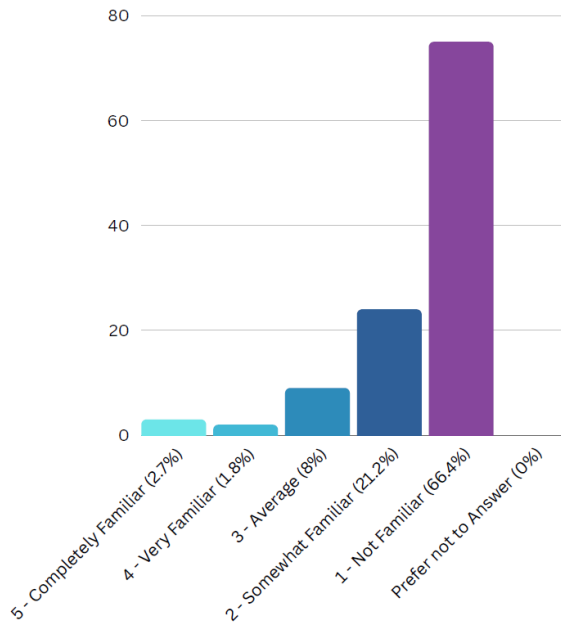
- A multi-state compact would give licensees the ability to relocate without the inability to practice (four responses); and
- A multi-state compact would (hopefully) expand insurance reimbursement (three responses).

Further, six respondents indicated that they would participate in a multi-state compact for telehealth purposes, and five pointed out that they would be interested so long as they maintain the same privileges that they currently have.

Conversely, 13 respondents indicated that they would not be interested in participating in a multi-state compact. Two of these respondents credited retirement for their lack of interest, and four cited their age as reasons. Nine respondents stated that they might be interested, with five of these licensees saying that it would depend on the other states participating in the compact. Three respondents indicated that, while they are not interested right now, they may be in the future.

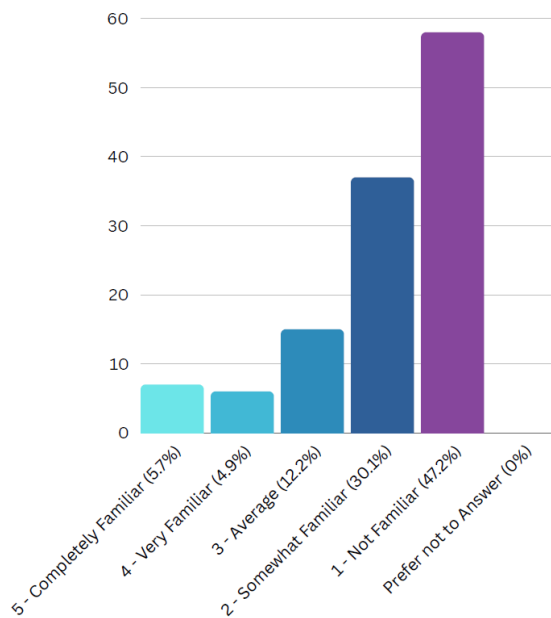
Question 12 (LMLP and LCP). *To assist the work of the Board, the BSRB has seven standing Advisory Committees (one for each profession regulated by the Board), which are primarily composed of licensees in each of the seven professions. Advisory Committees discuss topics relevant to the work of the Board 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 Master's Level Psychology Advisory Committee?*

LMLP Responses



Out of the respondents that answered question 12, the vast majority (66%) noted they were not familiar with the Advisory Committee, followed by respondents noting some familiarity (21%). All other answers were under 9%.

LCP Responses



Out of the respondents that answered question 12, the majority noted no familiarity with the Advisory Committee (47%), followed by individuals noting some familiarity (30%), then average (12%). All other answers were under 6%.

Question 13 (LMLP and LCP). Over the past two years, based on your observations and experience practicing in the master's level psychology 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?

LMLP Responses

Ninety-six LMLPs answered this question, identifying a wide variety of comments. (Responses for all licensees can be found in Appendix #8 on page 59).

Thirty-seven respondents indicated experiencing no practice-related negative issues, and fifty-nine respondents reported that they had experienced such issues. The most frequent negative issue reported (twenty-four responses) centered around the need for more training. Specifically, Licensed Master's Level Psychologists report a need for more training in autism, neurodivergence, trauma, suicide intervention, addiction, telehealth, and the LGBTQ+ community.

While less frequently identified as the above issue, other licensees pointed out issues regarding diagnostics, assessments, and insurance, legal information and updates. Others reported issues of resistance and/or lack of recognition from doctoral licensees and employers.

LCP Responses

One hundred and three LCPs answered this question, identifying a variety of issues. (Responses for all licensees can be found in Appendix #9 on Page 63.)

46 respondents indicated having experienced no practice-related negative issues in the past two years. 29 responses centered on the need for more training. Specifically, the most frequently reported training needs are in the following areas:

- Treatment
- Diagnostics
- ASD and Neurodivergence
- Trauma
- Psychological Testing
- Marital and Family Therapy
- Sex and Gender Affirming Care
- Evaluations
- Psychological Assessments
- Diversity and Cultural Issues

While less frequently identified as the previously noted item, other licensees pointed out other practice-related negative issues concerning insurance barriers and the fact that most other states do not recognize master's level psychology licensure. Other respondents indicated seeing concerns in the areas of substance use/abuse diagnoses, dual relationships, and suicide (crisis) care. Concerns were also raised regarding there not being a way to confirm that nonclinical Licensed Master's Level Psychologists (LMLPs) are receiving proper supervision.

Question 14 (LMLP and LCP). Over the past two years, have you experienced any issues concerning telehealth, either through professional practice or observations of other practitioners?

LMLP Response

One hundred and five LMLPs answered this question, identifying a wide variety of comments on Telehealth. (Responses for all licensees can be found in Appendix #10 on page 59).

The most frequent survey response (seventy-four responses) was that individuals have not experienced any issues concerning telehealth. Of this seventy-four, six respondents expressed strong support for telehealth. Three respondents indicated that they either had no experience with or do not provide telehealth.

Twenty-eight responses provide insight into issues concerning telehealth. The most frequently reported issue (nine responses) was connectivity and technology issues. While less frequently identified, other issues identified included insurance issues, clients wanting telehealth services while out of state, and difficulties with clients finding a private setting for telehealth services.

LCP Responses

One hundred and seven LCPs answered this question and identified a variety of issues. (Responses for all licensees can be found in Appendix #11 on Page 63.)

Seventy responses indicated having experienced no issues concerning telehealth, and after providing this response, some respondents mentioned that telehealth has improved the accessibility of services. Thirteen respondents expressed support for telehealth.

Both positive and negative remarks were identified in responses to this survey question. Amongst the positive remarks, the most frequently occurring statements were as follows:

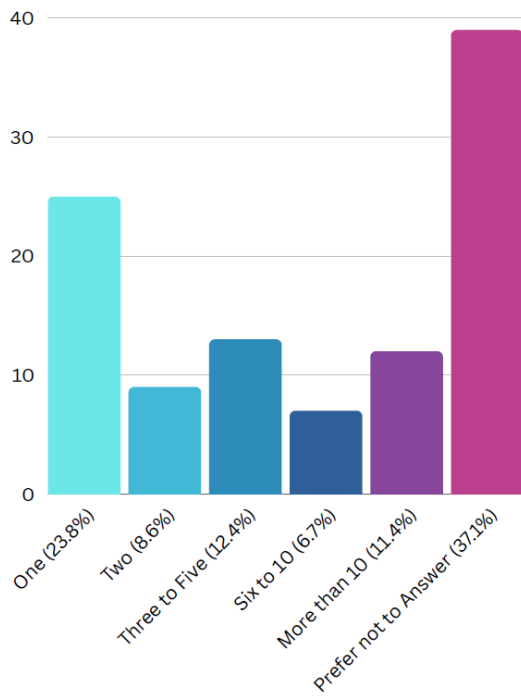
- Telehealth is easy;
- Telehealth requires less paperwork than in-person services;
- Telehealth reduces no-shows;
- Telehealth benefits rural outreach;
- Telehealth is helpful when transportation issues arise; and
- Telehealth works well with adults.

The following negative remarks about telehealth were the most frequently reported:

- There are additional insurance barriers to face if providing telehealth;
- Providers cannot continue to provide telehealth services if clients move out of state or leave the state temporarily;
- Connectivity and Internet issues occur with telehealth; and
- There are privacy and confidentiality concerns with telehealth.

Question 15 (LCP). How many individuals do you currently provide supervision to?

LCP Responses



Of the respondents that answered question 15, the largest number noted they were prefer not to answer, which is attributable to the lack of an option to answer zero. The second most popular answer was one (24%), followed by three to five (12%), then more than 10 (11%). Other answers were less than 9%.

Question 15 (LMLP)/Question 16 (LCP). Over the past two years, have you experienced any negative issues involving supervision? If so, please explain.

LMLP Responses

One hundred and two LMLPs answered this question and identified a variety of issues. (Responses for all licensees can be found in Appendix #12 on Page 70.)

The most frequent survey response (eighty-five responses) was that individuals have not experienced any negative issues involving supervision. Seventeen respondents indicated that they had experienced negative issues involving supervision.

Of the seventeen responses, the most frequently reported issues (six responses each) were being unable to find a supervisor and poor quality and/or inadequate supervision. Examples cited for poor quality and/or inadequate supervision include discrimination, being treated as inferior and a burden by supervisors, and judgmental, unreachable, and unsupportive supervisors.

While less frequently identified as the issues noted above, other licensees pointed out that the cost of supervision is too high for them to afford (five responses). Two respondents also indicated experiencing power struggles in supervision.

LCP Responses

One hundred and ten LCPs answered this question and identified a variety of issues. (Responses for all licensees can be found in Appendix #13 on Page 70.)

88 respondents indicated experiencing no negative issues involving supervision over the past two years, and 10 respondents stated that they do not provide supervision. 11 respondents reported experiencing negative issues related to supervision. The only negative issue that was reported more than one time was the recurrence of supervisees being unable to pass the EPPP at the clinical level. Other negative issues pointed out issues revolving around turnover, workload, and professionalism.

Question 16 (LMLP)/Question 17 (LCP). Do you currently use artificial intelligence (AI) in your practice? If you do, in what areas do you use AI?

LMLP Responses

One hundred and six LMLPs answered this question and provided a variety of responses. (Responses for all licensees can be found in Appendix #14 on Page 80.)

The most frequent survey response (ninety responses) was that individuals did not use AI in their practice. Of the ninety, five noted either that they would be interested in using AI, or that they plan to start using it soon.

Sixteen respondents indicated that they do use AI in their practice. The most frequently reported use of AI (nine responses) was that AI is used to assist in progress notes and note-taking. While less frequently identified, other areas identified included using AI for differential diagnosis, documentation, formatting, generating checklists, personal study, reframing concepts, and writing outlines.

LCP Responses

One hundred and nineteen LCPs answered this question and provided a variety of responses. (Responses for all licensees can be found in Appendix #15 on Page 83.)

One-hundred-and-six Licensed Clinical Psychotherapists who responded to the survey indicated that they do not use AI in their practice. Of these one-hundred-and-six responses, five expressed interests in learning more about how it is used.

Thirteen licensees indicated using AI in their practice. The most frequently reported use of AI in practice was for note taking and progress notes. Less frequently reported uses included documentation, report writing, billing, basic template creation, and research.

Question 17 (LMLP)/Question 18 (LCP). 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?

LMLP Responses

Eighty-eight LMLPs answered this question. (Responses for all licensees can be found in Appendix #16 on Page 87)

The most frequent survey response (fifty responses) was “No,” meaning that they did not have any recommendations on additional ways that the BSRB could protect and serve consumers of services offered by BSRB licensees.

After the “No” answers, the most frequent survey response (nine responses) on recommendations and additional ways the BSRB could protect and serve consumers of services offered by BSRB licensees related to insurance barriers, specifically to broadening and expanding billing abilities and coverage. These responses also included comments regarding the issue that not all insurance companies recognize the Licensed Master’s Level Psychologist license.

Other licensees recommended expanding the ability to practice outside state lines, having more communication between the BSRB and licensees, analyzing EPPP requirements, and allowing individuals to practice without supervision after holding a license for a specific period of time.

While two responses recommended reducing the influence of state and community mental health centers (CMHCs), one response expressed support for these centers. Furthermore, respondents expressed a desire for more affordable continuing education and for licensure barriers to be removed. Licensure barriers, in this context, referred to the cost of LMLP licensure and to the transition from LMLP to Licensed Clinical Psychotherapist (LCP) licensure.

LCP Responses

Ninety-four LCPs answered this question. (Responses for all licensees can be found in Appendix #17 on Page 92.)

60 licensees reported having no recommendations or additional ways the BSRB could protect and serve consumers of services offered by BSRB licensees.

The most frequently reported ways in which the BSRB could protect and serve consumers of services offered by BSRB licensees (seven responses) included advocating for better and higher insurance, Medicare, and Medicaid reimbursement. Six licensees recommended advocating for either a multi-state compact or reciprocity with other states.

Other respondents indicated a need for the master’s level psychology profession to be better recognized. There were also recommendations made concerning the EPPP examination, specifically in regards to reducing the passing score.

Question 18 (LMLP)/Question 19 (LCP). 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 master's level psychology profession?

LMLP Responses

Eighty-four LMLPs answered this question and identified a variety of issues. (Responses for all licensees can be found in Appendix #18 on Page 101.)

The most frequently occurring topic (seven responses) was the EPPP licensing examination. Specifically, recommendations were made to lower the clinical passing score, allow for retakes prior to the completion of clinical hours, and to not require the EPPP-2. Responses also pointed out the financial burden that the EPPP examination creates. The second most frequently occurring topic (five responses) was the expressed support for a multi-state compact.

While less frequently identified, others pointed out the inability to receive supervision or get clinically licensed at a reasonable cost, insurance barriers faced by licensees, and the growing shortage of practitioners. Responses also pointed to the idea of being able to practice without supervision after being in the field for X number of years, as well as staying up to date with the APA's accreditation of master's programs.

Thirty-nine respondents did not have any additional comments or feedback to provide.

LCP Responses

Eighty-five LCPs answered this question and identified a variety of issues. (Responses for all licensees can be found in Appendix #19 on Page 107.)

The most frequently reported topics in responses to this survey question included insurance barriers and advocating for either reciprocity or a multi-state compact (six responses each). Five respondents recommended advocating for better recognition of the profession.

LMLP Q1. In what Kansas county/counties do you practice the profession of master's level psychology? (111 responses)

20 counties of High Plains Mental Health Center catchment area

All counties in KS except Johnson and Sedgwick

Allen, Anderson, Bourbon, Linn, Neosho, Woodson

Anderson

Anderson, allen

Barton

Bourbon

Brown

Butler (3 responses)

Camanche, Clark, Finney, Kiowa, Edwards, Ford, Grant, Gray, Greeley, Hamilton, Hodgeman, Kearny, Lane, Morton, Reno, Scott, Sedgwick, Seward, Stanton, Wichita,

Cowley

Crawford County

Crawford, Bourbon

Douglas (3 responses)

Douglas, Shawnee, Franklin.

Ellis (6 responses)

I live outside of Kansas.

Jackson, Brown, Nemaha, and Doniphan

Johnson and Miami (2 responses)**Johnson (9 responses)**

Johnson and Franklin

Johnson, Shawnee, Wyandotte

Johnson, Shawnee, Wyandotte, Osage, Douglas

Johnson, Wyandotte, Miami, Leavenworth, Douglas

Kansas

Kiowa, Edwards

Labette

Leavenworth (2 responses)

LY, CF, WB, OS, CH, GW, MR

Lyon (2 responses)

Lyon and Chase

Lyon and Coffey

Miami

Montgomery (2 responses)

Montgomery, Elk, Chautauqua, Wilson, Cowley

Nemaha, Brown, Doniphan, Jackson, Riley, Geary, Cloud, Atchison, Pottawatomie

Neosho

None (8 responses)**Pawnee (2 responses)**

Pratt County

Reno

Rice County

Riley & Geary

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| Riley (4 responses) |
| Ruce |
| Saline (2 responses) |
| Sedgwick (18 responses) |
| Sedgwick, Butler, Harvey, Reno, Pawnee, Shawnee |
| Sedgwick, Cowley |
| Shawnee (3 responses) |
| Shawnee and surrounding counties |
| Shawnee County |
| Wichita |
| Wyandotte (5 responses) |
| Wyandotte, Johnson |

LCP Q1. In what Kansas county/counties do you practice the profession of master's level psychology? (123 responses)

13 in SW KS - Compass region

All (2 responses)**Atchison (2 responses)**

Barber and Harper

Barton

Bourbon

Brown, Nemaha, Jackson and Nemaha

Butler

Butler & Sedgwick

Butler, Shawnee, Cowley

Cherokee (2 responses)**Crawford (3 responses)****Douglas (4 responses)**

Douglas, Johnson

Ellis (3 responses)

Ellis, Johnson, Sedgwick, Wyandotte, Saline

Ford and Sedgwick

Franklin (2 responses)

Jackson

Johnson (23 responses)

Johnson and Douglas

Johnson and Leavenworth

Johnson and Shawnee

Kansas

Kiowa, Edwards, Comanche and Clark counties in Kansas.

Leavenworth

Linn and Bourbon

LV

Lyon (4 responses)

Montgomery (2 responses)

Montgomery, Chautauqua, Wilson, Elk, Cowley

Montgomery, Wilson, Elk, Chautauqua, and Cowley

None (4 responses)

none currently

Open for all counties.

Pawnee (3 responses)

Pratt, Barber, Reno

Reno (4 responses)

Riley

Saline (4 responses)

Saline, Sedgwick,

Sedgwick (19 responses)

Sedgwick (primarily)

Sedgwick, Cowley

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| Seward, Haskell, Stevens, Meade |
| Shawnee (6 responses) |
| Sherman and Thomas |
| The 20 counties in the far northwest corner |
| Thinas |
| Wyandotte (2 responses) |

LMLP Q6. Do you maintain an active license, but no longer work as a master's level psychologist? If so, please explain why you are not providing services currently. (82 responses)

Active license (5 responses)

Active License is currently maintained

Current job does not require license, but use skills related to field. I work in healthcare quality improvement leading and facilitating teams.

Currently working as an LMLP but getting a second Master's in social work because of hirer billing potential.

Currently working for MCO.

Having my license is a very valuable tool in the health care insurance industry. If I ever wanted to go back to utilization management reviews, I would have to have an active license so therefore, that is why I keep it, but I do not practice.

I am currently working as a school counselor, so my license is not being utilized for diagnostic or billing purposes.

I am employed as a policy analyst and had an opportunity both pay and work experience I could not pass up.

I am still providing services.

I carry a small caseload and perform testing however I am in a senior leadership position and any form of licensure, and maintenance of licensure, is required.

I currently hold a position that requires licensure but does not require providing services although it is an option.

I currently practice

I do not work actively with clients anymore but in quality improvement for a mental health organization.

I maintain an active license and still work.

I maintain an active license and work as a masters level psychologist

I maintain my LMLP license. The state of Arizona, which is where I live, does not recognize my license.

I still work and use my active license

I work

I work in the field but work in a different state (Tennessee)

I've worked in child welfare services for over 20 years. I've never actively used my current license as it's not required for my job. I was employed years ago with an agency that required a license and at the time, I had a temporary license I was operating under.

No (47 responses)

No, currently active

No, I have an active license and still work as an LMLP.

No, I maintain an active license and work as a masters level psychologist

practice using a different license- Illinois LCPC

Predominately in administration, but practice minimally

Retired-Have not used my LMLP license since 2007.

Too many insurance companies do not recognize LMLP licensure for coverage

Yes, I am a student Support specialist (counselor) in an elementary school. I provide interventions, but not therapy or billable services

Yes, I make more income in my current role.

Yes, I work in a different industry but do serve on a mental health center board and do not want to let my license lapse.

Yes. I am a school psychologist who has worked as such in KS for 25 years.

LCP Q6. Do you maintain an active license, but no longer work as licensed clinical psychotherapist? If so, please explain why you are not providing services currently. (83 responses)

Active license (2 responses)

Burn Out

Have an admin position now

Healthcare administrator in behavioral health setting. License is relevant for supervision of staff but I do not directly provide services to patients.

I am currently a full-time faculty member at KSU Salina.

I earned my EdS and currently work as a school psychologist, but keep my LCP license too.

I have licenses in several other states however I had to be licensed as a professional counselor due to state requirements. I primarily work under the LPC license

I have LMLP and LCP

I hold an active license but work for a Medicaid organization and do not provide direct care or therapy

I maintain an active license

I maintain an active license and still work in Kansas, only.

I obtained a Specialist in Education degree and have worked as a school psychologist since obtaining that degree. However, I have maintained my license in the event that I would once again provide therapy services.

I only provide supervision on Zoom for a couple of masters level psychologists who are working toward their licensure as LCPs.

I provide counseling services in Oklahoma

I work for a managed care organization, primarily operations but within the behavioral health segment.

I work in the field but work in a different state (Tennessee)

Looking right now

Moved from LMLP to LCP and now in BH Administration; continue to hold license

N/A (not applicable)

N/A: I currently practice.

No (51 responses)

No, I still practice

No, still work in profession.

Part time retirement

Part-time contract work only. Retired from full-time practice in a public setting.

Retired May 2024

Still working at mater's level.

Working as a PA

Working as a professor at a Kansas college

Working as a school psychologist

Yes. I maintain licensure but currently do not use it. I am a Suicide Prevention Program Manager for the US Army Reserve. I do not do any counseling or therapy. I manage a program that provides regulatory training plus connects Soldiers to resources.

Yes. The ceiling for Master's level clinicians in the healthcare system, financially and professionally, felt lower than what I wanted/deserved. So I transferred to an adjacent field that offers less stability but more growth.

LMLP Q9. Are you currently working towards attaining a Licensed Clinical Psychotherapist (LCP) license in Kansas? If you are not taking steps to receive an LCP license, please explain why you made that decision: (109 responses)

Already have it

Already have one.

Arizona does not recognize the LMLP or LCP license.

At first, I really thought it was a must, but now I am not sure about that.

Because I have a PHD. If I go for a higher license it will be the LP.

Cannot afford supervision, testing fees, or licensure fee.

Cannot afford to at this time

Currently working toward LCP

Did not believe I would need a clinical license and by the time I believed it would benefit me I did not want to retake the EPPP

Did not pass the ePPP at the clinical level

Do not want to retake test

Don't want to have to take the EPPP again. Too expensive, and it in no way is a measure of my clinical abilities. In college, a student goes through a long and vetted process to prove clinical abilities just to be told, "that's not enough!" Like socials workers, whose exams are easier (in my opinion) my years of supervised clinical experience should prove that my skills are solid and safe for public consumption, and that Should be able to work on my own without supervision.

Have both.

I already have my LCP but maintain my LMLP

I am currently in supervision

I am looking for someone to supervise me for the LCP, once I have a supervisor then I'll start the process.

I am not pursuing the LCP due to the cost of supervision hours.

I am not, mostly due to financial constraints. The EPPP is a costly exam and my work doesn't provide a good allowance for supervision if you choose to go outside the company. They also don't have any available supervisors currently.

I am working toward attaining my licensed psychologist license.

I am working towards an LP after I finish my predoctoral internship in clinical psychology.

I couldn't find someone in my area to be my supervisor. As a result I shifted career paths to quality improvement. Now there are more supervisors but I no longer work with clients to get the min hours needed.

I do not work in a roll where I am providing therapy so I can't accumulate hours

I don't want to take the EPPP again.

I have dual licenses, LCPC & LMLP, in two States and I am older than 55 years.

I have one

I have sat for the exam three times just missing the 500 score by a few digits. I have decided not to pursue the exam as it is costly to register, the study aid is very expensive, the time invested is so much especially when working and having a family to care for. I have spent \$1800 dollars just to sit for the exam, and other 3000 to buy study material and have studied for over 8 months just to be failed by missing a question or two. We need the money to feed our families and pay our bills, but it seems no one cares.

I no longer live in the state of Kansas and I was screwed out of my client contact hours to begin with so it is really not worth my time, trouble, life energy.

I recently obtained my LCP in September

I worked for years for the state when licensing wasn't required. Later I used an LMAC license. Now debating on whether or not to move ahead and get Clinical license.

I would enjoy working towards an LCP, but as a crisis therapist, and now as a crisis services director, I've never gotten enough direct hours

I'm taking steps to obtain my LP

Ineligible due to not achieving high enough on EPPP. May consider retesting but cost is primary factor.

I've completed my supervision hours, but have been unable to obtain a 500 on the EPPP.

No - was not clear what was needed at time if return to Kansas to get clinical

No (9 responses)

No Have it already

no- unable to find a supervisor

No, already licensed as LCPC as well

No, because I do not want to retake the EPPP or complete the supervision required as I have over 15 years experience already.

No, because there are no incentives or benefits of doing so at my current place of employment and I have no desire to have my own practice.

No, due to time and cost I am not pursuing that option at this time.

No, I am currently working on obtaining an LMAC license and LP license since I have a PhD in clinical psychology.

No, I'm working toward an LP

No. In my current role, this would not benefit me professionally.

No. Already have LCP.

No. Couldn't pass the test at a high enough level, it's been too long now to retry.

No. Don't have enough clientele to meet requirements at this time.

No. Expecting to move out of state and requirements for LCP not realistic.

No. I have thought about taking that step have not am not sure if I have the time to commit to to that process.

No. I haven't been able to work in an agency that provides clinical supervision and haven't been able to find an LCP or LP to provide supervision. Also the expense associated with supervision and it doesn't offer significantly more opportunities than are currently available to me. I'd be more likely to pursue LPC so I can have reciprocity with Missouri.

No. I should have been grandfathered in as LCP back when it was introduced, but there were unusual circumstances that prevented that.

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| No. If I stopped working in schools as a school psychologist, I would pursue licensure as LCP. |
| No. I'm not that motivated to do extra work, nor making enough money to comfortably pay for supervision. |
| No. I'm working towards obtaining an LP license and LMAC. |
| No-see above |
| Not at the current moment. At first it was no preference of wanting to increase client load. But now my agency doesn't have a person who can supervise easily, so that the idea of starting the LCP license is stalled by that. I should say that by being stalled, I mean that I am still in the phase of thinking about starting that process up. |
| So much paperwork, tracking, and finding supervision. If I had started my LCP application when I graduated it would have been easier but now that I'm almost 10 years out of school getting records and contact with people is difficult. Also, the EPPP is ridiculous expensive. That is a month to two months of daycare. |
| Test is expensive and the process is exhausting, after several unsuccessful attempts, I'm taking a break. I really wish I had my lcp though. |
| The billing potential is not great so I am having to get a Master's in Social Work and then clinical licensure in that because of billing. It's ridiculous but I want to help my clients so it's what I have to do. |
| The current position I hold doesn't require a license. I keep my license as a back up and ongoing interest in the field. |
| The number of supervision hours required for LCP has made this goal unobtainable for a small practice |
| To change to Tennessee license they would require me to take one more group therapy class and redo supervision. I have worked so many years I do not wish to do these things. |
| Trying to pass the eppp |
| Yes - I am working towards LCP. I decided to take that next step to have more autonomy and ability to be independent. |
| Yes - need to take EPPP |
| Yes - VERY frustrating process with that exam. Definitely overrated, unrelated to work with clients, overpriced, etc! We've lost multiple great clinicians because of this exam! |
| Yes (28 responses) |
| Yes I am working towards my LCP |
| Yes only have to test |
| Yes, I am planning on doing so. I just have not solidified everything with my clinical supervisor, but should be doing so soon. |
| Yes, I am working toward obtaining a LCP license |
| Yes, I have recently submitted my application! |
| Yes, I would like to work towards the highest possible license. |
| Yes. Currently looking for a clinical supervisor |

LMLP Q11. Currently, no multi-state compact exists for the master's level psychology profession. If a multi-state compact was created under a model that would allow individuals to practice in other compact states by changing from a single-state license to a multi-state license for an additional cost, would you be interested in obtaining a multi-state license under such a compact? Please explain. (111 responses)

Absolutely, I have clients that move and want to retain the relationship.

Absolutely, that would give us more ability to choose good fit areas, to help more people overall, and potentially continue working with current clients that have moved to any of the other states

Absolutely. I work with many military families and students that move when they are transferred or graduated and with telehealth it is so sad that we have to refer to a new therapist when continuity of care could take place through telehealth.

Absolutely. It would allow for more widespread and accessible services for clients, as well as the opportunity for additional clientele for providers. As a specific example, it would make therapy more accessible for clients attending school outside of their home state.

I am close to retirement now. If I was earlier in career I would like the multi-state option for added flexibility.

I am not sure, probably

I am unsure. It would depend on if it would be difficult to move back to a single-state license from the multi-state, and how much the additional cost is. There are already so many different costs with licensure that it's difficult for me to keep up with.

I do have clients I worked with that moved and instead of referring I could continue services for continuum of care

I would definitely be interested in obtaining a multi-state license, and would be much more likely to pursue an LCP.

I would like that very much actually. This would allow more flexibility and opportunities for many LMLPs in Kansas.

I would, it would be nice to be able to expand.

I'd actually reached out to Psy-pact in the hopes that they allowed LMLPs. I would love this.

It would depend on how much the additional cost was.

Maybe

Maybe in the future

Maybe, it would depend on the states.

No

No, that would require only telehealth for my location.

No. Will retire soon.

No. I am almost 60 and will be retiring in seven years

No. There is plenty of work to be done in just one state.

No-see above

Not at the present moment, however, possibly in the future dependent upon life circumstances.

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| Not at this time as it does not fit in with my current home life plans. |
| Not now but maybe someday |
| Not sure |
| Not sure. Possibly. |
| Possibly (2 responses) |
| Possibly but not super interested in it |
| Possibly. It would create more access for consumers with less barriers. Would also allow those that move to continue with provider and/or consumer. |
| Probably not right now. I might be interested in this when I leave my current job. |
| Sure, more the merrier. |
| That would be interesting to me. |
| This would be ideal living in the KC area with so many healthcare organizations with sites on both sides of the state line. |
| Uncertain. Kansas is the only state in which I am aware that an LMLP can practice successfully. Other states do not recognize this level of licensure to my understanding. |
| Unsure but there is value in this for our profession |
| Yes (12 responses) |
| YES absolutely that would be great and I'd pay the extra cost. Because as a CCBHC working near the Missouri state line, there are times it would be of great benefit to be able to see our client where they're at, even if it's just over the state line. We are increasingly seeing clients asking for our crisis support when they are traveling to other states, too. |
| Yes absolutely! I think it would be wonderful to have a multi-state compact. This would open many doors and opportunities. Given that Kansas is one of the only states with an LMLP licensure it can be limiting. Please consider this option! |
| Yes for MO so I can work more effectively in KC |
| Yes I would be interested in that so I could work in multiple states |
| Yes I would be very interested in paying the additional cost to maintain a multi-state license compact. |
| Yes I would like that so I could reach more clients for telehealth. |
| Yes please!! I think this licensure is unique and special and deserves more recognition and benefits for our incredibly hard work to earn the license credentials! |
| YES then I could do telehealth with patients in other states |
| yes to be able to provide more services to populations that don't have access or a long wait time to see a clinician |
| Yes! I practice near the state line of Kansas and Missouri, which affects my referrals, and I have family out of state and would benefit from a multistate license. |
| Yes! I would love to continue providing therapy. If I understand correctly, this would allow me to practice in other states, would give other patients AND myself flexibility in geographic location. |
| Yes! This is the only reason I decided to get my LCP. |
| YES! This would be super beneficial for us to expand our services like actual psychologists. |
| Yes!!! I want to move to Florida to be with family |

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| YES!!!! VERY!!! I would love to see this license become more transferable |
| Yes, that would be amazing, as long as the cost is not too high. |
| Also how will that affect supervision, since lmlp's can't practice independently?! |
| Yes, absolutely |
| Yes, absolutely. I would love to be able to expand my practice or offer care to Missouri residents since I work close to the border. It also would allow for other career opportunities. |
| Yes, allows for more mobility. |
| Yes, but depends on what states. |
| Yes, especially when clients move and takes a while for them to transition to new providers |
| Yes, for the states of Missouri and/or Ohio (my birthplace) |
| Yes, I am a doctoral student who will be going on internship and post-doctoral positions in the next few years, possibly not in Kansas. My home state is Pennsylvania, and I plan to return to Pennsylvania on completion of my PhD. A compact that allows me to maintain my LMLP licensure across multiple states would be beneficial. |
| Yes, I live close to the border and could provide services to more clients. And it would open up options to live in New places |
| Yes, I regularly have to turn down potential clients from other states because of the current interstate agreements, or lack there of. |
| Yes, I travel back and forth to missouri a lot and would like to provide services there. |
| Yes, I would be interested in obtaining a multi-state license. Other states don't recognize the LMLP license. Practitioners with an LMLP license are obligated to practice only in Kansas. The LMLP license should have endorsement or reciprocity by other states at least as an licensed clinical professional counselor (LCPC) to be able to practice independently due to our rigorous training and passing score of the EPPP (which is more difficult than the counseling exam). |
| Yes, I would be very interested in obtaining a multi-state license. To my knowledge, a LMLP or equivalent does not really exist in other states so it limits my ability to move, unless I want to get my LPC. |
| Yes, I would be very interested. |
| Yes, I would like to increase opportunities to provide therapy with so many in need. |
| Yes, I would like to move to another state and this would help me with job security. |
| Yes, I would love to be able to practice in other states; independently without supervision. |
| Yes, I would not mind providing support to states such as Nebraska, Missouri, and Oklahoma if needed. |
| Yes, I would. |
| Yes, it would give me more freedom to move where I want and prefer to be. |
| Yes, rather than being licensed in multiple surrounding states, it would be easier to keep up with one license. |
| Yes, that would be helpful in my current position working at a college counseling center. |

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| Yes, that would make it much easier to reduce barriers to care. Especially living so close to Missouri. |
| Yes, there is a demand and would love to be able to help more people |
| Yes, this would be hugely impactful for the LMLP licensure. As a Missouri native, my license has virtually no reciprocity which is disappointing considering the work/hours I've put in to obtain my license and working toward clinical licensure. Opening a multi-state compact opens the door for this incredible licensure to provide needed services in more states including those with poor LMLP reciprocity! |
| Yes, When I joined the profession it was not for money as we make peanuts, it was to help those who cannot help themselves. So yes I will apply for the multi-state license. |
| Yes. I live in Kansas, but am just a few miles from the Oklahoma border. |
| Yes. I am interested in being able to provide services to KS residents while they are traveling out of state temporarily. |
| Yes. I believe this would open up opportunities for Telehealth and the ability to reach more patients. I also think it would be helpful for obtaining dual license in multiple states, which I plan to do. |
| Yes. I currently work under a non compete clause that has a big enough radius that practicing outside of my current job role in Kansas is hard. If I could practice outside of Kansas then it would be easier. |
| Yes. I have avoiding moving out of state due to licensure limitations. A multi-state license option would be great! |
| Yes. I have had clients that have moved out of state and would have benefitted for services continuing while they set up services in their new state. |
| Yes. I live in a city close to state lines, so it would be beneficial. |
| Yes. I live in Colorado and travel throughout the year. |
| Yes. I think it would be beneficial to me to be able to be licensed in multiple states. It would make me more marketable. |
| Yes. I think it's smart to have flexibility in licensure for clients who move, continuity of care, etc |
| Yes. I work in the Kansas City, Kansas area and being able to see client's who live in Missouri at their home or via telehealth would be beneficial. |
| Yes. I'd love to be able to see more people wherever they are needed to be seen at. Also helps if I were to move states again. |
| Yes. It gives more options to not only myself for work but companies who use telehealth when short on staff like the department of corrections. |
| Yes. It would be beneficial to have consistency in licensure for the profession across several states. |
| Yes. It would be nice to have the option even if I don't need it currently. |
| Yes. It would open me up to new opportunities to serve clients in other states which would dramatically increase my career opportunities. |
| Yes. My family has wanted to move out of the state of Kanas but because my license is only good in Kansas we have not. |

Yes. My wife (an LCP) and I plan to move to Colorado or Massachusetts within the next 8 years. We want to continue to practice but neither state offers reciprocity or an opportunity to have a license consistent with LMLP or LCP. We would have to become LPCs (which neither of us want to do). On top of that, we are in the KC metro and our client pool is limited to the KS side of the state line. That seems silly.

Yes. The ability to practice in other states (especially contiguous states) would be a benefit to my practice and free me to make decisions for family life not contingent on state lines.

Yes. This would allow me to serve clients from other states and surrounding areas.

Yes. Would allow to expand client base and potentially meet needs in under-serviced areas

LCP Q11. Currently, no multi-state compact exists for the master's level psychology profession. If a multi-state compact was created under a model that would allow individuals to practice in other compact states by changing from a single-state license to a multi-state license for an additional cost, would you be interested in obtaining a multi-state license under such a compact? Please explain. (120 responses)

Absolutely! I am struggling with the fact that I can't practice out of state and can only be licensed in KS unless I go back to school and take a few classes and go through supervision again because my licensure is not seen as comparable to LMFT or LPC of LSCSW.

Absolutely!!! I was unaware when in grad school that LMLP/LCP was not available in other states. This hinders ability to relocate if desired, or to expand telehealth services to other areas in need of therapists. I would love to be licensed in multiple states without excruciating steps.

Absolutely. The fact that this doesn't already exist is such a limitation for me. A compact would allow me to uphold greater continuity of care for many on my caseload.

I see the value of it, but I would not be interested at this stage in my life.

I would be interested. However, I would want to know what would aid the board in providing a multi-state license.

I wouldn't due to my age but if I was younger I would like this option.

If I were to return to providing therapy service in a remote or hybrid capacity, I would consider it.

Maybe? I plan to retire in about 10 years. I anticipate staying in Kansas but the flexibility afforded by a multi-state license might be nice.

MO, TX, FL, MS, LA, AR, OK

No (6 responses)

No, am fully retiring in 2 years

No. I am approaching the end of my career and will be exiting the profession, not expanding service opportunities.

No. I don't plan on leaving Kansas. But I do think this would be great for young professionals entering the field.

Not at this time

Not interested, I plan to be a faculty member until I retire.

Possibly (2 responses)

Possibly serving in Colorado.

Possibly, but it would depend on which state(s) were involved.

possibly, it would depend on what states were included and other factors

potentially due to the proximity to MO

probably not but maybe in the future

Probably not. I don't think being able to practice in more places would impact my professional decisions

Unsure but the option would be nice.

Very much. I am interested in seeing if the master's in psychology license can qualify for the Licensed Practical Counseling License to work toward the clinical level and be eligible for Medicare and Tricare payment models.

Yes (19 responses)

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| Yes absolutely. |
| Yes- absolutely. I feel that masters level psychology is not widely accepted, and Kansas is a great state for masters level psychology. I would love to have a multi-state license- especially since I work so close to the Missouri line. |
| Yes because I live in Oklahoma. |
| Yes definitely, I have my LCP and passed the EPPP w/ 80% above the doctoral level, we need to have Reciprocity at this level to practice in any state. |
| Yes definitely. |
| Yes depending on what states are included. |
| Yes- I would be very interested. I work in a college town so it would be advantageous to be able to continue to see clients after they graduate or go home for the summer. I also see adolescents that go to college in other states. I have several clients who have homes in other states where they live part of the year. I have clients that travel out of state for business. In all of these situations, it would be advantageous to be able to continue services when clients are out of state. |
| Yes I would like the opportunity |
| Yes live near Missouri and would be great to be reciprocal |
| Yes! (3 responses) |
| Yes! I am in the KS/MO border, so that would be so helpful! |
| Yes! Our current structure inhibits me from ever considering a move to another state due to differences/restrictions in other state's licensing. |
| Yes! This profession desperately needs this, and we are behind the other professions. |
| YES!! This would be of great benefit to both the LCPs and the clients for continued care, building a practice, and getting the quality of care people want. |
| Yes!!! I think this would be a great value and all others to work in KS and those from KS to work in boarder states, or other states as well. |
| YES!!!! |
| Yes, as long as I don't have to go through a huge, long process and take any testing. |
| Yes, because this would open up the opportunity for expanding my work. |
| Yes, being able to expand my practice is always a good thing. If I can be available to more people who are in need of affirming treatment in these dark times, I must. |
| Yes, but I am unsure what state(s) except Missouri |
| Yes, continuity of care would be nice for service members, family members of service members and students who graduate and move to other states. Telehealth makes that possible. |
| Yes, depending on the cost. |
| Yes, depending on the cost. I see college students and feel limited in being able to provide care when they return home for breaks, move on to graduate school in another state, etc. |
| Yes, due to how close I reside to MO. |
| Yes, especially when clients move and takes a while for them to transition to new providers |
| Yes, feel this is essential as we move forward in enhancing access to treatment |
| Yes, for more flexibility and options. |
| Yes, for semi-retirement purposes should I decide to leave KS which is unlikely but it would be nice to have. |

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| Yes, for telehealth client purposes |
| Yes, I am interested, I appreciate practice options |
| Yes, I believe it would be beneficial for LCPs to have multistate licensing. Many younger people move around like I did with my husband when he was active duty military. |
| Yes, I currently am licensed in Oklahoma but would also like to be licensed in Arkansas and Missouri because I live close to both states. |
| Yes, I have clients who move or travel for work to neighboring states that don't want to disrupt their treatment. I also work with rural/agricultural clients who typically have limited resources and could benefit from more therapists who have specific training/understanding of their unique experiences whether they are in or out of state. |
| Yes, I live in a small town in Kansas that borders Missouri and would love to have that as option to help more clients. |
| Yes, I live in Colorado and travel to multiple States for another job and would love to have the flexibility to provide services to people in other states. |
| Yes, I reside close to Oklahoma and have another home in OK and would like the option to work part time in another state. |
| Yes, I work with military families and clients in Missouri. I also frequently travel to Florida. |
| Yes, I would be interested, as it allow me to be more marketable and to provide services to a larger clientele base. |
| Yes, I would be interested. This would help us be competitive with other professionals. |
| Yes, I would like to be able to have the possibility to work in other states |
| Yes, if I was younger |
| Yes, I'm very interested in that |
| Yes, in case I want to do private practice work in another state. |
| Yes, it would be beneficial to serve students who go home in the summers to reside with their parents who live out of state and to continue to serve clients who move out of state. |
| Yes, Missouri and Colorado |
| Yes, my work involves supporting multiple markets across the US. A multi-state license could provide opportunities to work for other markets in certain capacities. |
| Yes, provided the state(s) are geographically in the same region. |
| Yes, so long as I would be able to practice independently as a master's level psychologist/clinical psychotherapist in order to provide therapy and psychological testing (without supervision or having documentation signed off by a LP). |
| Yes, that would make a big difference for swks rural area. |
| Yes, this would assist clients through telehealth that reside in other states. |
| Yes, this would broaden my ability to expand my opportunities, I have never had as an LCP |
| Yes, we are so close to Missouri and Oklahoma, this would be of interest to me. |
| Yes, work close to state lines need it |
| Yes, work in Overland Park so would be easier to see clients in MO, easier access for teletherapy. |
| Yes. Absolutely! This is a number one priority for master's level psychology! |
| Yes. I live in OK and would like to be able to practice there |

Yes. I may want to retire from my current position and provide telehealth therapy one or two days a week.

Yes. A multi state license would simply offer more flexibility and allow me and other licensees the opportunity to serve a broader range of people in various regions of our country and neighboring states either through direct services or supervision.

Yes. But only if it doesn't change how I am allowed to practice. I do not support having a more restrictive license.

Yes. Credentialing is a mess for master's level psychologists, especially at the Psychotherapist level. Multi state telehealth is growing, and national companies do not understand the psychotherapist licensure.

Yes. I have a speciality that is not widely available and I would love to help more clients with my services. I would also welcome the ability to relocate if needed without worry for transferring my caseload to another provider.

Yes. I would be very interested in this. I live on the state line (in fact my office is less than 5 mins from MO) which can limit my ability to see clients. I am an LCP and would want to maintain this license in all the states.

Yes. If it allowed me to still practice in the parameters that the state of Kansas allows me to as a licensed clinical psychotherapist. I would not be interested in changing my license to a counseling license, as many states offer.

Yes. I've had a number of clients who live right across the border in Missouri. It would be helpful if I could provide telehealth services to some of them.

Yes. There is significant shortage of testing in other states due to licensing limitations which creates excessively long wait lists.

YES. Unequivocally yes. The limitations specific to being a master's level psychologist are frustrating and have often made me regret pursuing this specific type of licensure. I would love to be able to offer services to more states and/or be eligible for employment with agencies that require more versatile licensure.

YES. I would be able to practice in my home town where I reside. I would not have to commute as I have done for almost 25 years.

Yes... increase flexibility and provide care to those not able to access otherwise

Yes...If no additional hoops, barriers, existed. In my opinion, it should already meet the criteria...the Social work LSCSW has been that way for decades. And arguably the LCP has more educational hours, with testing ability. It is politics that have kept the degree down. Also...When I stated in 1988 I could bill Medicaid and I had as a credential MS Clinical Psychologist. At the masters level only social work and a Masters in clinical Psychology could bill medicad. And of couse Medicare and medicaid refused to pay for Substance services. Thus started a grant convoluted system that still exisits with silly hoops, addtional unnecessary credentialails. So Psychologist and social workers were already able to DX and TX Substance and would typically find an appropriate Primary DX of MH. Then Marriage and family therapists, Counseling field, Art Therapy, etc. began to try and ask for Parity with other degrees. And some succeeded more than others. In summary...The issues is not about education and instituing new tests and etc. It is a legislative issue and the APA for one continues to undermine master's level psychology from rising if/when they can.

LMLP Q13. Over the past two years, based on your observations and experience practicing in the master's level psychology 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? (96 responses)

Actually, I feel outside agencies need to understand our LCP are "stand alone" therapists and should be included in reimbursements and job positions available to MA degree social workers...frustrating!!

Telehealth ethics and billing rules would be important.

Deeper dives into diagnosing (not so simplistic) - when many symptoms overlap (anxiety, ADHD, PTSD), cycles, etc.

Best practices for specific diagnoses...

Addictions comorbid with other issues

Additional training for diagnosing.

Assessment (2 times)

Behavioral interventions/therapy

Billing and credentialing. People need more training on how to do it for themselves correctly

Community Clinics do not view the masters LMLP to have any significant weight as compared to LPC's, or LMSW. As such, these positions often pay the least or are not hired for. As a result, those with the LMLP may seek leadership or administrative positions outside doing clinical work.

Compared to doctoral psychologist, I do feel our training could include more formal assessments. However, I feel competent when I'm comparing my skill set to a doctoral level therapist.

Compartmentalization. Really the self work that is so important

Continuing education on not diagnosing everyone with ASD and playing into the "everyone is neurodivergent" narrative.

Court testimony.

DEI and accessibility training

Diagnosis is probably the weakest for most

Diagnostics, assessment, and ethics.

Difficulty in insurance coverage, specifically Medicare and TRICARE

Doctorate level beliefs that Master Level are not sufficiently qualified. Lack of general understanding of more urban professionals to the challenges of working in a rural setting.

Lack of available therapists to adequately serve the needs of the population.

EMDR & trauma-informed services

Ethical responses in the current political and legal climate related to immigration, ICE, non gender affirming practice requirements, etc.

I also think that the hours required for face to face practice should be lowered or waived for those who have been practicing for many years in the field under a non clinical license without issue.

It would be helpful if we could get responses when we reach out via email to our BSRB licensing personnel. I know it's changes often over the years - maybe create a general email box for LMLP or LCP persons to reach out to

Focus on self care, advocacy skills, ways to stay informed on legal issues impacting our work and clients

FYI....I have been a mental health practitioner since 1985 and started out as an RMLP.

I have 3 negative practice-related issues:

#1 RESISTNACE FROM PhD. Psychologists

In my humble opinion based on 40 years of service in this field, some of the Ph.D. Psych's appear to feel threatened with the LMLP license and have lobbied against it at the federal and state level for 30 years. I was actually told by a Ph.D. psych that the "terminal degree for a psychologist was a Ph.D. and LMHP's were not worthy of being called psychologists." AND the American Phycological Ass. has also implied the same opinion resulting in my resignation from that organization. They did not value, support or respect the masters level psychologists. These licensing issues are rarely an issue of training or competency and in my humble opinion and are more related to egos.

#2 RE: EVALUATIONS:

KDADS or other state agencies have statutes and regulations that require only PhD's to complete certain types of assessmentsexample: see KSCPOST

<https://www.kscpost.gov/>.....regarding psych evals for Law Enforcement candidates. But there is an extreme shortage of PhD's who can do them. Last time I checked, there were just 5 for the whole state. So, the KSCPOST staffers were asking CMHC's if they have any LMLP's that could do them as there was a back log? Implying they would just look the other way regarding the statute that expressly required a PhD. Psychologist. Being the Clinical Director of our CHMC, due to the liability issues, I won't allow our masters level psych's to get involved until the statute is changed. There have also been similar concerns about other types evals.

Good practices with diagnosis and with treating complex trauma and individuals with developmental disorders are areas that could improve.

have not worked long enough to answer - my supervisor is helpful in most areas

I am currently employed at Osawatomie State Hospital and we struggle to both hire and maintain therapists. There are minimal opportunities for free CEUs and there are no incentives for moving from LMLP to LCP.

I am not aware of any negative issues I have encountered within either the LCPC or LMLP practices. The governing boards of each have always been fair and helpful.

I believe I could use some more training, but this is why I am still pursuing my PhD and intend to become licensed at the doctoral level. I have not seen any colleagues who I believe are distinctly in need of additional training or continuing education outside of what I would expect (as in, I believe they're comparable to my own need. Such individuals are also pursuing their PhDs, however).

I believe there is too much reliance on DBT and CBT. I believe they are great theories and skills but the "art" of therapy is lacking

I feel limited by my license to take some insurances. I would love to have a way to transition from my current level of practice to an LP so I have the same ability to practice, especially once I become an LCP. I would like some way to use my years of work experience and schooling to be able to do the research and get my LP through one of the programs in Kansas. I would also like to be able to take the EPPP again before my two years of supervision are up. I fell just short of the needed score and now I have to wait.

I feel practitioners have little training in suicide intervention often leading to missed connections to care and immediate interventions. In a macro level clinicians often don't understand cross systems work collaborations and the broad scale effect of connections to care.

I have not see a lot of negative issues.

I have not seen anything that was not able to be quickly altered when noticed, through supervision or through continuing education through the agency.

I have not worked with other LMLP's.

I live in Kansas city Metro. Having a mo license would be helpful for televideo but Missouri does not see Imp as equivalent to LPC. Based on title alone

I specialize in issues surrounding neurodivergence. I often find that many clinicians and med providers still have a very outdated understanding of the diagnostic picture across the diagnoses under this umbrella. It leads to frequent issues of ineffective treatment due to mis-diagnosis.

I think all masters' level practitioners could use more training on suicide assessment and risk management, as well as trauma-informed care.

I think coping with treating SPMI and suicidality is crucial today as it is left mostly to state funded clinics. Private practitioners tend to treat more surface level anxiety and depression because of supply and demand and more severe disorders and not reimbursed at a higher rate by insurance companies (and should be)

I think helping clinicians understand the changes that have occurred in diagnostics (you cannot just diagnose ADHD or Autism by a brief meeting and based solely on report).

I think people have a poor grasp of diagnosing. I say this because either the DSM statistics are wrong or people are over diagnosing certain diagnoses. Also please look into more material on psychopharmacology and supporting dialogue about this with and between psychiatrists

I think we need more training in the world of telehealth, crisis, and social media

I'm not practicing with my license however, I think people focused professions should be well versed in trauma informed care. I also think mandated reporter training is important.

Improved trainings overall. The 'HOW TO' work with clients. More than just the basic DSM, common sense material.

In the 18 years that I've been an LMLP, I've encountered so many bosses/organizations that don't know that LMLPs exist and dismiss our value as a result. I feel like I have consistently been treated like I'm clinically inferior to my LMSW and LPC colleagues.

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| Issues arise with more specific diagnoses that I do not see often such as psychosis and lack of experience. I have some limited experience in such cases, but not enough always to be the best provider. I will often refer to other more specialized clinicians. I also struggle to keep up with some of the LGBTQ+ terminology and growing issues, such as legal ramification and such. |
| Lack of those that can provide supervision for those wanting to be LCP |
| More training on practical and positive ethical resolution with ethical, legal, and moral dilemmas, especially with the changing federal landscape. |
| More training to meet the needs to work with neurodivergent populations |
| No (25 times) |
| No concerns related to training |
| No negative issues within KS |
| Not enough training in trauma. |
| Not in Kansas but in Tennessee they have a lot less CEU requirements and several well known evidence based theories they do not know about. |
| Not sure. |
| Not that I have seen or observed. |
| Ongoing training is highly emphasized where I work, so have not noticed any significant issues. |
| Sex and gender education is lacking. I have clients who want answers and come to me specifically for my expertise there, but I have very few referral prospects for that area of treatment, and few trainings that I can find that can help providers become more comfortable in that knowledge. |
| Suicide risk assessment |
| Telehealth |
| The biggest issue is the barrier of not being able to have Medicare, Tricare and EAPs cover services under LMLP and LCP licenses. |
| The CEUs are adequate . |
| There are concerns related to therapy no longer be a safe place due to the number of lawyers issuing subpoenas. |
| There do not seem to be enough practitioners that are qualified to complete adequate Autism Assessments. Additional information regarding telehealth services with children is needed as well. |
| This profession is under represented in Kansas as academics are more rigorous than other professions. Similar with ceu requirements. To be honest I like hiring this discipline as more diagnosis savvy than say social work. |
| Too many providers doing poor evaluations |
| Treatment for bullying and LGBTQ clients |
| WHAT are we allowed and not allowed to diagnose when it comes to autism. I have been told we MUST have a special license now...??? |
| With the expansion of serving developmental disabilities in CBCHCs, it would be beneficial to have more CEU and other training options available. |
| Working with parents of children and adolescents. Work with autistic individuals. |
| Yes |
| Yes, in the areas of addiction and neurodiversity. |
| Yes, practitioners need more training on issues related to addiction and neurodiversity. |

Yes, substance abuse and properly diagnosing substance related conditions.

Yes. It seems Master's level training programs have become watered down particularly in the area of the counseling arena. Emporia State's Counseling program is best considered shameful. I assume others are similar whereas the goal has become to meet accreditation standards but has wholly lost the importance of training to be a good provider. Sad really...

LCP Q13. Over the past two years, based on your observations and experience practicing in the master's level psychology 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? (103 responses)

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"Life Coaches" acting as therapists.

APA Ethics versus BSRB statutes. More direct guidance and assistance with working through ethical questions (e.g. ethical release of information, limits of confidentiality, reporting of abuse, etc).

Applying substance use related diagnoses.

Ignoring the negative impact of substance use.

Appropriate training for providing treatment for certain conditions, such as OCD

BSRB and many others don't know about Accelerated Resolution Therapy that I brought to Kansas 8 yrs ago. It needs to be spread more rapidly as it can treat PTSD and other issues in 1-5 sessions. It is fast and effective and more people should know about the modalities as it is evidence based and it works for more people than one could ever imagine. I train in this modality and would be happy to discuss this with anyone that is interested.

Crisis management for suicidality- general training is lacking new practitioners are not trained enough on how to help those who are in crisis.

Diagnosing and treatment planning

Diagnostic clarity.

Diagnostic training and training on forensic evaluations.

Dual relationships and boundaries

Empathy.

For those doing on line education, more training on psych testing.

I am not aware of any but do not know many people with this license. The one situation I can think of is a person with a different MA KS license- in counseling I believe. Therapist hired his previous client as a therapist in his practice and less than 6 months after seeing this client in therapy.

I am not aware of any particular areas.

I do not have information on this

I have concern that there is no way to confirm non-clinical LMLPs are actively receiving supervision, particularly if they do not have an active training plan.

I have issue with current licensing for LMLP/LCPs. The licensing needs to be similar to other licenses for LMLP/LCP. For example: It would make more sense to be called a Licensed Clinical Master's Level Psychologist than to be called a Licensed Clinical Psychotherapist. Many lay-people and even some other mental health clinicians are confused by this.

I have not encountered this concern.

I have serious concerns about the lack of supervision the nonclinical licensees have in private practice. If they aren't under a clinical supervision training plan, they are getting no meaningful oversight.

I have witnessed many very good clinicians struggle with the EPPP test. I thank God I am old enough to have “grandfathered” in because (a) the cost of testing and appropriate study materials is debilitating for some candidates, (b) the content of the test is mostly irrelevant to what MLPs typically practice, and (c) it causes such an undue level of anxiety that some clinicians choose to leave the field of psychology for other related professions.

I really struggled to provide therapy during Covid. I hope there’s never a global pandemic that results in a shut down again, but if there is, it’d be nice to have some guidance on how to provide therapy during that time.

I reported a BSRB-licensed individual (LMSW) for professional misconduct and, beyond confirmation that the complaint was received, never received any feedback or outcome report re: an investigation into the same.

I specialize in psychological testing, and there are several insurance companies that do not allow this, they only allow PhD level to do testing.

I think there is always a need for more training!

I think we are in a good position to maintain ethics and stay current with dx and tx. Trauma informed therapy is often sought after for my Soldiers.

I was in a supervisory position in community mental health and took training in supervision for clinical level licensure. It is extremely inconvenient and annoying that as their supervisor I could not supervise them for the clinical license. I wish the disciplines would accept any masters level clinician meeting the requirements.

I work in the field specifically with children with ASD, and it seems like psychology related continued education is very limited. I see a lot on the ABA side, but when it comes to diagnosis and treatment, I find it to be challenging. Additionally, I would love for more education to be readily available for working closely with young children, and the best practices for telehealth. I feel that it can be very limiting to work with young children via telehealth and crisis care via telehealth has numerous challenges as well. My team has worked hard to brainstorm ways of providing crisis care via telehealth, but the liability seems high as well.

IDD and developmental disorders

In my experience, it seems that many practitioners tend to view BSRB as strictly regulatory and less assistive and supportive. This is unfortunate because while a regulatory board is indeed tasked with maintaining and overseeing the integrity of the profession and those who provide services in the public interest, it is also important to have direct and frequent communication with licensees throughout the state in an actively supportive and receptive way. Also just as a suggestion, rather than saying to licensees that they are welcome to view the meetings of various committees on You Tube, time constraints may be problematic for some. Even finding the YouTube channel where the meetings can be viewed is new news to many. Is there a way that you can create an outreach mechanism on perhaps a quarterly or even semi annual basis whereby you communicate the substance of the committees’ major discussions being held at those meetings? The idea of the multi state licensing, for example, is one that might be enthusiastically received and supported if licensees in the state knew that they had input to the matter. Can the committee members themselves be more representative of licensees throughout the state, most importantly, the rural areas which tend to be highly under represented on state boards in Kansas?

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| It would be imperative to increase training in various trauma disorders and autism spectrum disorders. Likewise, couples therapy would benefit from the same. |
| I've had good experiences overall but the length of time it takes to get credentialed to be a BCBS provider is frustrating in addition to other third party payers. |
| Less "pop" psychology, more focus on clinical syndromes. |
| More education on low needs neurodivergence (ASD/ADHD) and how this can present in teens and adults. |
| More training in diversity and cultural issues. More training in gender affirmative care. |
| More training is needed for recognition of trauma and it's special need for integrative approaches. Also training is especially needed for marital therapy and recognition of abuse factors and when it is not appropriate or is damaging to suggest. |
| Neurodivergent assessments |
| No (38 times) |
| no comment |
| None identified from practicing LMLPs or LCPs. |
| not enough education opportunities in person. |
| Not in Kansas but in Tennessee they have a lot less CEU requirements and several well known evidence based theories they do not know about. |
| Our healthcare system (AdventHealth) has over 50 hospitals across the nation; other states do not recognize LMLP - thus creates issues with job descriptions, pay, etc. |
| Our license (LCP) is still not recognized by some insurance companies. |
| Our license as LCP is equivalent to PhD or PsyD, however, we have no Reciprocity, and it can be difficult to get licensed in other states as they are not familiar with LCP or LMLP. Additionally the LSCSW is recognized in all 50 states and they require less CEU's every two years then the Master's level license. |
| Outcome based measurement |
| Practitioners fresh out of school seem to have little to no experience in actually working with people. I recall my generation had more experience actually doing therapy prior to internships while still in school. |
| Primarily the need for appropriate supervision and clinical guidance |
| Psych Testing - who can do what - (including other licenses) and the much-needed requirements for a psychometric understanding of measures administered. Across licensed, not just psych- supervision vs oversight/under direction of nonclinical licensees in general as well as in private practice. |
| Psychological assessment |
| Psychological testing and evaluation. |
| SAB |
| See it less in our discipline compared to some others. |
| See my ramble above. Again...At the master's level I compare the clinician much like a rural physician. You treat everything, you are qualified and when you don't want to treat or want to refer to someone who specializes (or enjoys or loves) a specific dynamic send the person there. Much of what is being done is unnecessary and overreaching. |
| some people are giving psych assessments with only parent interviews. that bothers me as parents sometimes are not completely honest then they leave with a diagnosis for their kid that is not accurate. |

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| Suicide care, actual therapy skills |
| The biological basis of behavior |
| The interns I have worked with do not always seem to realize that they have to have a clinical person supervising them. Once in a while I have people that can't respond to who their clinical supervisor is and they are in private practice. |
| There are significant limitations in terms of Medicare clients due to the services of LMLP/LCP not being covered. I have several clients who have to use the nonprofit's sliding fee scale due to Medicare not paneling various master's level providers. |
| There is still a need for education surrounding gender and sexuality for practitioners. |
| There's a lot of confusion about new federal guidelines for DEI, transgender care, and potentially for funding. Also, new ethical guidelines regarding AI. |
| Treatment planning especially with help in determining the level of care a client needs to meet their goals, based upon their level functioning. |
| Uncertain |
| Very young clients and those across the lifespan with Autism Spectrum and other developmental disorders are increasingly coming into services, and need specific treatment interventions. There's also an increase in need for SUD treatment with all ages and especially younger clients. |
| We need more training and support to serve our agri-businesses and personnel. They are a group of persons who do not seek help, but have major stressors in their lives. |
| Well, personally I'm pursuing more training on trauma. |
| With CCBHC, which we are, we have increased our training and staff feel much more confident as a result |

LMLP Q14. Over the past two years, have you experienced any issues concerning telehealth, either through professional practice or observations of other practitioners? (105 responses)

Better inclusion/exclusion criteria or guidance would be useful for telehealth practice.

Connectivity w the platform we've purchased is inconsistent

Difficulty in working with younger populations, but it does provide opportunities for clients to obtain these services who may otherwise be unable to access them

Good option for some patients but not all

I do not provide telehealth.

I don't really use telehealth all that often. So far, I have not experienced any issues.

I have had clients let their partners stay in the room during session and it creates a bit of tension discussing HIPAA

I have little experience with telehealth, so I have little to say in this regard.

I have not done any tele health nor participated in it as a client.

I have not experienced any negative issues with telehealth but it is still very new to me and I am still learning much at this time.

I have seen issues with an LCSW but not an LMLP.

I just always want to make sure everything I do is ethical and up/to-date, and those specifics are sometimes hard to find.

I live in Kansas city Metro. Having a mo license would be helpful for televideo but Missouri does not see Imp as equivalent to LPC. Based on title alone. This is irksome when living in the Kansas city metropolitan not being able to deliver televideo from mo to Kansas patients.

Issues only related to insurance not paying for provided services .

It is difficult sometimes for clients to find a private space when they live with family in order to complete sessions effectively.

I've observed a therapist appear to be distracted, possibly playing a game on the computer while in session.

Just insurances not wanting to pay the same amount as in person when research shows it's just as effective

No (61 times)

NA - I provide minimal telehealth services

No not directly since I don't provide direct care. I have heard through my work the ongoing issue of broadband access, availability of telehealth services across the state.

No significant concerns

No Telehealth should stay!

No! Telehealth is wonderful and has decreased no shows dramatically, it is easy to jump on a session and has helped with rural outreach incredibly in my opinion. I love working hybrid.

No, I just feel that it is much to impersonal and I still prefer the old-school of having patients come to the office, BUT I know the practicality that some folks just cannot do so...

No, Telehealth has been a very helpful tool. I used Telehealth for 3 years and a half and it was very convenient for me and the client. Especially, for those individuals struggling with medical conditions, physical disabilities, addiction's, etc.

No, Telehealth is an excellent and convenient tool.

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| No. Its an amazing tool. |
| Not that I am aware of, other than typical issues with telehealth. |
| Occasionally clients will try to have sessions in places inappropriate for therapy work or there are unknown observers present compromising the client's confidentiality. |
| Only clients attempting to do therapy via telehealth in public settings. |
| only connectivity at times. Does not seem to impede actual therapy. I am happy this is in place. My preference is still in-person. |
| Our agency operates solely via telehealth. At times, we experience technology barriers with consumers in rural areas. |
| Practitioners being asked by clients to see them when the client is traveling to other states; client's trying to connect via poor quality devices/connections; practitioners needing to ensure professional standards for their own dress, privacy, and workspace when working remotely. |
| some providers have done phone therapy |
| Sometimes connectivity is a barrier for those in frontier areas including quality of signal and ability to afford home internet services. |
| Sometimes, my platform doesn't work as effectively as I would like. I attribute this to normal internet issues. |
| Technology issues are typically the struggle with sessions |
| Telehealth is well integrated into my employing agency and appears to work well. |
| The only issue would be clients requesting to do telehealth when they are on vacation and out of the state. Sometimes they do not understand why it matters, even after explaining it to them. |
| There are significant limitations to reimbursement for non clinical licenses, especially with the extra scrutiny that comes with Telehealth visits. In addition, having more education on crisis management via Telehealth would be nice. |
| When telehealth platforms are not functioning correctly due to a bug, glitch, etc. though this is to be occasionally expected with technology. |
| Yes bc it is only a KS license it is an issue and bc I need a supervisor, I can't work for telehealth companies. Which they do need clinicians in this area. |
| Yes, usually connection issues with our EHR |
| Yes. Cultural relevance is important and many providers practicing telepsych in Kansas have no awareness of the cultural landscape or particulars of Kansas. |
| Yes. Overall, I believe it is poorly done and overrated. |

LCP Q14. Over the past two years, have you experienced any issues concerning telehealth, either through professional practice or observations of other practitioners? (107 responses)

Am not using telehealth.

I am provider on an online platform, it is super easy, requires less paperwork and the pay is not great but I much prefer this to dealing with insurance and or meeting productivity standards.

I appreciate telehealth so much. It has reduced no show rates immensely. It is very easy to switch an in person session to meet online. Telehealth has been great for rural outreach and for individuals who just feel more comfortable being at home.

I have had to discontinue with several clients due to them moving out of state and not being able to continue services due to me not being licensed in the neighboring states.

I have not observed or heard of problems personally, but I do worry there could be HIPPA issues if not used carefully.

I have not; however, I did an online ethics continuing education program that was about telehealth and found some of the information to be thought provoking.

I have observed practitioners providing out of state services to patients in states where the practitioner is not licensed.

I've only had a handful of patient's insurance, not covered TeleMed. But it'd be nice if they all covered it.

In the work that I have seen, there have been significant advancements in telehealth services and the ease of setting up these platforms.

Just the inability to offer this even on a temporary basis for college age clients who are relocating.

Just the issue of patient's not always being in the state of Kansas on their calls even though they are instructed to for licensing purposes. I live close to the Kansas/Missouri border so this issue arises frequently. I am only licensed in Kansas.

Many providers are still confused or not even aware about place of service, who needs to be where to provide the service (this goes for both therapist and client).

My observation is that it's overuse in schools decrease the requirement for parent involvement in treatment which inhibits true therapeutic benefit. Use of phone-only telehealth as a true therapeutic modality also seems concerning. Limitations of state-lines that are arbitrary and lack of inter-state compact for our license with others are able to obtain this.

My response to Number 8 would be zero if this were an option - -I only want to practice in person and my Agency supports me in this. I know many staff like Tele and that is prerogative. It does help some but in W. KS, most people in service want it to be Live.

No (61 times)

No - telehealth has dramatically improved the accessibility of mental health services.

No concerns, nice addition to our services

No issues. I do support telehealth. We would be severely understaffed without it.

No, alternatively, I have experienced telehealth be quite an asset.

No, it has been a blessing to my clients and has significantly increased participation and continuation of services.

No. Have see. Great benefits for accessibility for clients especially as a rural provider.

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| No. Having the option of telehealth has improved access for those in underserved areas. |
| None, it has been huge in helping my rural population in all states access quality behavioral health services. |
| Not necessarily. As I work mainly with kids, I really view telehealth as more of a placeholder for therapy than a primary intervention e.g. it's useful if there are periodic transportation issues or weather related concerns affecting attendance but I don't like it for primary interventions with children. |
| Only the inability to see clients if they are not located in Kansas |
| Other than occasional problems with access to a platform, no. |
| People love telehealth and its privacy and ease of services. |
| Sometimes, internet connectivity is an issues. |
| The tele health system is creating a new dynamic where mostly younger people want to connect immediately with someone. I would not really call it treatment...but of course everyone chases the money and creates programs that will enable them to capture the money and meet a desired service. |
| Telehealth does not compare positively to in-person therapy. |
| Telehealth has been a lifesaver for several people in our area, rural no public access transportation or very limited at best. Without this option several people would go without services. |
| Telehealth has been an amazing modality that clients everywhere have benefited from to some extent. I was providing telehealth under BCBS insurance and they failed to tell me they were changing their policy for Telehealth and I lost a lot of money due to their lack of information. We should be able to use telehealth wisely for our clients with less restrictions. |
| Telehealth has been mostly positive for reaching clients in remote areas with high travel needs to access services that may have not accessed services before telehealth was available. There have been some challenges with some clients having reliable access to wifi and some clients crossing state lines during their appts for travel or work not realizing we are not able to complete a service outside of Kansas. There are also some issues with some clients trying to do a service when they are not in confidential spaces, like a grocery store. It's an opportunity for educating them on privacy boundaries although can mean a missed session |
| Telehealth has not been helpful in serving youth and children, very well. It has been helpful to those adults who have transportation issues. |
| Telehealth is limited to Kansas only due to the lack of recognition of the Psychotherapist Licensure by other states. |
| Telehealth is not suited for children with ADHD or ODD. |
| Telehealth with adults went fairly smoothly when we used it. Children struggle, more when not in person. |
| The biggest issue I run into is not being able to see clients virtually when they live over state lines. |
| The biggest problem hasn't been with the professionals, it is helping the client understand the need for their to keep things private on their end. |
| Threats of insurance no longer covering telehealth or at a reduced rate |
| Very few of my patients want/need it now... |
| Was never certain how permanent and or changes taking place with telehealth |

We were the only profession (psychologists included) that were not allowed to do telehealth for those in Missouri when we are only divided by a river and many of my military dependents live in Missouri

Without oversight by someone, a LCP might treat someone who resides outside of the State of Kansas. This a violation of licensing rules. For those w/o direct oversight, this might need consideration to monitor.

Yes- see above. While telehealth has been a great addition and helps us reach so many rural populations, I feel that there is additional training that is necessary when working with specific population (Examples: individuals with eating disorders, clients with suicidal ideation, etc.).

Yes, cannot see clients out of state which can cause interruptions in services (ex: client moves for college, vacation, living close to MO line)

Yes. Some professionals are not practicing in places where they are not in a safe, secured location.

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| LMLP Q15. Over the past two years, have you experienced any negative issues involving supervision? If so, please explain. (102 responses) |
| Cost of supervision, but not the board's fault |
| Currently looking for a clinical supervisor. Would be helpful to have a central database or list of LPs and LCPs providing supervision in the state |
| Difficult to find supervisors and it's very expensive. |
| Even within organizations that tell me they'll provide/pay for supervision for me, this hasn't materialized in the 18 years I've been an LMLP. I haven't been able to find, and afford, clinical supervision. |
| I could not find a supervisor in my area or within a 50 mile radius who was accepting new people. |
| I have had a supervisor who had become increasingly unreachable, eventually leading to his leaving the position and resulting in me getting a new supervisor. |
| I have not but I am still learning going into my fourth month since working exclusively as a remote/telehealth therapist. Supervision to me currently includes more IT support than anything at this time. |
| It is difficult finding supervision as there are not many LCP's. Especially because of the price of supervision, I have struggled affording it. |
| It is often more about being judgmental than being supervision and you leave feeling "less than" |
| Just lack of those providing supervision |
| Mostly a higher rate of turnover in therapist staff with experienced therapists opting for private practice, schools and hospital programs. |
| My supervision has been completed. |
| No (75 times) |
| No issues with supervision. |
| No, I've had great supervisors. |
| No, my supervisor is helpful |
| No, only the limited options for supervision and how to find a supervisor. |
| No. Both my supervisors are extremely knowledgeable and professional. |
| Not the past 2 years |
| Not under supervision |
| Not yet- see #13 above |
| Nothing of note. |
| Sadly, my supervisor Dr. Dave Provorse died recently and it was difficult to get answers to questions I had about how to proceed with my license application in light of his death. He is sorely missed! |
| The quality of supervision I have received is very poor. My supervisor made me feel that supervision was a burden and treated me as inferior at every turn. |
| Yes, my supervisor was not providing adequate supervision and then had a psychotic break. |
| Yes, power struggles and discrimination due to race, ethical issues, and political views |
| Yes, power struggles and lack of support. |
| Yes. I was financially exploited by a supervisor. Luckily I was able to terminate the professional relationship after a few months. |

LCP Q16. Over the past two years, have you experienced any negative issues involving supervision? If so, please explain. (110 responses)

Clinical supervision is 2 people but I do provide professional and administrative supervision to more than 10 people. No negative issues encountered. Now, I will say this is where I will do Zoom and I appreciate the Board opening this opportunity. When staff need a specific license to do supervision under, it is nice for them to have options

Currently do not supervise any longer due to retirement would consider offering supervision to those seeking clinical license, if other disciplines would accept the masters level psychologist to do that.

Difficult having enough time to adequately supervise team and meet other programmatic duties

Frequent turnover in staff is the most prevalent issue with an increase in options for practicing and the high documentation, caseload sizes, severity of reasons for referral, and other regulations under the CMHC and CCBHC Models that are more demanding.

I am not certain as to the actual question here?

I do not provide BSRB clinical supervision but have 50+ in my downline of reporting structure.

I do not provide this service

I have not participated in supervision.

I only supervise employees that are non-clinical at this time. Formerly, I have provided supervision to interns primarily.

In question number 15, there is not an option to say that you provide supervision to 0 supervisees- which is my answer.

I had an MA intern who had a professor that had in the field a number of years and this person had received no training in trauma informed care and was making therapeutic suggestions to my client that went directly against what trauma informed care would suggest.

Interns failing to show up as scheduled with no notification.

It is hard for new graduates to find supervisors and to able to afford to pay for supervision.

Mostly the difficulty of masters level psychologists being able to pass the EPPP so they can obtain the LCP.

My direct supervisor is not a Masters Level Psychologist or a Licensed Psychologist so, unfortunately, our clinical discussions are not particularly helpful

my supervisee did not pass the EPPP

No (83 times)

No, have not provided supervision for a number of years.

No, I am a LCP and do not require supervision

No, I have not provided supervision the past 2 years.

No. To clarify I am not supervising clinicians who are providing therapy

No. To clarify I currently supervise one graduate student and one professional working towards her professional licensure.

None. I do not supervise others.

Not from our licensure.

Not provided supervision

nothing atypical for the work

Persons not passing the EPPP at necessary levels.

The hardest part is helping staff understand that our company has spent lots of money to develop guideline based upon law and occasionally it conflicts with the APA ethical standards. The other issue is electronic records management sometimes is more of a challenge with new staff understanding how to manage.

Yes. Some staff do not see me as a supervisor, but more of a colleague. This is primarily staff who are not licensed professionals.

LMLP Q16. Do you currently use artificial intelligence (AI) in your practice? If you do, in what areas do you use AI? (113 responses)

Hell no

I am not using much AI in my practice yet.

I have not seen it used and would likely not utilize it.

I use AI but not for practice.

I use AI solely as a form of writing outlines for community presentations

I use it for report writing smoothness, or generate behavior checklist or DSM criteria checklists

My agency has started implementing one for the use of documenting some sessions.

N/A not interested at all.

No (76 times)

No and never will

No but have considered will soon for session notes

No but the company plans to move this direction soon.

No but would love to learn

No I do not use AI

No, but I could see where it could be helpful as long as we stay mindful that humans need to final say. Having AI listen to my sessions for insurance to determine if they pay is on the horizon and we need to fight back.

No, but I would be interested in using AI for documentation

No. Absolutely not.

Not currently, but my agency is looking at utilizing it to assist with note taking and documentation.

Only to the extent if I am curious about information that may be helpful in session, how to reframe concepts in a way that is digestible for my clients, or to help with differential diagnosis

Personal study.

Progress notes

Suggestions for appropriate formatting of letters

We use Eleos for writing progress notes

Writing progress notes.

Yes, but limited to help with human error to catch any high risk clients.

Yes, center -approved AI for completion of progress notes.

yes, for writing progress notes.

Yes, generating progress note template and recommending resources at times

Yes, to help with writing notes.

Yes, we use an AI at my work to assist with writing notes.

Yes. Note taking.

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| LCP Q17. Do you currently use artificial intelligence (AI) in your practice? If you do, in what areas do you use AI? (123 responses) |
| A little for report writing |
| Billing |
| Dictation |
| Employer uses Eleos for documentation as an option |
| I do not but my agency does in a limited capacity |
| I don't personally, but more and more professionals are using it to organize meetings, projects, and documents. |
| I have not yet embraced it; only just exploring it. If I did use it, I could see a way to use it for providing client educational materials/handouts. |
| I have- specifically with note-taking/not generating software with a BAA and vetted the company prior to its use and obtained informed written consent before employing. |
| No (88 times) |
| No and don't plan on it |
| no but interested in how others may be using this |
| No but we are planning to implement |
| No, but am interested to learn how AI may be of benefit to adding efficiency. |
| No, but I'm curious about what it can do. |
| No, but it would sure be nice if AI could be used to generate my progress notes. |
| No, though I have seen an increase in AI programs aimed at helping write reports. |
| No. But I have done a few CEU's on the topic. |
| No. I don't use AI in my practice |
| No. I have pretty major concerns on the lack of regulatory Oversight in this area. |
| No. I won't. |
| Not at this time, but I am looking into it. |
| Not generally- at times we have used it when we create a standard operating procedure (SOP) outline for policies in the company, and we will use AI to generate a basic template of key points that we can edit. |
| Not that I am aware of. |
| Occasionally for progress notes |
| Only to research information. |
| Our agency is scheduled to start AI to help with progress notes. The purpose is to save time. |
| To help write my notes. |
| We are looking into this for documentation but are not there yet. |
| We did not we did not use it in any meaningful way. |
| Yes, an agency approved AI product that aids clinicians with completing service notes only. |
| Yes, I use it for documentation. Clients sign a consent form and are given a choice of whether it is used in sessions. |
| Yes. writing progress notes. |

LMLP Q17. 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? (88 responses)

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| Allocate better conditions, protections, and advocacy for the providers? |
| An area I am concerned with is the lack of consistent and effective treatment from the CMHCs. This hurts clients and I do not believe has been as effective in keeping children out of the hospital. I know it is harder in rural areas, but we still have clients that need help there. |
| Approve LMLP,s to practice independently in other states after 2 years of supervision to help with the under staffing nationwide |
| Assessing for competency skills for therapist prior to them being able to provide a therapy service |
| Assist in opening reciprocity to more states across the US. |
| Broader billings abilities for LMLPs. For example, it was my experience when providing direct client care that only an LMSW could bill Medicare. KS laws often support language on broadening the scope of practice for social workers but not LMLPs which are just as capable as providing the same services. |
| Expanding licensure practice and removing barriers to obtaining licenses. |
| I believe a lot of skills are learned in the community mental health setting where there is a variety of consumers, including high needs but lots of supervision, requirements and controls in place. Individuals should start out practicing at this level prior to private practice. |
| I believe the BSRB does a great job so far. I feel like more consistent communication with licensees would be beneficial of any changes, updates, and provide opportunities to have conversations about the changes. |
| I believe we are doing ourselves a disservice by making the clinical level licensing requirements so high. We already have to take a test that mostly doesn't apply to our specific field and pass at a doctorate level, then also complete a high amount of service and supervision hours on top of it when it's hard to even find supervisors. |
| I could use more communication from BSRB in regards to what is going on in our field in general all the way around... |
| I do not have any recommendations... the KS BSRB has always been helpful and useful in my past experiences and contacts. |
| I found the entire licensure process a bit confusing. However, any time I had questions, members of customer service were always very helpful in explaining things. Maybe if there was a more clear cut outline for how things work after graduation, like applying for temporary licensure, applying to sit for the EPPP, etc. that would be super helpful. |

I have colleagues who are LMSWs/LSCSWs who are excited about the continuing education requirements being lowered. These are the same people who have bullied me to ignore HIPAA, and report they ignore HIPAA because it's essentially an annoyance. For example, a colleague with an LSCSW regularly talks to patients' emergency contacts in nonemergency situations so they can both shame/nag patients with a substance use disorder. I have consistently found LSCSWs to be the least clinically sound/most unethical practitioners. I think lowering the continuing education requirements for them are a bad idea.

Although I certainly don't want to face additional tests, but some of these LSCSWs aren't aware of interventions like motivational interviewing, have no idea about body-based interventions (and have never heard of The Body Keeps the Score), shame patients with problematic behavior (repeating their family is disappointed/disgusted by the client), and think that dumping alcohol will make someone with alcohol use disorder stop drinking. The folks who demonstrate these sorts of behaviors have been licensed for years and years and haven't bothered to learn anything since grad school. One brags that she is able to get the required CEUs by free one-hour sessions so she doesn't actually have to learn anything new. She follows this by stating she has been a social worker for 30 years and doesn't need to learn any of "that new stuff." Her approach is problematic but I don't have proof of reportable ethical violations.

I would look more at Availa university as needing to improve their education. I have had many interns through them that came to internship very unprepared.

If the board could work toward reciprocity for an LMLP being qualified to obtain an LPC license and an LCP obtaining an LCPC license so the barrier of Medicare, Tricare and EAPs covering services, that would be amazingly helpful!

It would be extremely beneficial to allow LMLPs to retake the EPPP BEFORE completing LCP hours.

It would be nice to have more affordable continuing education.

Just having a way to transition from LCP to LP. It would allow us to work with more consumers' insurance.

LMLP's who have had many years of work experience should be able to see clients without having supervision.

Make all licenses the same! Why do I have to get 50 hours and other degrees can get less.

make it easier to file a complaint online if necessary

Make the LMLP license more likely to be accepted on more/additional insurance panels.

More affordable CEUs so I can take more classes and continue learning without the stress of the cost

No (46 times)

No doing a great job

No I have only had positive experiences with the BSRB- maybe help out with insurance regulation things have the masters level psychologist get the same recognition as the LSCSW for some reason in this state we are confusing as LCP's and LMLP's they don't even know really what to do with us really our licenses are not even a choice when getting credentialed. This is problematic. AND confusing.

No you're doing a good job.

Not sure.

Numerous private practice locations around Wichita, use contracts that essentially seem to take away client's ability to follow their therapist when they transition to new clinics. When I left on practice, in particular, I HAD to tell my clients that I would need to transfer them to another clinician in the that clinic, and if I were to get "caught" providing services to that client within a year of leaving the practice, I would have been sued. That's seems unacceptable, to me.

Please inform centurion inc or MHMS services that defining a LMLP as pre licensed is insulting and derogatory. <- Half kidding.

Reduce influence of state mental health centers.

Revamp the EPPP.

Grandfather in clinicians of 20+ years!

See # 13

Since I live in Arizona, I would recommend educating the Board here. My MA is in psychology (clinical) and the Board does not recognize that either. I am in limbo since I don't belong with the psychologists or the other Master's level professionals.

Support/education that the MA level psychologists (LCP) should be able to apply for the same job opportunities and have comparable reimbursement rates to LPC & SW. Seems just because it was the "older" licensing credential, we are being eliminated/replaced.

The EPPP is excessively hard and costly.

There isn't anything I can add here.

This discipline needs to be included in national legislation for serving Medicare

Though it might be difficult to do anything, anything that would allow for LMLP's to lower the costs associated with working towards their LCP would be incredible.

Work towards education of insurance companies to expand coverage for LMLP

Work with state legislature to protect vulnerable populations

Yes, the profession lacks licensed psychologists (LPs) so that more consumers could be helped in various places.

LCP Q18. 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? (94 responses)

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| Advocate for higher reimbursement rates from insurance, as well as advocate with Pearson and other testing material companies for price gouging. |
| advocate for our license (LCP) to be better recognized and regarded |
| Advocating for us with Medicare and insurances. |
| As noted above, better oversight of nonclinical licensed providers in private practice. |
| Assist w/ reciprocity to other states |
| Make the CEU requirements the same as other master level professionals |
| BSRB is, in my opinion, serves the consumer well. However, that is a subjective opinion. |
| BSRB website could be more user friendly. |
| expand insurance panels for this license |
| Expand licensing for masters level psychologists across state lines, reduce passing rate on EPPP to 400 for independent licensing |
| Find a way to make the EPPP more relevant for clinical practitioners who do not have IO or research oriented backgrounds. I know the test was meant for PhD licensure and back in 2000 when we were able to get licensure the EPPP was meant to show that LCPs could show equivalent training/knowledge but it is an expensive stumbling block for masters level psychs. |

Honestly, in my employment there are a large number of LMSWs. In learning the educational requirements, steps for licensure, etc. in comparison to LMLP/LCP, it is quite appalling that some licenses don't require a specific number of direct client practicum hours and can then become fully licensed. I recently saw the application for an LMSW and laughed, as it is not required to list out all classes, hour requirements in certain domains, when this is required for LMLP, LPC, and LMFT. I would like to see increased educational requirements, practicum requirements, and advanced training for LMSWs. LMSW is viewed in the therapist world as the "easy" degree, that anyone can achieve without much effort. This is now how our field should work when we have a direct impact on human lives. Unfortunately, anecdotally, the LMSWs I have come into contact with have obtained minimal skills from their program to prepare them for the workforce and it is well known that the majority of their knowledge is obtained "on the job," which is unfortunate for clients who are working with a fully licensed clinician.

Additionally, I know of several situations where professionals would like to make an ethical complaint about another professional. However, have not done so due to this not being anonymous and fears of retaliation in the workplace setting. It would be ideal if there was a way, under certain circumstances, to allow a report on a coworker to be anonymous to the person the complaint is being made about.

I feel regulations are sufficient.

Improve the speed of your license approval process.

In my experiences with recruiting for therapists over the last few years, there has been a deterioration of the quality of students being allowed into graduate programs and who will later become licensed. A lot of fairly mentally ill individuals.

Initiate a multi-state practice compact!

Interstate reciprocity

It would be great if we could actually access help at the BSRB. There is a barrier to speaking with anyone there. Then, if we're able to get through, the BSRB staff is reluctant to help or give definitive answers. It's almost like the BSRB is hostile toward the licensees. This pertains to the individuals who are positioned to support LMLP/LCP.

It would be nice for others to be able to contact someone's clinical supervisor as part of the process when trying to work out issues amongst each other (i.e., contacting the supervisor in addition to the clinician with whom there is something needing addressed, in effort to avoid filing a formal complaint).

Limit state mental health centers influence.

Lobby for higher pay and more access to meaningful training to all those who serve our population.

Many of our clientele have no financial resources. As a member of a CCBHC, we can eat some of that cost, yet that does seem to impede some folks getting help when needed.

No (57 times)

No. I do think they could do more with legislature and helping the LMLP and LCP. In short...historically...when the master level psychologist did not exist (only PHD) the social work field made the terminal masters degree. While the pompous PSYCHOLOGIST'S slept, they made a wonderful program that got accepted nation wide and was almost equal the PHD psychologist. So the BSRB could be more proactive and alert to improve the status of LMLP and LCP.

Often issues with insurance companies regarding accepting or not accepting certain CPT codes and fee reimbursements

Please see my answer to Question 13 above.

Possibly develop a system for licensees to communicate for locating assessment services, psychiatric services, and supervisors for newly licensed professionals.

Promote LCP/LMLP to business. They do not list them in licensure needed for a job.

Promote more accessible education and support and increase provision of information about resources.

Provide education to clients on what is ethically inappropriate in relationships between therapists and clients and how to report anything unethical.

Reciprocal licensure

Some licenses appear to have had a reduction in requirements for clinical licensure and I don't believe LMLP/LCP's have - it would be nice if this was extended to our license as well.

Watch closely how Community mental health centers are skimping out on sessions for clients with SPMI issues (e.g., shortening sessions to 30 minutes, only seeing them every 2-3 weeks, burning out therapists with unreasonable amount of clients). Add some licenses for support staff that only require a 2 year degree such as a Behavioral Health tech for Community mental health settings or more Case management for the Health Departments for resource management. Community Health Centers that receive State and Federal Funding need to start prioritizing patients that are uninsured or who have Medicare and Medicaid over patients that have private insurance to stop the LONG wait lists for the poor and underserved.

We seem to be ones that insurance companies and EAP's choose to not allow/acknowledge.

What is the status in Kansas of the LCP being able to bill Medicare?

With the increasing Medicare population, trying to have LMLP and LCP-licensed clinicians be licensed under LPC and LCPC would be very helpful for reaching them.

Yes, (1) supervision requirements vs. "under direction" to nonclinical providers; (2) I also think for non clinical and temporary licensees, the BSRB license verification page should include who the licensees current supervisor(s) are or if they are "under direction". (3) It is notable the number of new graduates who go into private practice and do not know this information or are provided inaccurate information by others in power at practices about oversight/under direction or supervision and what counts or doesn't. (4) In 2016 the regs and statues changes a bit about various licensees being allowed in private practice or not and the requirements. I think there are some who are confused about a clinical training plan vs supervision vs under direction and the necessity for that. (5) I would also include the lack of understanding/awareness of CE requirements for all levels of license, especially Temps and non-clinical. (6) Across licenses, the number of those who are supervising non-clinical, who may be board approved or licensed themselves for more than the minimum time and are not familiar/aware themselves with the state laws and BSRB rules, regulations, and statutes. Suggesting some sort of proof/testing to become a "board-approved supervisor" for any licensee. (7) And lastly, consideration for non-clinical licensees to be supervised by other license holding board approved supervisors (e.g., lpc by a lscsw or lcp).

Yes. It would be awesome if the BSRB would work in cooperation with other state's behavioral sciences regulatory boards to relax the rules on providing services in other states, especially neighboring states. It would also be nice if we could see people via telehealth who live in other states. I think it should be the opposite of what it is, and as long as the therapist is licensed in the state they are in when providing the service, they should be able to see clients in other states. I support a multi-state compact.

LMLP Q18. 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 master's level psychology profession? (84 responses)

After 5 or 7 years of practice, lcp should be automatically granted if test (eppp) is not passed.

Change the LCP EPPP score to 450 to allow for more Kansas residents to receive mental health support. The EPPP 500 cut off score is based on a licensed psychologist (doctoral level) cut off and should be changed to reflect Masters level psychology. Masters Level Psychologists should be an independent license (same as MFT, LPC, Social Work), where a licensee, after completing their 3000 hours, and obtaining an EPPP score of 450 or more, would become licensed independently.

Clearer guidelines on appropriate CEUs. Recognition from the APA for the master's level psychology profession in Kansas, and the rest of the states

Cross discipline supervision options- there are not a lot of us so hard to provide supervision for clinical licensure when very few work in public entities.

Don't require the EPPP part 2

For LMLPs to obtain their LCPs, they must pass the EPPP with a score of 500, which is the same score required of LPs. If a LCP has received instruction in the administration and interpretation of assessments, what is the difference in services offered by the two licensures? Perhaps it would make sense to adjust the necessary score required on the EPPP for LMLPs to become LCPs to make a more distinguishable difference between the levels of licensure.

for master level psychology working towards LCP,
ex. minimum hours for testing/interpretation and/or consultation

Honestly, unpopular opinion, I think there should be some sort of official "check up" on anyone with a degree that is practicing. The amount of burnout within three years and increased concerning practices that flirt the line of a violation are concerning. Mental health folk seem to be bad at managing their burnout.

I am hopeful that a compact with other states is on the horizon...

I appreciate the continuing education

I continue to perceive LMLPs as well trained and on par with practitioners of other disciplines.

My main gripe now is not being able to get credentialed for Medicare when non-clinical practitioners of other disciplines are being credentialed.

I do think the board should consider allowing individuals to retake the EPPP prior to completing their clinical supervision licensure hours. It seems a little silly due to you already had to take the exam to have the LMLP, but then you can't retake until you complete all the hours which can be years. I believe that it would be much better suited that if someone is seeking out LCP or clinical supervision that you should be approved to sit for the EPPP. Please consider this option! I have heard many people voice this concern.

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| <p>I don't have specific recommendations but I wish I could get clinically licensed at a reasonable cost.</p> <p>I don't know how this could be done but I think it would benefit LMLPs if mental health organizations were more aware of LMLPs and what we're able to do.</p> |
| <p>I strongly recommend allowing LMLPs to retake the EPPP to pass at the clinical level prior to completing their hours.</p> |
| <p>I think additional surveys on the quality of supervision would be helpful.</p> |
| <p>I think it would be beneficial to allow first time licensees to retest the EPPP, if they did not pass at the doctorate level but passed at the masters level, prior to completing other requirements for LCP licensure. Having to wait two years to retest ensures loss of more obscure knowledge and possibly change in structure of the EPPP. It is unclear why individuals are required to wait two years to retake the exam.</p> |
| <p>I think it would be beneficial to explore the requirements for lmlps for those that attended school out of state, or those on the doctorate track that did not complete the program.</p> |
| <p>I would like to see the social workers be a bit more restricted OR have to have more education before they are allowed to do some of the things they are allowed to do....</p> |
| <p>I would like updates on the cross-state compact and encourage this agreement to move forward</p> |
| <p>I would reconsider the 15 hr to 1 hr supervision. I think it is helpful but it can get very costly for the supervisee if they aren't getting supervision through their practice.</p> |
| <p>I would strongly encourage allowing the LCP and LP to provide tele-health services to other states. Not only would it grow practices, but from a patient standpoint more access, diversity, more cost effective for them.</p> |
| <p>If u have been an LMLP for over 20 years u should be able to work at an. Agency without supervision.</p> |
| <p>It is incredibly challenging and disheartening to navigate the barriers associated with licensure as a master's level psychologist. The cost of the EPPP exam, combined with the expense of study materials, places an undue financial burden on candidates—especially considering that many graduate programs do not adequately prepare students for the content the EPPP requires at the LCP level.</p> <p>Furthermore, the limited ability to panel with multiple insurance providers and lengthy reimbursement timelines create additional obstacles for those working to provide accessible care. The restrictions on practicing across state lines only add to the frustration, especially given the growing demand for mental health services. These systemic barriers make it difficult to build a sustainable and impactful practice.</p> |
| <p>It would be really helpful to have a list of states that do have the equivalent license, or outlining more of the limitations of our license by state.</p> |
| <p>It would be wonderful if the LMLP license could be recognized and credentialed with more insurance companies. And to have easier transfer of master's Level licenses across states.</p> |

It's well known and frustrating that people in our profession say Imp's worked harder than they needed to get the license and pass the EPPP just to have the same job:pay as counselors and social workers. Honestly, it's tough to hear and frustrating that it's a joke made, I've heard this in urban and rural settings at PRTF's and CMHC's. It's commonly known. For me, I wanted to do psychological testing and receive the highest possible training I could without the doctorate, that was my motivation. Luckily, I was blessed with five wonderful, special years of doing the psych testing in a PRTF setting! It was worth every bit of extra work in school and EPPP studying to have that privilege. Plus received good compensation available only to Imp's and Lcp's to perform the testing. So, honestly, I think we're all important to the field but now just block others out who poke at Imp's extra work for what those see as needless unless we do psych testing. Some student forgiveness don't recognize Imp (so I've heard but I have not experienced this) and so anyway what I would love is some systemic macro change and more professional and thoughtful recognition to be given to the unique Imp/LCP license instead of the discussion that we over worked for it. I know there are many changes being implemented in the field with CCBHC connecting mental medical and behavioral health etc to improve our field training and federal and state funding to improve training, staffing recruiting and retention and salaries . However, it takes time and change in mindset and systems for these things to really catch on and for all professionals in this field to be properly compensated to do the crucial job of helping others to improve their lives!

License reciprocity in more states.

LMLPs require a significantly higher amount of continuing education than closely related degrees (social work, counseling, etc). While CEUs hold high value, the number and frequency in which they must be collected is high and can be a financial burden and stressor. It would be appreciated if the number/policy could be reduced to a more feasible amount or time frame (3 years rather than 2)

Look at lowering or going away from the clinical level hours and supervision requirements for those who have an active license for 10 or more years without any notes issues. We are already one of the smallest licensed groups in the state, which means we have almost no voice when it comes to lobbying for reimbursement requirements. It's nearly impossible to financially survive in private practice unless you are clinically licensed. We have essentially hurt ourselves in this way because the requirements are too high and now people are leaving the profession or like in my case, no longer working directly with clients and applying my knowledge in other areas.

More public knowledge of KAMP. Thank you!

No (36 times)

None right now.

Thanks for all you do!

None that have not already been stated.

Thanks for listening!

Not at this time, thanks for asking!!

See 17.

See above. You can also email or call me.

Thank you for allowing me to have input.

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| Thank you for requesting feedback and thank you for your time and support! |
| Thank you for trying to help make things better. However I wish things were more equal across the degree types. It seems we have to do more than most and get paid less. I should have to get a second Masters for the same job just to be able to bill higher. |
| The EPPP Part1 is difficult for some to pass and an expensive exam to have to retake if you fail. The addition of a Part 2 could deter some from going into the field. Hopefully they can find a way to adjust these exams so we can increase recruitment of new practitioners, especially while we are experiencing a shortage of qualified staff already. |
| The statute needs changed which states that an LMLP cannot call themselves a psychologist as long as your credentials are explained to consumers. |
| There is a HUGE shortage coming in the mental health profession. Maybe think about licensing an Associate degree level Behavioral Health "tech" for community mental health centers so someone can just be trained to be support staff or supportive listeners. Stop the practice of what seems to be happening in the "turn and churn and burn" model in those community mental health centers where they are starting to limit the sessions to 30-45 minutes per client. Some SPMI or suicidal clients need a full hour and need to be seen more than every 2-3 weeks. I don't know if this is an issue for the BSRB but there could be more case workers in the health department to help with immediate homelessness, and SPMI, and linking people to immediate resources. That might be creating a Associates degree in case management (community). We need HELP as therapists so we can do therapy and have support to have people get resources for day to day living. |
| There should be a path to independent licensure through supervision, alone. We pay a ton for our education, and to have pay absorbent fees for an exam, that doesn't have anything to do with clinical competence, is unnecessary. Supervisors provide attestations to the knowledge and clinical abilities of clinicians, already; which seems far more useful for than expensive exams, on top of paying for supervision. |
| This may be a national standard, however, I think the clinical EPPP pass rate being at the same level as doctoral level psychologists is a stiff standard and would love to see revision in this area. |
| Training of future psychologists needs flexibility to deliver content in different modalities. When APA accredits Masters level programs, some consideration for easing licensure should be implemented. |
| We need to keep the LMLP/LCP for frontier KS needs MORE professionals providing service. |
| While I have not utilized my license to practice in several years due to N overseas deployment I still maintained. It would be nice if overseas military installations would be available to practice in with the LMLP license. The need is great and along as supervision is accessible it would be helpful. Thank you. |
| Yes, enable those who have an LMLP, have an APA school doctoral/ APA internship, and 10 years of service in the field receive an LP license. |
| Yes, I think an LMLP license should be considered or have endorsement with the LPC license. Our education and regional exam (EPPP) is more broader and difficult than the regional exam to become a licensed psychotherapist (LPC). |

LCP Q19. 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 master's level psychology profession? (85 responses)

Advocate for master's level psychology advancement, that is not limited by what seems to be doctorate level resistance considering other master's level clinicians are achieving it.

advocate for our license (LCP) to be better recognized and regarded

Again, my biggest concern is the EPPP. Persons able to pass it are do not always provide the same quality of care as those who do not.

As a hiring position for clinical staff, it would be helpful once we have an agreement to hire an employee licensing can take several weeks and would be important to be able to obtain licensure quicker.

Clinical Psychotherapists are restricted from reciprocity to other states yet our training is more stringent. A federal system of licensure would be helpful.

Does the Advisory Committee see any reason to be concerned about threats to the ability of LMLP and LCP to practice in the future?

Equality among us and social workers (job availability, reimbursement equality) and having the ability to work in other states would be fantastic!

Even as an LCP, I find it very challenging to work with numerous insurance companies and many still do not accept my license. It is very frustrating having to fight to get services approved or to have to continue to work under another professional if the insurance company does not accept my license.

Glad there are interested individuals in the profession that wants to add support for the LCP's at masters level.

Would like to have some additional support for school psychologists practicing with EdS. Degrees and licensing

Help us get insurance companies to accept a master's level license.

I am grateful for the third-party licensing which BSRB offers us in this state.

I appreciate all the work being done.

I appreciate the continuing education

I do not believe enough is being done to educate Kansans and Companies/Agencies about the LCP Licensure. Clinicians are being sought throughout Kansas but ask for every other license than the LMLP or LCP.

I have always felt that the name of our license seems backward. For example, I feel like once you complete the additional hours and supervision, your title should be "master's level psychologist" and not "licensed clinical psychotherapist." I feel a clinical psychotherapist does not accurately describe what my job entails.

I think I've covered most areas. One other somewhat related area is for the need for dually SUD licensed clinicians. It can be a barrier to have clinicians agree to treat clients under the SUD Program regulations due to the more stringent rules.

Thanks for your time and inquiry!

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| <p>I think much of the history is forgotten or unknown and there are many issues that interplay with the workings of today. Not only licensing but also funding. There has been silly workings of the system to garner sole monopolies on money, services. e.g. case management, psychosocial group, attendant care. From the historical "certified match" days when the CMHC's really did not match the funds but could/would justify and the rates were super inflated so the federal share would support the service. (for example a PHD at the time could get \$60 per hour and a non-degreed lay person with 2 years experience could bill over \$120 per hour for case management). I think there are many things the BSRB can do and I hope they focus on the "right" 20% and ignore the 80% that really does not help.</p> |
| <p>I would greatly appreciate the opportunity to join a multi-state compact. I hope this will be moved forward.</p> |
| <p>I would have to hear and/or see the most current prospectus for recommendations first.</p> |
| <p>I would like to be able to use the term psychologist at the higher level of licensure. LMLP to LCP does not make a lot of sense</p> |
| <p>I'm not aware enough of what it being considered to have useful comments.</p> |
| <p>It would be nice if receiving reimbursement from insurance companies and ability to work with telehealth companies was easier.</p> |
| <p>keep the standards high</p> |
| <p>Master's Level Psychologist appear to have one of the more rigorous master level programs and CEU requirements yet have less recognition than other master-level providers.</p> |
| <p>No (48 times)</p> |
| <p>Not that come to mind right now. If I were still actively practicing, I would appreciate this opportunity to provide input (and would probably have more insight to offer).</p> |
| <p>Please change the name for the clinical license for masters level psychs. Every other license just adds clinical in the title. We should be Licensed Clinical Masters Level Psychologist (LCMLP).</p> |
| <p>Please consider relicensure as frequently than every two years. Please robustly pursue the multi state licensure approach. Please expand representation on the masters level committee to include more rural participants, particularly west of Salina. Thank you so very much for providing the survey. It is a great step in the right direction.</p> |
| <p>Please help with having the LCP recognized by the insurance companies AT ALL!! We have a clinical degree at LEAST equivalent to a LSCSW and LMLP or LCP are not even listed as choices for credentialing with any major insurances making it a confusing and difficult process in the state of Kansas. Thank you for all the work you do. I don't even know if this is something in your wheel house but it is certainly an issue for us in Kansas.</p> |
| <p>Reciprocity w other states. Including provisions for us grandfathered in that didn't test.</p> |
| <p>Reciprocity with surrounding states would be awesome. It's my understanding that other states are considering adding master's levels licensing and being able to work in multiple states may attract more students to choose to complete a master's program and remain in the area.</p> |
| <p>See above. Thank you.</p> |

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| Thank you |
| Thank you for asking for feedback! |
| The LCP is confusing to some of the public when you explain that you are a master level psychologist at the independent level, but our license says licensed clinical psychotherapist. It would be easier if it follow the other disciplines of Licensed clinical master level psychologist. |
| This is the first I have ever received a survey in my 30 yrs. It is a good idea and I appreciate your inquiry to make things better. Thank you. |
| This may not be relevant, but I would like to know of ways to help lobbying as a MA group for our license to be included with LMFTs and Licensed Counselors and LCSWs to be able to provide services to Medicare clients. It makes no sense that our license is not considered on par with these licenses in being able to serve Medicare clients. It is disruptive to treatment to have to refer clients to other providers once they turn 65 years of age. It prevents our license from working with those 65 and older. |
| Yes, it would be great if they could advocate for us to be on the same level as a LSCSW, as we have more hours post graduate, our exam is at the doctorate level, and yet we are not recognized by the VA as being "qualified". They accept LSCSW, with less training and a much less intense exam, but will not recognize the LCP which should be vied at the same level as a PhD or PsyD |