

# **Behavioral Sciences Regulatory Board**

## **Survey of Marriage and Family Therapists**

**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 marriage and family therapy profession. As of February 2025, Kansas offers two levels of permanent licensure for the marriage and family therapy profession: (1) an independent level of license called a Licensed Clinical Marriage and Family Therapist (LCMFT) license and (2) a non-independent Licensed Marriage and Family Therapist (LMFT) license. LMFTs 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 Marriage and Family Therapy 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 marriage and family therapy 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 marriage and family therapy profession in Kansas totaled 1,183, including practitioners with a LMFT license (305) and practitioners with a LCMFT license (878). From January 24, 2025, to February 23, 2025, all LMFTs and LCMFTs 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, 296 individuals completed the survey, for an overall response rate of 25.0 percent. For the LMFT level of license, 69 individuals completed the survey, for a response rate of 22.6 percent, and for the LCMFT level of license, 227 individuals completed the survey, for a response rate of 25.9 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 (LMFT and LCMFT). In what Kansas county/counties do you practice the profession of marriage and family therapy?***

68 LMFTs answered question 1.

Full responses are included in Appendix #1 on page 27.

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

- Sedgwick (21 responses); and
- Johnson (16 responses).

226 LCMFTs answered question 1.

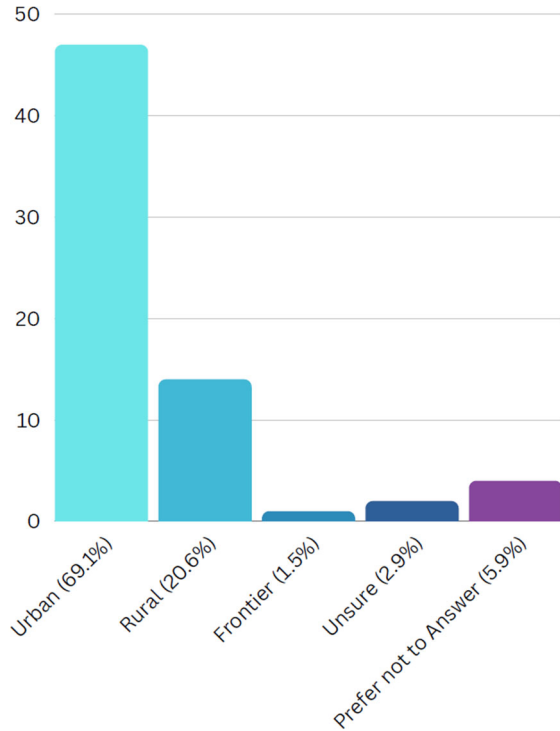
Full responses are included in Appendix #2 on page 28.

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

- Johnson (59 responses);
- Sedgwick (58 responses); and
- Riley (17 responses).

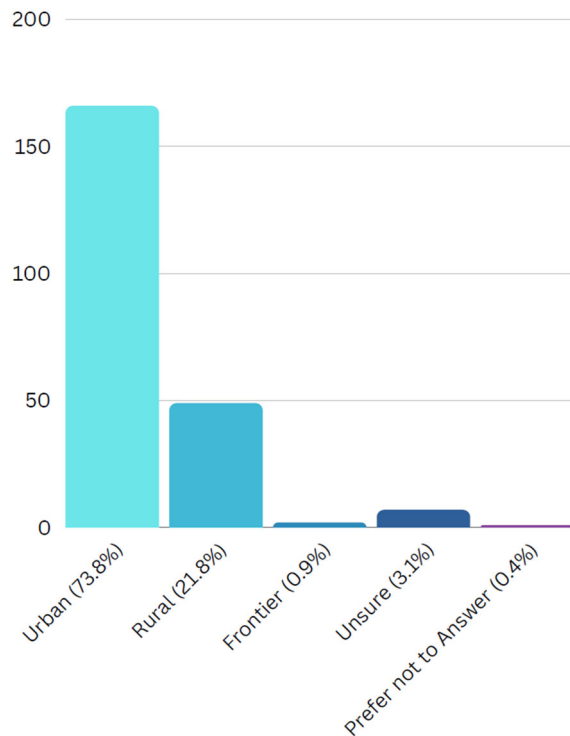
**Question 2 (LMFT and LCMFT). Do you practice in a predominantly urban area, rural area, or frontier area?**

**LMFT Responses**



Of the 68 LMFTs that answered question 2, two-thirds (69%) reported living in an urban area, followed by licensees living in a rural area (21%). All other responses were less than 6%.

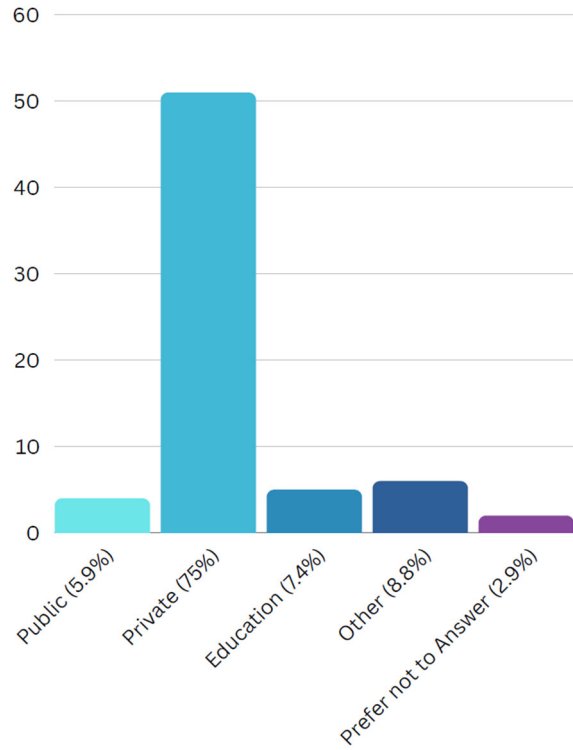
**LCMFT Responses**



Of the 225 LCMFTs that answered question 2, the largest amount (74%) reported living in an urban area followed by individuals living in a rural area (22%). The survey results reflect that the ratio of practitioners practicing in urban areas compared to rural areas is fairly similar between LCMFTs and LMFTs.

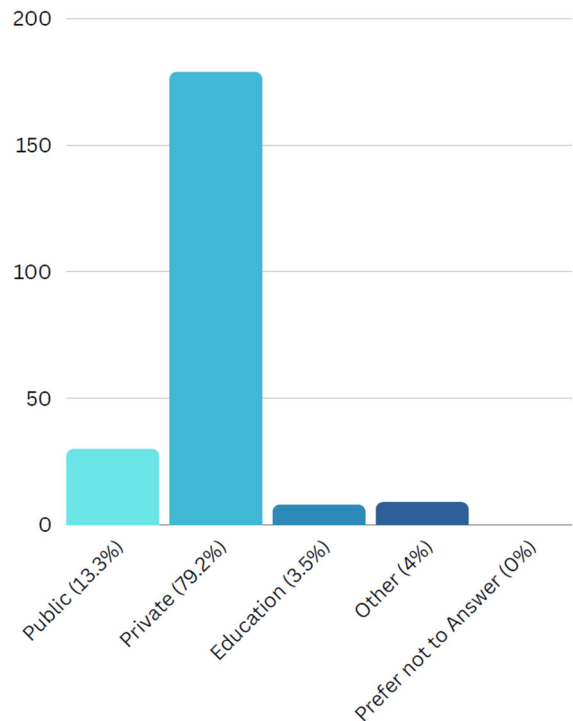
**Question 3 (LMFT and LCMFT). Do you primarily work in a public practice, private practice, educational setting, or another setting?**

**LMFT Responses**



Of the 68 LMFTs that answered question 3, three-fourths (75%) work in private practice, while all other responses were less than 9%.

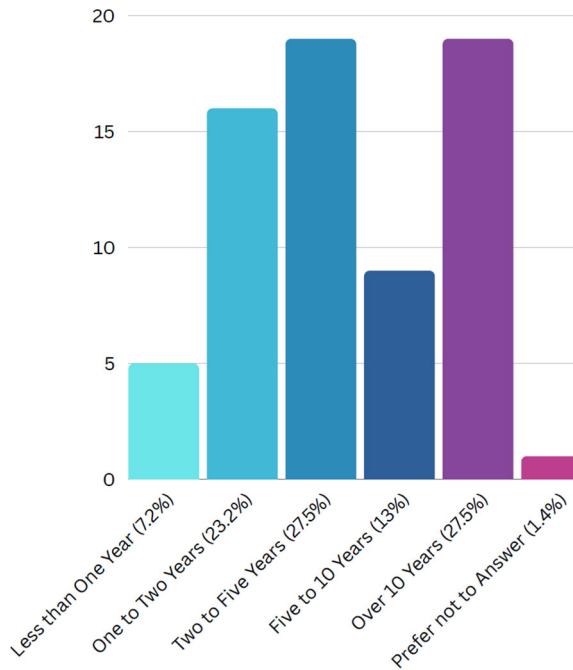
**LCMFT Responses**



Of the 226 LCMFTs that answered question 3, it is notable that the most popular response was private practice (79%), followed by individuals working in public practice (13%). All other responses were under 4%.

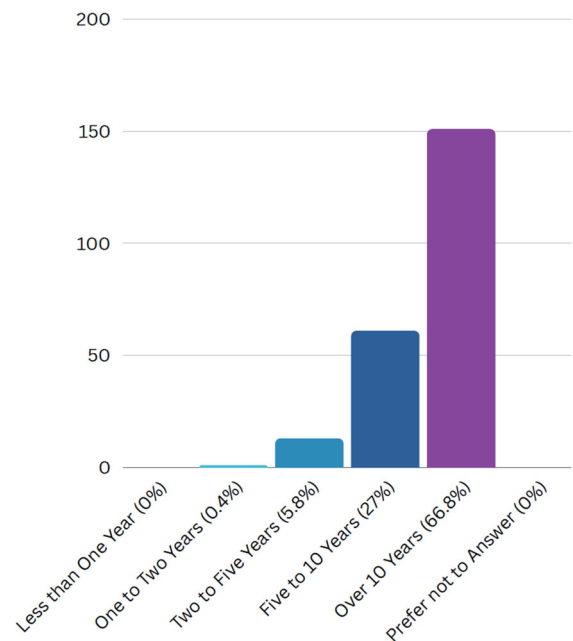
**Question 4 (LMFT and LCMFT). How many years have you practiced the marriage and family therapy profession (if applicable, you may include years practicing marriage and family therapy in other states)?**

**LMFT Responses**



Of the 69 LMFTs that answered question 4, when individuals were asked how many years they had been practicing marriage and family therapy, the two most popular responses were between two to five years (28%) and over 10 years (28%), followed closely by one to two years (23%), then five to 10 years (13%). All other responses were under 8%.

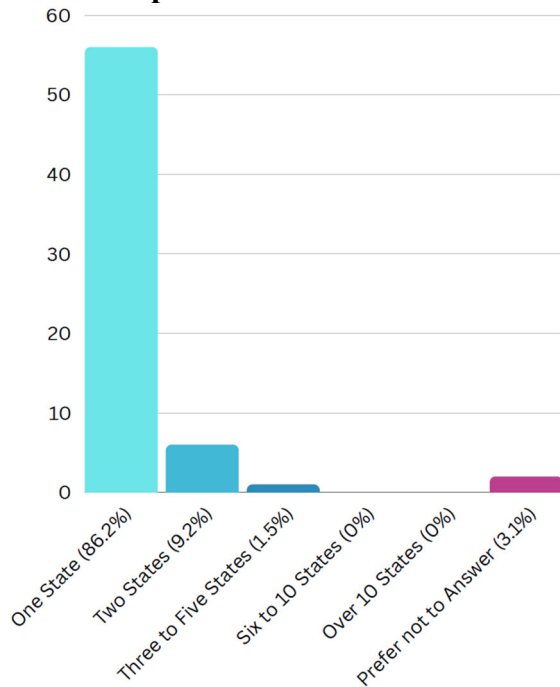
**LCMFT Responses**



Of the 226 LCMFTs who answered question 4, the biggest group of respondents (67%) reported practicing marriage and family therapy over 10 years, followed by individuals practicing five to 10 years (27%). All other responses were under 6%.

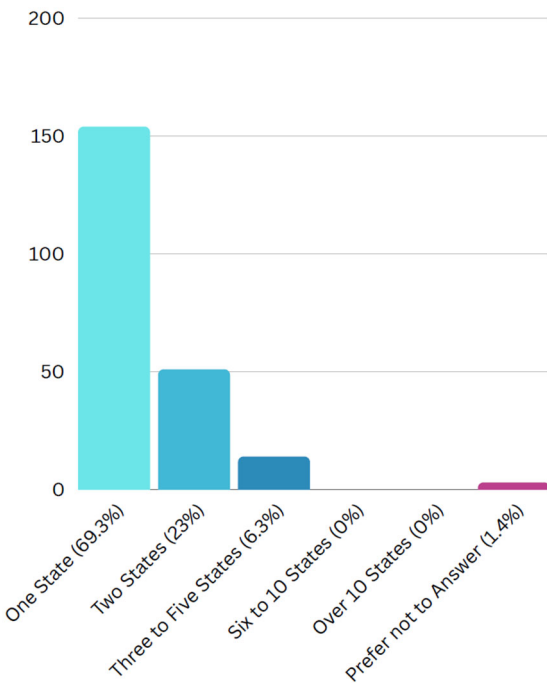
**Question 5 (LMFT and LCMFT). Including Kansas, in how many states are you licensed as a marriage and family therapist/in the marriage and family therapy profession?**

**LMFT Responses**



Of the 65 LMFTs who answered question 5, the vast majority of licensees (86%) report being licensed to marriage and family therapy in only one state, though a small number of licensees report being licensed in two states (9%). All other answers were under 4%.

**LCMFT Responses**



Of the 222 LCMFTs who answered question 5, the most popular response was from individuals only licensed to practice in one state (69%), followed by practitioners licensed to practice marriage and family therapy in two states (23%). All other responses were less than 7%.

***Question 6 (LMLP and LCP). Do you maintain an active license, but no longer work as a marriage and family therapist? If so, please explain why you are not providing services currently.***

### **LMFT Responses**

Forty-three Licensed Marriage and Family Therapists answered this question, identifying different reasons as to why individuals maintain an active license without providing services. (Responses for all licensees can be found in Appendix #3 on page 30).

The circumstance stated in the question did not apply to thirty-three respondents. Of those who indicated that they do maintain an active license but do not provide services, the following reasons why were cited:

- Providing services is not required for current job;
- Health issues;
- Family care responsibilities;
- Provides supervision but not services.
- Works in a different state.

### **LCMFT Responses**

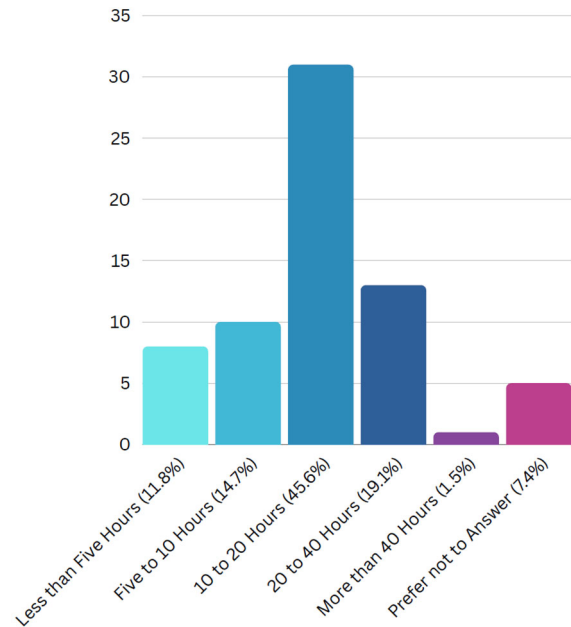
One hundred and twenty-five LCMFTs answered this question, identifying reasons why individuals maintain an active license but no longer provide services. (Responses for all licensees can be found in Appendix #4 on page 31).

One hundred and seven respondents indicated that this situation did not apply to them, as they were still providing services. Of the responses from individuals maintaining an active license but no longer providing services (eighteen responses), the most frequently reported reason why (six responses) is due to providing services not being required for one's current job. One of these respondents did, however, note that they plan to start providing services again soon.

While less frequently identified as the reason above, other licensees pointed out that they maintain an active license for supervision purposes. Other respondents indicated that they are either retired or a stay-at-home parent.

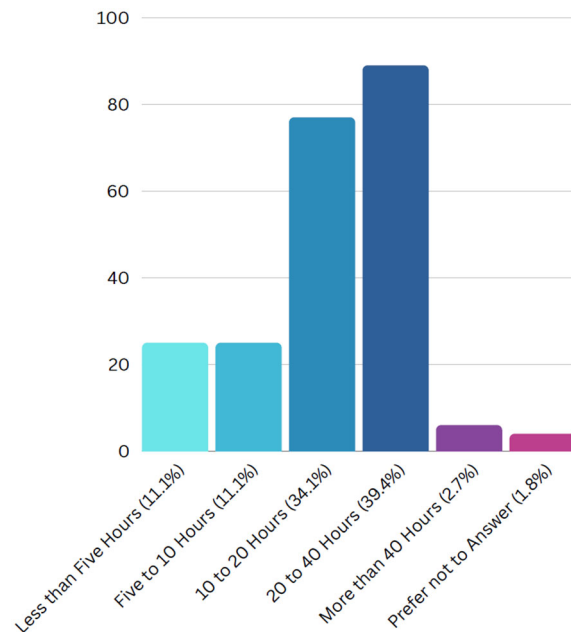
**Question 7 (LMFT and LCMFT). In a typical week, how many hours do you provide in-person services to clients?**

**LMFT Responses**



Of the 68 LMFTs who answered question 7, the most popular response was between 10 to 20 hours (46%), followed by 20 to 40 hours (19%), then five to 10 hours (15%), then less than five hours (12%). All other answers were under 8%.

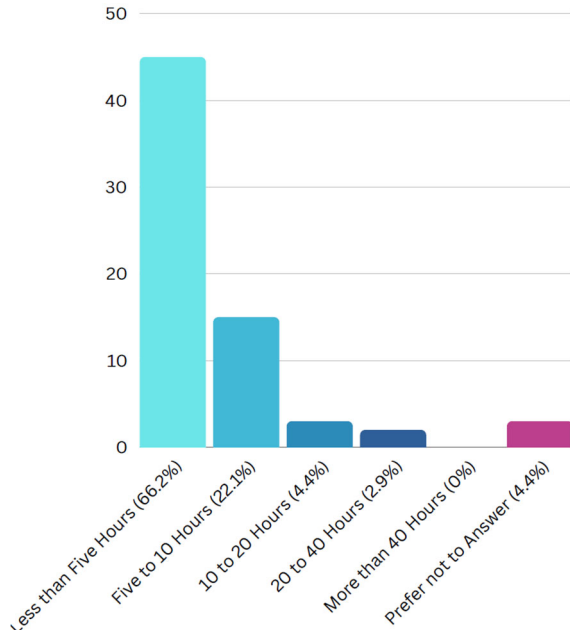
**LCMFT Responses**



Of the 226 LCMFTs who answered question 7, the most popular response was between 20 to 40 hours (39%), followed by between 10 hours and 20 hours (11%), then between five and 10 hours (22%) and less than five hours (11%). All other responses were lower than 3%.

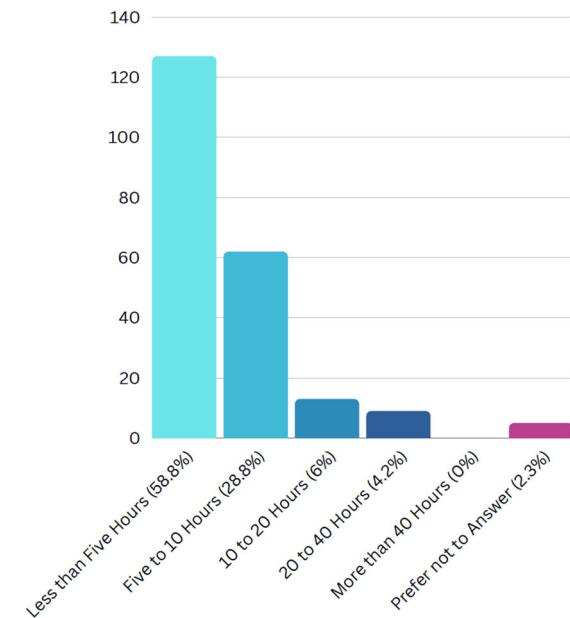
**Question 8 (LMFT and LCMFT). In a typical week, how many hours do you provide telehealth/remote services to clients?**

**LMFT Responses**



Of the 68 LMFTs who answered question 8, the most common response by far was less than five hours per week (66%), followed by five to 10 hours per week (22%). All other responses were less than 5%.

**LCMFT Responses**



Of the 226 LCMFTs who answered question 8, the most common response was less than five hours per week (59%), followed by five to 10 hours per week (29%). All other responses were less than 6%.

**Question 9 (LMFT).** *Are you currently working towards attaining a Licensed Clinical Marriage and Family Therapist (LCMFT) license in Kansas? If you are not taking steps to receive an LCMFT license, please explain why you made that decision:*

### LMFT Responses

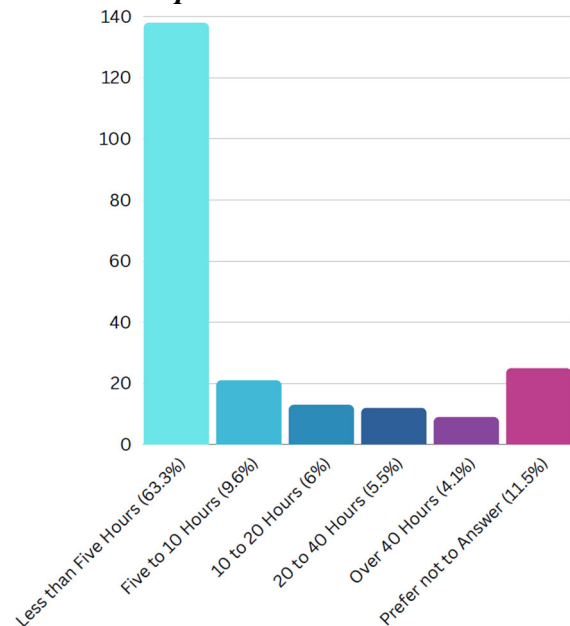
Sixty-six LMFTs answered this question. (Responses for all licensees can be found in Appendix #5 on Page 32)

43 respondents noted they are actively working towards attaining a LCMFT license in Kansas. For respondents noting they were not pursuing an LCMFT license, common themes included:

- Difficulty passing the licensing examination at the clinical level;
- Financial to repeat taking the licensing examination;
- Lack of interest in attaining a clinical license;
- Preference for ongoing direction and case consultation using the LMFT license; and
- A clinical license not being required for current employment duties.

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

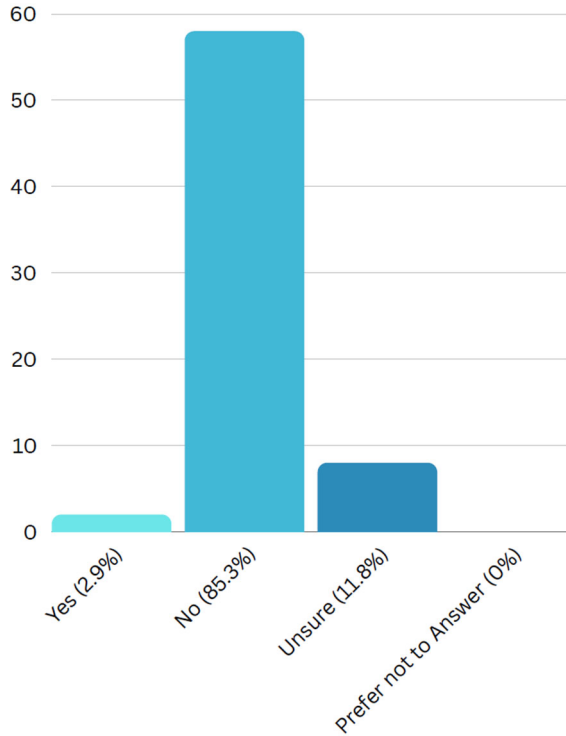
### LCMFT Responses



Of the 218 LCMFTs who answered question 9, the vast majority of responses were less than five hours per week (63%), followed by respondents preferring not to answer (12%). All other responses were less than 10%.

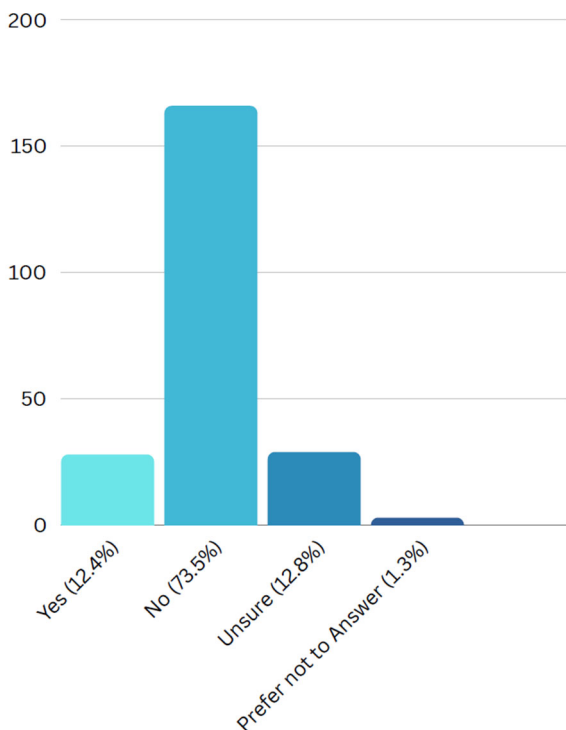
**Question 10 (LMFT and LCMFT). Do you anticipate retiring from the marriage and family therapy profession in the next five years?**

**LMFT Responses**



Of the 68 LMFTs who answered question 10, the most common response was “no” (85%), followed by “unsure” (12%). All other responses were under 3%.

**LCMFT Responses**



Of the 226 LCMFTs who answered question 10, the most common response was “no” (74%), followed by licensees answering “unsure” (13%), then “yes” (12%). All other responses were under 4%.

***Question 11 (LMFT). Currently, no multi-state compact exists for the marriage and family therapy 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.***

### **LMFT Responses**

Sixty-eight Marriage and Family Therapists answered this question, identifying interest levels in a potential future multi-state compact. (Responses for all licensees can be found in Appendix #6 on page #34).

Four respondents indicated that they would not be interested in joining a multi-state compact, and four said they would possibly join it.

Fifty-nine respondents expressed interest in joining a multi-state compact. Reasons why include the following:

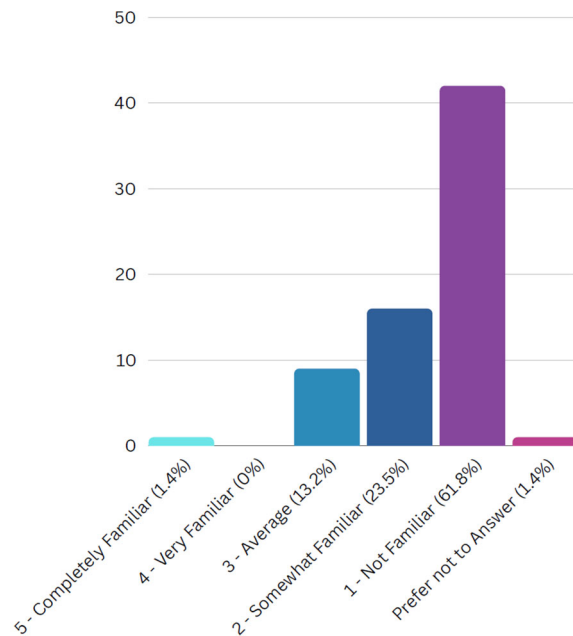
- A multi-state compact would allow for better and easier continuity of care when clients move or travel out of state.
- Licensees who live near border states must frequently turn down new clients for not living in Kansas.
- A multi-state compact would allow licensees to move out of state with less uncertainties about the future of their careers.
- A multi-state compact would increase access to behavioral health services.
- Reciprocity and/or managing multiple different licensees and Boards is complicated.
- A multi-state compact would allow licensees who want the ability to practice in multiple states to do so more easily.

### **LCMFT Responses**

*Note:* Due to a technical error, this question was omitted from the survey for LCMFTs.

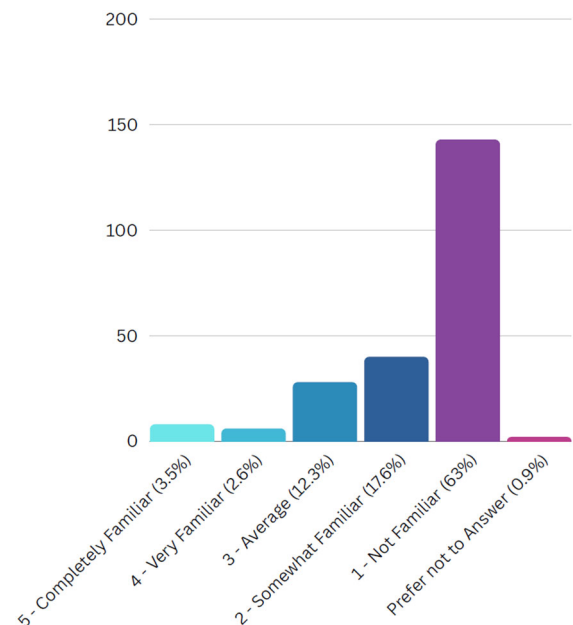
**Question 12 (LMFT)/Question 11 (LCMFT).** *To assist the work of the Board, the BSRB has seven standing Advisory Committees (one for each profession regulated by the Board), which are primarily composed of licensees in each of the seven professions. Advisory Committees discuss topics relevant to the 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 Marriage and Family Therapy Advisory Committee?*

**LMFT Responses**



Out of the 69 respondents that answered question 12, the vast majority (62%) noted they were not familiar with the Advisory Committee, followed by respondents noting some familiarity (24%), then average familiarity (13%). All other answers were under 2%.

**LCMFT Responses**



Out of the 227 respondents that answered question 11, the majority noted no familiarity with the Advisory Committee (63%), followed by individuals noting some familiarity (18%), then average familiarity (12%). All other answers were under 4%.

***Question 13 (LMFT)/Question 12 (LCMFT). Over the past two years, based on your observations and experience practicing in the marriage and family therapy 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?***

### **LMFT Responses**

Forty-eight Marriage and Family Therapists answered this question, identifying practice-related negative issues. (Responses for all licensees can be found in Appendix #7 on page #37).

Fourteen respondents indicated seeing no practice-related negative issues. After providing this response, a couple respondents indicated that they have seen issues in other professions, but not in the marriage and family therapy profession.

Practice-related negative issues reported included insurance, diagnostic concerns, a lack of self-awareness, and a lack of continuing education options. Other practice-related negative issues reported related to ethics, practitioners, and training, specifically. Ethical issues reported include:

- Standards are not consistent across professions.
- There is no guidance for resolving professional disputes.
- Current ethical guidelines are in need of updating.

Practitioner-related negative issues reported include conflicts of interest, lack of employment opportunities, practitioners imposing religious views onto clients, and sexism. Additionally, various areas requiring more training were reported, including CBT, ADHD, neurodivergence, documentation, and somatics.

### **LCMFT Responses**

One hundred and seventy-five LCMFTs answered this question, identifying a range of practice-related negative issues. (Responses for all licensees can be found in Appendix #8 on page #40).

Forty-four respondents indicated having seen no practice-related negative issues.

Frequently reported practice-related negative issues can be broken into six main areas: ethical issues, court issues, artificial intelligence (AI) issues, telehealth issues, areas needing more education or training, and other issues. The following ethical issues were reported by licensees:

- Boundaries with clients
- Social media
- AI use
- Unethical billing practices
- HIPPA violations
- Dual relationships
- Practicing outside one's scope of practice
- Abuses of power
- Manipulation
- Use of non-evidence-based practices
- Personal biases
- Marriage and family therapists providing legal advice

- Client exploitation

Court issues reported centered around the need for more education and/or training in court documentation, the role of therapists in the court system, and working with the courts in general.

The following AI-related issues were reported by respondents:

- a lingering risk of confidentiality breaches.
- concerns about general AI use in practice.
- a need for ethical and legal guidelines on AI.
- a desire for more education on the potential implications of using AI.

Issues pointed out regarding telehealth included the fact that regulations are lacking. Additionally, licensees expressed a need for more guidance on confidentiality and the “Location of Client” requirement. Fifty-four responses spoke solely to areas needing more education and training. Frequently reported areas included:

- Working with insurance and billing
- Trauma
- Diagnoses
- Working with children
- Documentation
- Treatment Plans
- EMDR
- Crisis
- Knowing when to refer out
- Diversity
- Suicide prevention, assessment, and ideation

Other respondents pointed out communication issues between clinicians, a lack of self-awareness in therapists, and an increase in burnout.

***Question 14 (LMFT)/Question 13 (LCMFT). Over the past two years, have you experienced any issues concerning telehealth, either through professional practice or observations of other practitioners?***

### **LMFT Response**

Fifty-four Licensed Marriage and Family Therapists answered this question, identifying issues concerning telehealth. (Responses for all licensees can be found in Appendix #9 on page 48).

Forty respondents indicated experiencing no issues concerning telehealth. After providing this response, some licensees mentioned that, while telehealth has increased clients' access to services, they prefer face-to-face services.

Frequently reported issues concerning telehealth included concerns regarding location of client, connection/internet issues, confidentiality/privacy concerns, and the inability to continue services if a client is out of state.

### **LCMFT Responses**

One hundred and seventy-nine Licensed Clinical Marriage and Family Therapists answered this question, identifying a variety of issues concerning telehealth. (Responses for all licensees can be found in Appendix #10 on page 49).

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

- Ten respondents expressed support for telehealth;
- Telehealth makes it possible for more people to receive services (six responses);
- Telehealth has increased access to services in rural areas (five responses);
- Licensees might benefit from more clarity on the rules regarding telehealth across state lines; and
- Licensees like having telehealth as an option, even if they choose not to use it.

While the feedback following reports of no telehealth issues is mostly positive, some report not supporting telehealth and believing that in-person services are more effective. Two respondents indicated that they do not provide telehealth. The following were frequently reported issues experienced concerning telehealth:

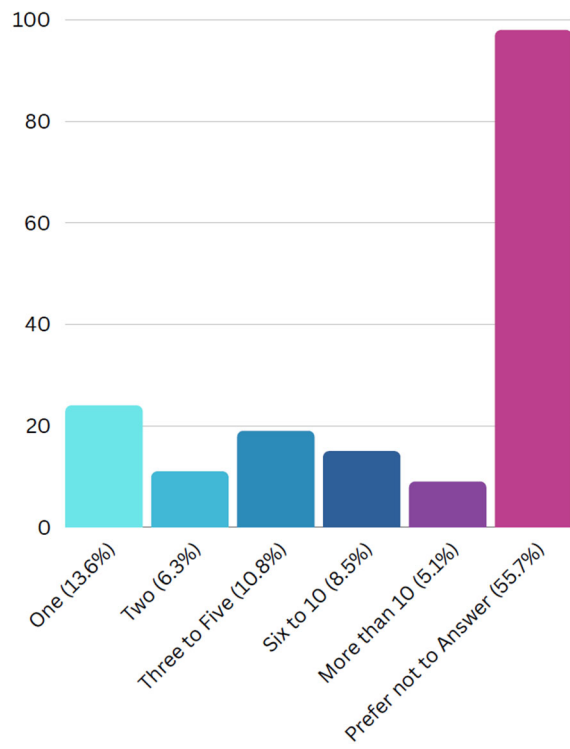
- There were concerns about "Location of Client" requirements hurting continuity of care;
- HIPPA/confidentiality concerns;
- Internet/connectivity issues;
- There were concerns about licensees providing telehealth services for their own benefit, rather than that of the client(s);
- Confusion concerning telehealth guidelines;
- Telehealth is ineffective;

- Clients not being in private for therapy sessions; and
- Poorly trained and/or inexperienced clinicians providing telehealth services.

Seven respondents, while sharing telehealth-related issues, also expressed their gratitude for telehealth increasing accessibility to services. Six respondents expressed that telehealth is not suitable for everyone, particularly children.

**Question 14 (LCMFT). How many individuals do you currently provide supervision to?**

**LCMFT Responses**



Of the 176 respondents that answered question 14, the largest number noted they prefer not to answer (56%), which is attributable to the lack of an option to answer zero. The second most popular answer was one (14%), followed by three to five (11%). All other answers were less than 9%.

**Question 15 (LMFT and LCMFT).** Over the past two years, have you experienced any negative issues involving supervision? If so, please explain.

### **LMFT Responses**

Fifty-six Licensed Marriage and Family Therapists answered this question, identifying negative issues involving supervision. (Responses for all licensees can be found in Appendix #11 on page 54).

Forty-six respondents indicated experiencing no negative issues involving supervision. After providing this response, some licensees complimented their supervisor and/or supervision experience, and others expressed how supervision allows for the sharing of experiences with others in the field.

Recurring issues reported included supervision being a financial burden on supervisees, there being a lack of guidance and support from supervisors, and instances of supervisors inserting personal biases.

### **LCMFT Responses**

One hundred and seventy-five Licensed Clinical Marriage and Family Therapists answered this question, identifying negative issues involving supervision. (Responses for all licensees can be found in Appendix #12 on page 55).

Thirty-five respondents indicated that they do not provide supervision. Of these respondents, only one reported interest in providing supervision in the future.

One hundred and fifteen respondents indicated having no negative issues involving supervision. After providing this response, some respondents mentioned having positive experiences with supervision and/or supervisors, while others reported a severe lack of trainings for supervisors.

The most frequently reported negative issues involving supervision fall into five categories: training plans, training plan amendments, Board-approved supervisor requirements, underprepared recent graduates, and other issues.

Reported issues concerning training plans included confusion around seeing clients while waiting for training plan approval and around the role of emergency supervisors.

Issues concerning training plan amendments included clarity around when exactly they are needed, as well as supervisees failing to submit amendments and, consequently, have to redo hours.

Shifting to Board-approved supervisor requirements, respondents reported there being a lack of continuing education and trainings available to meet requirements. Others mentioned that the requirements are too strict, making it too difficult to become a Board-approved supervisor.

The following issues were reported about the under preparedness of recent graduates:

- Recent graduates struggle with work-life balance;
- Recent graduates struggle with self-sufficiency skills;
- Recent graduates are unable to be proactive; and
- Recent graduates have poor ethical instincts

When reporting these issues, some respondents shifted focus to graduate programs, expressing a desire to understand why programs are producing less prepared graduates. Other respondents indicated that it is challenging to find supervisors and/or supervisees.

***Question 16 (LMFT and LCMFT). Do you currently use artificial intelligence (AI) in your practice? If you do, in what areas do you use AI?***

**LMFT Responses**

Sixty-nine Licensed Marriage and Family Therapists answered this question, identifying uses of AI in practice. (Responses for all licensees can be found in Appendix #13 on page 59).

Fifty-four respondents indicated that they do not use AI in their practice. After providing this response, some respondents mentioned hearing positive feedback from others, while others have privacy concerns on the matter.

Reported uses for AI reported by licensees included treatment planning, note taking and summarizing, and template creation. AI was also reported to be used for marketing, research, social media, design, and website purposes.

**LCMFT Responses**

Two hundred and twenty-seven Licensed Clinical Marriage and Family Therapists answered this question, identifying common uses of artificial intelligence (AI) in practice. (Responses for all licensees can be found in Appendix #14 on page #60).

One hundred and sixty-nine respondents reported that they do not use AI in their practice. After providing this response, some respondents mentioned privacy concerns surrounding AI, while others stated that they are either considering or working towards implementing AI in their practice.

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

- Email/letter generation;
- Marketing purposes;
- List generation; and
- Documentation purposes.

Additionally, it was reported that insurance companies use AI. It was also expressed that AI works well for writing purposes but should not be involved in diagnoses or be used without human guidance.

***Question 17 (LMFT and LCMFT). 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?***

### **LMFT Responses**

Forty-nine Marriage and Family Therapists answered this question, providing recommendations on additional ways the BSRB could protect and serve consumers of services offered by BSRB licensees. (Responses for all licensees can be found in Appendix #15 on page 62).

Twenty-seven respondents indicated having no recommendations to provide. Frequently reported recommendations include:

- Prioritizing more communication between the BSRB and licensees;
- Considering reciprocal privileges with other states or a multi-state compact;
- Offering more online options and services; and
- Developing ethical guidelines for the use of AI.

### **LCMFT Responses**

One hundred and sixty-one Licensed Clinical Marriage and Family Therapists answered this question, providing recommendations on additional ways the BSRB could protect and serve consumers of services offered by BSRB licensees. (Responses for all licensees can be found in Appendix #16 on page 64).

Eighty-six respondents indicating having no recommendations to provide.

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

- Establish regulations and best practices for artificial intelligence (AI);
- Fight for improved insurance reimbursement;
- Allow anonymous complaints, particularly when a licensee is reporting another licensee;
- Speed up the investigative process;
- Give more severe consequences for disciplinary matters;
- Educate the public about the marriage and family therapy profession;
- Prioritize getting more providers into rural and frontier areas;
- Consider requiring peer consultation hours and suicide prevention continuing education with each renewal;
- Add, in statute or regulation, language concerning professional conduct in the community;
- Support expanding the ability to virtually see clients across state lines; and

- Create a method for regular communications and updates from the BSRB to licensees.

Some respondents focused more on group and private practices, expressing that both require more regulated oversight. Additionally, it was requested that the BSRB advocate against harmful legislation. This being said, opposing statements were made as well, reporting that the BSRB should remove themselves from politics all together.

***Question 18 (LMFT and LCMFT). 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 marriage and family therapy profession?***

### **LMFT Responses**

Forty-four Licensed Marriage and Family Therapists answered this question, providing comments and feedback that may be helpful for members of the Advisory Committee to receive when evaluating possible recommendations for changes to the statutes and regulations for the profession. (Responses for all licensees can be found in Appendix #17 on page 71).

Thirty respondents indicated having no comments or feedback to provide. Of the comments and feedback provided, the most frequently reported recommendation was to either join a multi-state compact or find a way to make reciprocity easier.

Comments and recommendations specific to the BSRB included:

- Loosening clinical requirements;
- The belief that the BSRB is too restrictive;
- Prioritizing empowerment of licensees; and
- Maintaining an up-to-date list of available clinical supervisors.

Client-specific comments made regarded the challenges faced by therapists when clients are out of state and want services. Additionally, recommendations were made to specify, for the public, the differences between the professions overseen by the BSRB.

Licensee-specific comments made included the need for more behavioral health providers and the commonly held view of feeling unsupported in the field.

### **LCMFT Responses**

One hundred and forty-nine Licensed Clinical Marriage and Family Therapists answered this question. (Responses for all licensees can be found in Appendix #18 on page #73).

- 90 respondents indicated having no other comments or feedback to provide. The following is a list of the most commonly reported comments and feedback:
- Prioritize license portability across state lines or a multi-state compact.
- More communication or notifications from the BSRB was requested when changes occur.
- The high ethics and training standards in the marriage and family therapy profession are valued by licensees.
- More guidance on artificial intelligence (AI) was requested.
- There is a need for accountability with insurance companies.
- There is a need for higher pay for marriage and family therapists.

- Comments and feedback directed to the BSRB or Advisory Committee pointed out that there is no language, in statute or regulation, that includes a community protection standard for licensees. Other respondents requested clarity on boundaries and leniency in small towns, as well as on the “Under Direction” and “Location of Client” requirements.

Other comments and feedback highlighted the need for more education in diversity, systemic issues, the LGBTQ+ population, sex and gender, and ethical and effective therapy.

Additionally, the following comments and feedback stood out, reflecting potential issues:

- Licensees have witnessed other licensees ignoring conflicts of interest.
- Therapists need more support and fear losing their careers to online or AI services.
- Attention was brought to the issue of not having a way to report someone who is providing services but has never been licensed.

**LMFT Q1. In what Kansas county/counties do you practice the profession of marriage and family therapy? (68 Responses)**

All of Kansas

Any

Barber, Harper, Kingman, Pratt, Reno, and Sedgwick

Brown

Butler

Douglas and Leavenworth

Ellis; virtually in many other counties

**Ford (2 responses)**

Gardner

Geary

Greenwood

Harvey

Harvey and Sedgwick

I don't currently practice

**Johnson (16 responses)**

Johnson and Shawnee

Kansas

Labette and Mission

**Leavenworth (2 responses)**

Linn

Neosho

None

None at this time; in the past, Johnson

**Riley (3 responses)**

Riley and surrounding

**Sedgwick (21 responses)**

Wichita

**Wyandotte (2 responses)**

<b>LCMFT Q1. In what Kansas county/counties do you practice the profession of marriage and family therapy? (226 responses)</b>
All
All counties
All counties and cities virtually
Atchison
Barber and Johnson
Barton and Pawnee
Bourbon and Crawford
<b>Butler (6 responses)</b>
<b>Butler and Sedgwick (6 responses)</b>
Butler, Harvey, Johnson, Sedgwick, and Shawnee
Butler, Johnson, and Sedgwick
Clay, Marshall, Pottawatomie, and Riley
Coeley, Douglas, Johnson, McPherson, and Sedgwick
<b>Cowley (2 responses)</b>
Cowley and Sedgwick
Crawford
Dickinson
Dickinson, Ellsworth, Lincoln, Ottawa, and Saline
<b>Douglas (6 responses)</b>
<b>Douglas and Johnson (3 responses)</b>
Douglas, Finney, Harvey, Johnson, Reno, and Sedgwick
Douglas, Johnson, Reno, Sedgwick, Shawnee, and Wyandotte
Fort Scott
Geary
Geary and Riley
Geary, Leavenworth, and Riley
Geary, Pottawatomie, and Riley
<b>Harvey (2 responses)</b>
<b>Harvey and Sedgwick (2 responses)</b>
Harvey, Marion, and McPherson
Jackson
Jackson and Shawnee
<b>Johnson (59 responses)</b>
Johnson / Online
Johnson and Miami
Johnson and Sedgwick
Johnson and Shawnee
Johnson and Wyandotte
Johnson, Miami, Wyandotte
<b>Leavenworth (3 responses)</b>
Lyon
Marion
McPherson
<b>Mitchell (2 responses)</b>

N/A
Nemaha
Osborne, Phillips, Rooks, Russell, and Smith
Pottawatomie and Riley
<b>Reno (3 responses)</b>
Reno and the entire state via teletherapy (Johnson and Sedgwick)
<b>Riley (17 responses)</b>
<b>Saline (7 responses)</b>
Scott
<b>Sedgwick (58 responses)</b>
Sedgwick primarily but I have clients in many Kansas counties
<b>Shawnee (5 responses)</b>
Sherman and Thomas
Stevens
Wichita
Wyandotte

**LMFT Q6. Do you maintain an active license, but no longer work as a marriage and family therapist? If so, please explain why you are not providing services currently. (43 responses)**

Active license and providing services.
Current position does not require license.
Currently practicing
I am currently working
I do work as an LMFT
I have an active license and use it.
I have significantly reduced my hours and explain in the next sections.
I have and utilize an active license
I keep my license up to date but rarely conduct therapy due to health issues.
I maintain my license, supervise a social worker grant in the education setting. Also a school behavior coach for staff.
I see a limited number of clients via telehealth due to family care responsibilities.
<b>No (27 responses)</b>
Working in child welfare in leadership roles
Yes, but not currently serving clients
Yes, currently working in Texas
Yes, I am a full time professor and do not have time to practice with current work and family obligations
Yes.

**LCMFT Q6. Do you maintain an active license, but no longer work as a marriage and family therapist? If so, please explain why you are not providing services currently. (125 responses)**

**Active and practicing (3 responses)**

Active and working full-time

**Active license (2 responses)**

Active license and work as an LCMFT.

Coaching and corporate development is my focus

Find the different platforms difficult to manage if involved in one or more platforms. Would like to work for a company that respects its therapists and pays for the experience.

Hoping to find a better paying career soon.

I am actively practicing

I am still working

I am the executive director of the center and no longer have the time.

I currently practice only occasionally completing crisis or assessments. I do not have a regular practice due to my current role which primarily serves to supervise clinicians and managers and does not include regular ongoing therapy appointments.

I have a license and am currently working as an LCMFT.

**I maintain an active license (3 responses)**

I provide coordination services and consultation to an Educational setting

I retired 12/21/24

I work

I work as a school counselor.

I'm active

Just retired

Maintain an active license

My license is active and I am still active

N/A - active license and currently working

N/A- Still practicing

No - actively working

No I am licensed and work.

**No (83 responses)**

No, currently working as LCMFT

No. Currently practicing.

No. I am actively working.

Provide supervision

Retired

Retired but maintain license because I do some consulting at times

Stay at home mom

Taking a break ~ caring for family.

**Yes (2 responses)**

Yes, and working.

Yes. Recently transitioned out of agency work and looking to start private practice.

**LMFT Q9. Are you currently working towards attaining a Licensed Clinical Marriage and Family Therapist (LCMFT) license in Kansas? If you are not taking steps to receive an LCMFT license, please explain why you made that decision: (66 responses)**

Already a LCMFT

Completed my hours in Colorado, but had trouble transferring those hours to Kansas. Not worth the hassle.

Cost of supervision.

Currently studying to retake the exam this year.

Currently working towards attaining CMFT.

I am an LCSW in Kansas and a LCSW in Missouri.

I have a supervisor , and not good at test taking . Therefore unless of my years experience counts. I will continue as a LMFT and not LCMFT

I have had my LMFT Lic for a long time, my number is 007. I am content with the work I do and I work under a doctor.

I have the education, training and supervision requirements but do not have three years' practice consecutively in another state. (I am an AAMFT Approved Supervisor, but still do not meet the requirements for the KS LCMFT. I will do so at the end of 2025.)

I just received my LCMFT license from the KS BSRB.

I struggled to pass the exam by a few points.

In 2020 I was in a Covid coma for over two weeks and was not supposed to survive. I experienced hypoxia and now have Long Covid. This seems to have impacted my ability to process information/recall in stressful (test) situations. I was scheduled to take the exam when I was in the coma. I later discovered the testing centers had been closed and my test was rescheduled, but I did not receive the notice in time to request reasonable accommodations. I took the test as I could not get a refund or reschedule the test. I passed at the LMFT level. Since then I have been discouraged and frustrated by my continued inability to recall learned information. I lost my offices and most of my clients as my family did not think to inform my supervisor or implement the backup plan to have my lawyer notify my clients of my illness or pay my professional bills (like office rent).

I have been harassed by other mental health professionals in the workplace, and a person I would not agree to take as a client has been filing false complaints against me, sending letters to my home, filing false police reports, etc. and slandering me. I have had to retain legal counsel and the cost to continue working in the field is more than I can earn at this point.

I feel that the decision by Kansas lawmakers implementing a clinical designation/higher testing score for independent practice has unfairly hindered my employment options in other states. I must pass the test at the LCMFT level or continue to pay for supervision as I have over the last five years. This profession is my calling and passion and it seems there are too many obstacles for me to overcome to achieve my dream. It seems I could help more people and earn a higher income by being an unlicensed life coach.

No I am not. I don't want to take the test again and have to pay for it.

No I'm not. It would not be conducive for me at this time.

No, cannot afford the cost of supervision plus do not have direct client contact

No, fully licensed in Texas
No, it's not reasonable for disabled people like myself. I don't see enough clients for it to make financial sense.
No, not interested
No. Cost of testing
No. I have been looking for a LCMFT clinical supervisor ever since I moved to Overland Park from Wichita. However, I haven't been able to find a job where I can get supervision from someone onsite (or have the costs partially covered by the company). And I can't afford to pay for a clinical supervisor out of pocket for 2 years (That's over \$400 per month) with the current salaries available to LMFTs. I've considered working an insane # of hours at a private practice while seeing a clinical supervisor - in order to get to the # of hours I need quickly AND still be able to pay my bills...but I'm not married, so I would have to also pay for my own benefits. Because of this, I've been very seriously considering leaving the profession
Not at this time
<b>Not interested (2 responses)</b>
Not needed for current position
Reciprocity for other states; being clinically licensed offers more opportunities for employment; potential to supervise LMFTs
There are two major reasons, 1. I have severe test anxiety and struggled with the licensing exam and 2. I think case consultation is extremely important, and decided ongoing direction is something I would greatly benefit from.
<b>Yes (40 responses)</b>

**LMFT Q11. Currently, no multi-state compact exists for the marriage and family therapy 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. (68 responses)**

Absolutely YES, and I would pay a lot to be able to do this!

Absolutely. I find it frustrating to not be able to apply for reciprocity in the state of Kansas for a few years after I have already obtained a license in another state (especially one with stricter objectives to begin with).

Absolutely. This would allow more client retention and continuation of services, as often clients who move to other states would prefer to continue working with me.

Absolutely. Yes, yes, yes. Being able to provide services in multiple states allows continuity of care, better access to mental health care and broadens options of employment

Definitely. I would be very interested in be able to see clients more remotely and in other states. I have a large teen clientele, many of which go off to college and then I'm only able to see them during breaks or if they are back in town.

I do not need an additional source of clients, so I don't currently plan to.

I don't believe this would be fair or equitable since only four states require the LCMFT for independent practice and almost all other states require only the LMFT. The Kansas LMFT designation translates to a provisional license in most other US states, which would require redoing all the required supervision hours by a licensed supervisor in that state. Canada and Mexico do not have government regulated licensure in any Master's level mental health field.

I would be in favor of the option, single state or multi-state.

I would be interested because I live in KC, and it would be nice to be able to have clients that live only a few minutes away in Missouri to be able to have telehealth options

**No (3 responses)**

Not sure

Possible, as the VP of our FCH's program, I am responsible for several of states, but again I am not currently practicing.

Possibly

Possibly. I believe this helps provide better services to clients with options to help via tele-therapy services.

Sure, especially if this allowed people in more rural areas to access therapy services.

**Yes (16 responses)**

Yes , because I have friends and Family in Colorado.

Yes depending on the state

Yes that would help grow my desire to practice

Yes! I live in a border city between Kansas and Missouri. Each of their respective state boards have different requirements, and I can only manage a Kansas license. It would be so nice to have a compact to be able to see clients in both states for the price of one.

YES! I live in Manhattan and have a number of clients that are transitory to the area (KSU and Fort Riley). They end up moving to other states and would like to keep working with me as their therapist via telehealth. I've had former clients reach out from Texas, Ohio, New York. Continuity of care is helpful and it seems that the licensure is not keeping up with the technology. Telehealth opens the possibility up.

YES! That would be amazing

Yes, because I'm interested in serving clients via telehealth in hard-to-reach places.

Yes, definitely.

Yes, due to the location of my Kansas City practice I think being licensed in both states would be beneficial to clients and my practice. In addition, if a multi-state license was an option, I think it would greatly benefit this working profession and people would have more clinicians to choose from.

Yes, especially given that I practice in Kansas City, which spans Kansas and Missouri. I have several clients who live in Missouri to whom I cannot offer virtual sessions. This current restriction does not allow for the highest level of client care.

Yes, I absolutely would.

Yes, I would be interested in obtaining a multi-state license due to multiple clients moving to other states and indicating an interest in continuing to work together.

Yes, I would like the ability to see clients from other states. I would also like to receive specialized clinical supervision in my therapeutic model of choice. (Kansas has few specialized, clinical supervisors in Emotionally Focused Therapy.)

Yes, I would. It would be helpful to be able to provide services to clients when they are out of the state of Kansas should they need therapy services while traveling.

yes, living so close to the Missouri/Kansas boarder it would be nice to be able to easily practice in both states

yes, my clients often move and having to switch therapists due to licensure limitations across states seems unethical and a hindrance to continuity of care.

Yes, probably

Yes, that would be great. I would then be able to offer telehealth sessions to a larger number of folks.

Yes, that would be nice as I live close to OK and it would be nice to work there sometimes.

Yes, this would be very useful to have a multi state compact. Currently I am only licensed in Kansas. When my clients travel for work to other states, even when they are willing to do telehealth, I am not able to oblige and have to skip a week. This affects their mental health as well as my income. This is a frustrating limitation.

Yes, this would be very useful, as I work in a college town and some clients spend their summers in other states.

Yes, to be able to serve clients if they move out of state

Yes, very much.

I am originally from another state and would be open to moving there eventually but love my clients from Kansas. Transitioning or having to start over is difficult financially for therapists.

Kansas is a landlocked state by many other surrounding states and people love to take road trips and travel a multi-state license would benefit the clients and therapists here.

Yes, via telehealth and due to living in the KC metropolitan area.

Yes, would like to be able to continue client care for a variety of reasons: temporary moves, travel, etc.
Yes. I have people who have reached out to me to provide therapy but they were in MO or OK. I also had clients to moved and I had to refer them.
Yes. especially in Missouri so that I could live in Kansas City and take clients from either side of the river!
Yes. Flexibility in moving.
Yes. Given the close proximity with MO, it would be nice to have more options. In addition, I have considered moving to be closer to family in St. Louis and would like the option to continue practicing in both states as a result to include TH as an option.
YES. Having a multistate license in a two-state metro area would be hugely helpful. I have had clients stop seeing me because the drive becomes to much. Those clients said that if I was able to offer telehealth in Missouri they would be able to continue coming in person in Kansas sometimes with the option for telehealth sometimes. Also I have clients who live in Kansas but work in Missouri so would like the option to have telehealth during lunch breaks and don't have enough time for the commute and a session.
Yes. I am a military wife so that would be very helpful for all the moves.
Yes. I'd like the ability to move out of state in light of the current political climate and would like to be able to move quickly if needed. Also, I practice in the Kansas City area and not being able to offer telehealth to clients literally across the street from my office is frustrating.
Yes. It is easier to navigate than a bunch of different licensing boards and fees.
Yes. My husband and I have considered moving to Chicago at some point, but would like to move back to Kansas eventually. So, being able to more easily attain a license in IL while maintaining a Kansas license would be a big bonus.
Yes. Neighboring states, or potentially states that are under potentially underserved, under duress.

**LMFT Q13. Over the past two years, based on your observations and experience practicing in the marriage and family therapy 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? (48 responses)**

1. I am disheartened at how licensed practitioners in other professions see couples and families without sufficient training or supervision.
  2. When clients have to relocate to a state where I am not licensed, or when one partner/family member is working or living out-of-state temporarily, such as being deployed for military training while the spouse and kids stay in the home state, or travel regularly for business, I must cease relational therapy with the individual who is out-of-state until they return. I understand that there is only so much KS can do as the laws of the state where the person is located are in force, however, having a clear stated carve-out for limited services would be a great start to addressing this need
- AI is clearly uncharted waters and is, no doubt, already on your radar. Beyond that, I can't think of any issues that need attention.
- Basic understanding of brain processes that underlie therapeutic change
- CBT & ACT
- Continuing education
- Dealing with insurance claims
- Ethical challenges given changes in state and federal policies I think would be helpful to have additional guidance on.
- Hard to know if the trainings will provide usable information or just check a box for CEs.
- Haven't observed any problems.
- I am new to the field. Additional resources on DV would be nice.
- I believe it would be more helpful to get more trauma-informed education.
- I believe some practice-related negative issues include the lack of communication and clarity from the BSRB regarding ethics violations and complaints. Negative experiences include complaints being filed against MFTs, and MFTs not receiving communication from the BSRB Ethics Committee or investigators for over a year, resulting in a possible loss of liability insurance coverage due to on-going investigation. This could stop an MFT from practicing for a large period of time, and it could, in turn, result in more challenges for clients seeking care. This is unacceptable. The lack of communication and transparency is unfair to complainants and MFTs under investigation, as both are deserving of a swift and thorough process
- I have observed multiple instances where ethical question marks were raised especially in the area of owning a practice where one or more clinicians are either currently clients or were recently (less than 2 years) clients of the owner. Ethical questions are also raised when clinicians are encouraging clients to use illegal substances (marijuana, mushrooms, etc.) to aid in "healing". I have observed this often in the community I work in.

I have. I have seen people become therapists whose ethics and values do not align with the professions. In school, myself and other classmates have reported incidents of unethical behavior but little too nothing could be done. In my professional career, I have heard from various clients, friends, and community members where therapists have done similar unethical things to them. This feels like a systemic issue with the system that makes it hard to hold these people accountable.

I think another thing that is tough is that information regarding note taking, treatment planning, record keeping, ethics, and client management are very different depending on who you talk to. I think this has made it hard as a clinician to understand what is the correct way of doing things. I can understand that everyone does things different, but there seems to be very little consistency.

I haven't seen any issues with the board (just with insurance companies).

I myself do a lot of work with teens and families around the impact of ADHD. I consistently have found that many therapists are not really that familiar with the ADHD beyond the basics. The problem being that this might be one of the larger things that we will see in our practices. Some studies show up to 25% of our clients will have ADHD even if they have not been diagnosed. If we expand that to more of the neurodivergent community that number can increase to over 50%.

I think improving self-awareness during education/supervision would be helpful. My research (currently working on PhD) is with Self-of-the-Therapist and how this impacts our joining with clients and their subsequent outcomes.

I think the continuation to focus on ethics and diagnostics is essential. Trauma-informed trainings could be helpful or groups.

Lack of opportunities to practice unless in community mental health or private practice

LPC's and social workers do not have the exact same ethical standards, and there is no ethical standard in the LMFT code of conduct for how professional disputes should be resolved, how professional interactions with other disciplines should be maintained or by whom. I was verbally accosted and intimidated by two other practitioners (not LMFT's) in a shared office space when sited safety issues. They violated my privacy to other professionals and openly talked about me in a group setting where clients could hear them. I left the office.

There is not much recourse when a disgruntled, biased or unhappy client (or employer) can make blanket complaints of unprofessionalism without any form of mitigation before filing a complaint with the state. I have seen several peers in several states undergo tremendous stress from unwarranted investigations. At least two LMFT's I know have left the field because of this. This happened to me by an employer who violated their own hiring contract and when questioned, had their legal department intimidate me, created unsafe and unethical working conditions and when I pushed back they turned me into the state instead of firing me. That way if I were to quit I could not get unemployment and they could implement ways to make the work 'hostile'.

Maybe documentation...how to meet medical criteria for insurance standards while practicing as a MFT. (Some therapeutic models are less pathologizing than others.)

More training around Neuro-affirming care

Needing more ceus

**No (10 times)**

Nothing as this time as I am not currently practicing
Records for Medicaid and Medicare
Since I have experience working in both a larger city and in a rural community, I have been uniquely attuned to the stark differences specially related to resources/support, ethical issues, and education/awareness. As a clinician in a rural community, I find myself consistently wishing three things: 1. A refined network or community based group in Kansas to share information, resources, and experiences with. 2. A revised or up to date code of ethics for therapists in small communities. Rural therapists hold a delicate balance of upholding the importance of the code of ethics and realistic situations/issues in a small community. 3. I also think the MFT community would greatly benefit from more education and awareness around the adversity of practicing in a small community
Social workers continue to receive preference
Somatic work
Some therapists impose their religious views on their clients and client relationships. This is completely unethical in my opinion.
The self of the therapist.
There are a lot of seasoned therapists giving horrible ethical advice, or allowing themselves to be unethical and telling their colleagues about it, and creating environments of group think. Especially when there is a power structure that the "bosses" are asking for feedback, it puts others' jobs at stake if they openly disagree. Also there is a ton of sexism running rampant, and male therapists getting more resources, and space that feminine presenting/female therapists.
Too political. Practitioner should mind the code of ethics and stay out of politics. They also are not medical doctors and should not be giving out affirmation therapy related to gender ideologies and sex. To participate in any of this is to cause harm. We should not be political. I'd also like if there were a bridge for LCMFT's and LMFT's to be able to be trained to prescribe medication for mental health. There is a massive shortage in this area. We are here to serve all people with all issues.
Trauma-informed diagnosing/comorbidity and understanding of PTS symptoms versus stand-alone diagnosing of disorders impacted/influenced by trauma; complex trauma informed therapy, such as better understanding of attachment theory and interventions integrated with other interventions
Unsure
We need more and better training with assessing for diagnosing.
With marriage and family therapists, no. With other licensed professionals that I work with (I.e. LMSWs, LPCs), sometimes, yes.
Working with couples interacting with infidelity
Writing letters for courts

**LCMFT Q12. Over the past two years, based on your observations and experience practicing in the marriage and family therapy 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? (175 responses)**

<p>*Ethics in regards to dealing with ROIs and court in general.                  *AI and it's impact on our future and clinicians understanding the potential risks for confidentiality breeches                  *Ethics in regards to using electronic equipment and services such as personal PC, fax, printers, etc.                  *Understanding the requirements of doing telehealth--working from home requirements, confidentiality, location of client needs to be in the state you are licensed.</p>
<p>A lack of knowledge of how to relate to people who have attachment injuries. Some therapists have a business policy to only schedule people bi-weekly and put them on their cancelation list for the off weeks. I have seen several clients after they have been in this situation and they were harmed by it.</p>
<p>Addictive disorders</p>
<p>Adults with ADHD and Autism. How to handle political and religious differences with clients.</p>
<p>Appropriate professional boundaries</p>
<p>As a supervisor and a placement site for graduate student interns, I continue to see the need for continuing education in note-taking (progress notes, treatment plans, court documents, etc.).</p>
<p>Best current practices in treatment of trauma</p>
<p>Burn out has been an issue for me personally, as well as my colleagues. Continuing education seems to be something that is required, but hardly ever brings true growth.</p>
<p>Changing of federal regulations and dissemination of information. Telehealth regulations or expectations.</p>
<p>Clients are entering into care with an increase in multi problems, trauma, and suicidal ideation. Practitioners need ongoing training regarding experiential methods to treat clients that include EMDR, IFS , Yoga/Somatic Experiencing models and when approved medicine assisted therapies. Practitioners need training to treat clients in collaboration with health and wellness providers such as PCP, Nutritionists, Specialists etc.</p>
<p>Coding and efficiently navigating insurance billing procedures.</p>
<p>Communication, consideration of one another, pornography</p>
<p>Concerned about the use of AI in practice without a lot of training, regulation, or understanding.</p>
<p>Court is an area that many therapists are not comfortable with.</p>
<p>Crisis response, insurance billing</p>
<p>crisis/suicide ideation related issues</p>
<p>Cultural humility and contextual awareness in mental health treatment. The intersection of mental health and anti-oppression work seems to be an issue for some clinicians, particularly when it's not oppression that is directly experienced or observed.</p>

Cultural sensitivities, particularly around race and religion. I also believe additional training post-graduate school would be beneficial in working with couples and families.

Diversity and cultural awareness

Documentation and treatment planning

Documentation that is non bias and trauma informed

Documentation training is needed as noticed by me and others asking how to do so.

Doing their own therapy and self-awareness.

DSM 5 training CEUS

Suicide Prevention and Assessment

Dual relationships, understanding one's scope of practice, should a therapist treat the ind., the family, couple, all within one family system.

Ethical issues in regards to these issues are seen in other practicing LCMFT'S and are concerning to me

Education for therapists on how to identify power and control/narcissism and/or domestic violence in couples, adults, and with children. It is missed, as it doesn't present in a typical fashion, and then therapy is a tool for abusers and/or puts children and adult clients at risk. Also, education on the role of therapists in the court system. Having worked with severe sexual abuse and domestic violence cases, I continue to be shocked the number of therapists who don't just testify facts of a case, but make recommendations for custody, and answer yes or no if abuse has occurred based in their own bias. Most of these, outside of a narcissist filing, aren't not reported to the board as clients would face severe back lash in their own court cases if they did file. Recently, a mom lost custody of her children for 5 years, having 1 hour of supervised visitation only. in reviewing the therapists files and court testimony, both therapists on the case clearly testified that mom should have no contact. When in fact, the only allegation against mom was that she had "told" the kids dad sexually abused them--no abuse allegations other than that. Therapists on the case did not understand how children who are being abused and in custody of the abuser present, their role or ethical code around being able to recommend custody--and true harm occurred. The children are now with mom, and in therapy disclosing horrific abuse from dad, as well as how they were abused around therapy sessions in order to say what dad wanted them too. The children and mom will not file a board complaint, it's too much. This is one case of DOZENS.

Ethical and legal requirements surrounding the use of AI.

Ethical boundaries with clients seems to be an area I observe needs more attention and/or continuing education.

Ethical use of psychedelics in psychotherapy

Ethics

Ethics in private practice management

Ethics of asking for reviews on Google or social media

Legal/ethical considerations of mandated reporting, with examples

Ethics

Grief

Body work Trauma

Ethics, documentation, ethics around working with insurance companies (eg: what to release, what to include in documentation and treatment plans, how to resolve issues, etc)

Expectations and training have decreased over time. The pandemic has played a role in this as has billable needs of agencies.

Getting "clinical" treatment methods and diagnoses from social media influencers.

Group practices are predatory on brand new therapists and exploit them. DBT is not taught in school but CBT is despite it being shown it is less effective for a number of populations. Business practices and ethical practices as a solo provider are not well taught; or taught too early that it is less applicable.

How to deal with insurance/proper documentation

AI

I am unaware of any areas.

I have concerns about DCF reporting and the role that licensed professionals in the state play in the process. There is a social worker that "screens" DCF reports and tells mandated reporters whether they should or should not report case by case. I was taught that it is not up to school social workers to tell mandated reporting staff to not report situations that meet reporting guidelines. This has been a huge concern for me as it directly impacts the safety of children.

I have noticed a lot of need for seeing the link between mental health and physical health and how it is helpful for clinicians to support clients in being active in looking any of their physical health needs that may be impacting their mental health.

I have seen confusion for paths for further certifications, pathways for becoming a supervisor, and difficulty in how to run your business with a focus on increasing time for client care.

I have seen some therapists not report other therapist's bad behavior. I believe that we should all be holding each other accountable for unethical behavior.

I have worked in the military context for the entirety of my LCMFT licensure. DoD therapists are very well trained on all manner of topics.

I miss KAMFT

I presently work in a large (60+therapists) group practice. I do not have specific concerns regarding other therapists; I do have concerns regarding over what I see as a disorganized environment which results in concern for all of us. The practice lacks policies/procedures/standards of practice. It is concerning as there are a great number of therapists and no standardized policies. 60+ therapists is a large number of practitioners serving a variety of populations. Accountability, standards and risk management would be beneficial.

I see a high need for ethics trainings that are keeping up with technological changes--I.e., the use of AI in writing case notes; HIPAA compliant software/methods for maintaining client process notes between sessions; etc. I think many would also benefit from refreshers on state law regarding consent for minors and other more nuanced relational dynamics within confidentiality/consent/law.

I think diagnosis is always an area that could use work. As long as insurance is going to be a major way that therapists are reimbursed, I believe there is a discrepancy between what clinicians in training are learning and what that looks like post-training.

I think MFT profession needs more support in fighting insurance reimbursement etc.
I think that diagnosing for insurance purposes needs to be addressed. More continuing education in accurate diagnostics would be helpful. Also, insurance companies should be held accountable to help people, not make it harder for families to receive services. Couples therapy should be covered by insurance because parents who are happy and healthy have happy and healthy kids. It's science. Please advocate to change the law.
I think that providing therapy is a skill that is not necessarily "trainable". But no doubt each therapist has something to offer.
I think there is always a need to keep developing deeper competency around working with diverse clients, both in terms of racial diversity and in terms of lgbtqia clients.
I think we need more training in areas of sexuality and sexual health  Postnatal care
In being a sole proprietor and having an individual practice, I have not had any issues in maintaining continuing education. I primarily do online and conferences when available. I'm uncertain as to how other colleagues may be managing continuing education in group practices are larger agencies.
In my opinion, most often clinicians are severely out of touch with understanding how to work with African-American clients as well as other black and brown individuals. They have often times a lack of understanding about systemic issues that are faced daily.
In principle, I think additional focus on addictions issues as these intersect with couples and family work would be enormously helpful.
Inappropriate boundaries with clients with actual consequences. White Privilege A man's power dynamic in the therapy room.
Insurance diagnosis
It is my observation that as some MFT's begin practice, they do not appear to have as much confidence in systemic work as I experienced leaving school with the level of training I completed in relational sessions (I believe the standards for relational hours changed since I graduated my master's program). Many clinicians begin to become more comfortable in individual practice as they work in the field. I think it would be beneficial for MFT's to have a requirement on relationally based continuing education. This would ensure that we are continuing to be trained and educated on our specific specialty and pillars of our <u>profession and licensure</u> .
It seems like there are more and more clinicians not taking care of their own mental health which is concerning.
It would be useful if more individuals had training in trauma-informed care. It would also be helpful if people had more training on working with survivors of violence.
I've been privy to MFT's abusing power, manipulation and exploiting clients. In some cases this has been for financial gain and in other cases negative countertransference. There also seems to be deficit in the quality of supervision provided.

I've noticed a significant rise in the use of non-evidence based practices intermantly included in therapy services. I think the embracing of pseudosciences can be detrimental to the care of our clients and perhaps should be addressed at the educational or ethical level.
Lack of direction regarding legislation changes
Lack of EMDR training and business 101 CEUs for clinical therapists interested in opening a private practice
Lack of public advocacy against legislative malfeasance.
Lacking education in working with children and needing to expand on family therapy.
LMFT trainees could use more understanding with insurance processes. SWs have a disproportionate lack of methodology and ease of licensure
Managing their own biases and being neutral in the room.
Many MFTs are not fully HIPAA compliant. They are typically strong in their compliance with privacy regulations. They are woefully uninformed/unaware of the requirements in the Security Rule. The MFTs who do not contract with a compliance service are almost always unable to have a meaningful conversation about their security policies and/or how they comply with the requirements in the Security Rule.
Many therapists shy away from court related issues for individuals or families primarily due to lack of knowledge, lack of support, and fear.
Marketing, insurance (client and individual) and business growth
Marriage therapy
More continuing Ed and supervision is high priority always!
More education on clinical supervision
More education on dealing with social media
More education on neurological science
More good training in ADHD and autistic adults. People think ASD looks like "Rainman", and if it doesn't, they will say to the client "there's no way you could be autistic bc you are too verbal (or social or smart or fill in the blank). Many of my clients have been harmed by comments like these. Many of my couples are not getting the best care or being helped with the most appropriate "tool box" and it is harming couples.
Other gripes would be ethics, such as people who have not been trained as MFTs, or only had 3 hours class related to working with couples providing couples therapy, and then doing it poorly - that also harms clients.
After seeing the question below, definitely training in AI and is it ethical to use, how to use it ethically if so, etc.
More supervision training opportunities
More training on DEI, and HIPPA
My observation is that MFTs need additional training or continuing education in how to include children in therapy sessions.
N/A. I'm in a solo practice.
Navigating insurance companies, ethical practice, acknowledging political and social systems' impact on client symptoms and resources

Need more people to work with perinatal and young kids families
Need more therapists with eating disorder education
Need to have clinical license...
needs to be more training for MFT in the state.
New clinicians need help navigating credentialing and third party payment systems.
New grads do not know how to write a proper note in an EMR. MFTs need more training on evidence based therapies, especially trauma.
New therapists coming straight from grad school into private practice unsure of how to diagnose, write treatment plans, manage high risk clients. Yes, these are the skills that they can bring to supervisors, but there are basics of the field that don't seem to be covered well in grad school.
<b>No (36 times)</b>
No I do not see negative issues all my colleagues seem to seek out training to keep them prepared for necessary education
No observations
No, I have only been in KS for a year and in that time I have actually not run into other MFT's online LPC and LCSW.
No, not directly. I think intimate partner violence is always a pertinent issue to be sure appropriate training is provided, and to make sure the MFT and advocacy efforts are connected.
No; from what I've seen specifically for MFTs, we were prepared and trained very well
Not sure
Parenting and child development
Personality disorders
Political climate training; climate change/existential training.
Practical intervention application
Practitioners tend to need more continuing education training in referring out when beyond scope of knowledge.
Private practice providers need more education on managing crisis or appropriate steps for navigating a crisis. (For context, I work in a crisis environment and most interactions my team has with OP/Private practice providers is that they don't know how to classify a crisis and don't know how to appropriately manage non-crisis but "scary" situations like NSSI
Self care, burn out prevention, more opportunities to collaborate with other professionals. Additionally there is a loud stigma against conservative providers, put out there by other (presumably more liberal) providers.
Mutual respect, care, and consideration for one another in the field.
Self diagnosed "neurodivergence" - how to work with clients who are convinced this is the root of their problems even when it is not.
self of the therapist
Students need more training in diagnosis and ethics.
Telehealth
The BSRB is a consistent hassle to work with, but most in the field understand that it's the hangup on waiting for the next scheduled meeting for issues to be handled.
More continued education in working with the courts should be required to protect clinicians and better serve clients.

The Friends University program is excellent, so most of my colleagues in the area have excellent clinical skills.
The high out of school fees to clients that clinicians charge. Working with systems, when to allow the expansion of a system in the therapy room, and when to refer out. E.g. seeing an individual that now after x number of sessions wants to do marital with the clinician.
The mental health community is completely obsessed with gender identity issues and has supported their claims, positions, and practice theory on pseudo-science and politics. I am uncertain of how it should happen, but I am certain that training will be an important part of rolling back the result of activism that has replaced good sense in practice. I never thought I would see a time when responsible-seeming clinicians would make such desperate, ego-driven decisions based on bad, partial, or emotionally-derived information.
The need for interactive education remains however due to costs of hours lost this is now done by computer only.
The use of AI and the impact on our profession The challenges associated with the Trump administration racist, misogynistic, and discriminatory actions toward LGBTQ and immigrants
There are too many hoops to jump through to become a registered supervisor. Some of us want to give back to the next generation of therapists but don't want to jump through what feels like red tape.
To be completely honest, and as an MFT snob, I just don't see social workers having enough training to do extensive trauma work. More often than not people are coming to me after seeing a social worker for years and getting nowhere. I feel like the educational standard should be the same for everyone and it should be a very high standard.
Too focused on politically driven agendas vs focus on treatment, diagnosis, networking, billing/insurance issues
Training around insurance panels and claims
Training on dual relationship ethics for frontier mental health providers; court/custody training and the courts
Trauma training
Trauma work
Trauma
Treatment goals
Understanding Community Resources (Like what CCBHC's have to offer) and not practicing in a bubble.
understanding Medicare opt-out
Understanding the boundaries of their licensure- i.e. offering custody evaluations including recommendations for termination of parental rights by private clinicians with no training in these areas, providing expert testimony when they have been a provider for party in the proceedings, selling/recommending supplements instead of referring to medical provider
Unsure
Use of Televideo, professional standards. Safety procedures, referral procedures and etc.

Using process dynamics and systems theory more than content/circumstance (and their personal opinions/values about it) to inform their interventions.
We are in desperate need of therapist for children. So better systems to protect the therapists from having to go to court or spend so much time outside of therapy. I had a desire in this area but the work is too difficult for less pay.
What is going on in legislature in our field. Updates, trainings, podcasts, something
When doing specialized therapy such as EMDR; giving legal advice
Working with children
Working with LGBTQ+ clients; Sociocultural attunement; Working with neurodivergent clients
Working with LGBTQ+ population, minority populations, farmers, veterans. Familiarity of community mental health systems.
<b>Yes (2 times)</b>
Yes ethics in and out of the workplace. I left a group Practice guilty of unethical billing and unprofessional conduct
Yes!! New therapists consistently struggle with diagnoses/ assessment.
Yes. Collaboration between providers- being able to professionally interact vs being polarized by clients or share inappropriate or even had someone record someone's professional conversations and share with clients.

**LMFT Q14. Over the past two years, have you experienced any issues concerning telehealth, either through professional practice or observations of other practitioners? (54 responses)**

As I previously stated, one large corporate company could mandate unethical practices (like speaking to a new client without having their address or location) and impose unrealistic work hours and other negative issues without fear of repercussions.

I hear from a lot of clients when I tell them I can't see them in another state or country that their family member's therapist does it all the time, or that their former therapist did. I just tell them I am unable to do so due to the terms of my license and the laws/regulations of the location where they are.

I really don't like telehealth. We do it in the practice I work at but there are times I have to tell the client I can't do the therapy due to the location they have chosen to be at and /or they have other people around which makes confidentiality an issue.

Inconsistent and various understandings of the "location of client" requirement.

It is difficult when a client sets up a telehealth session and goes out of state without telling me. It would be helpful to be able to still hold session, even though they are out of state.

It is very hard to find clients who are rural from around the wider state of Kansas, say Dodge City, and for them to find us (ie - access to care) to tell them they can do Telehealth with an MFT who lives in a bigger city (ie - Kansas City). Also so many people move out of state and really want to stay working with their old therapist online, but aren't able when they move to a different state.

I've had connection issues related to the internet.

**No (36 times)**

No concerns. Personal preference is face to face.

No observations with concerns.

No, My advice is face to face in my office. Some parenting over the phone.

No, telehealth seems to have greatly increased access to folks who otherwise would not be able to regularly attend therapy. A good number of the folks I see for telehealth wanted someone with more education/expertise and were unable to find someone locally so see me via telehealth.

No...other than spotty internet issues from time to time.

Nothing major except reminding myself to ask for their address/repairing harm when session has to end due to address or lack of secure area

Nothing other than harm caused by political activism to clients and other practitioners.

Occasionally had issues when I worked at the Mental Health Association due to clients having poor boundaries with the use of telehealth and having to discuss appropriate locations for use of telehealth.

Technology issues seem to arise

While there is definitely appeal to telehealth, I personally do not like to use it as I feel that it limits the interactions and does not allow for as good of a therapeutic alliance.

Yes, most require and LCMFT or ability to practice in multiple states

**LCMFT Q13. Over the past two years, have you experienced any issues concerning telehealth, either through professional practice or observations of other practitioners? (179 responses)**

\*Ethics in regards to using electronic equipment and services such as personal PC, fax, printers, etc.

\*Understanding the requirements of doing telehealth--working from home requirements, confidentiality, location of client needs to be in the state you are licensed.

Becomes too convenient to use over face to face.

Certainly we've utilized telehealth, however no negative issues. It's been a wonderful thing that has allowed so many more people to receive support, whether it be working adults who are then able to do their therapy amidst their work day, or people who live in super rural underserved areas.

Challenges associated with faulty connections and inconsistent use

Clients love the accessibility and low-cost of time and travel...and even childcare.

Clients not being alone and the clinician not being able to tell if the client is truly in a private space where they won't be overheard for sessions.

Confusion over the location of the client receiving services.

Difficulty connecting to clients

Expansion is always welcomed for providing services and supervision of clinical license, especially for rural and frontier areas.

Families with connectivity issues

Great concern regarding confidentiality and legal issues connected to that subject. Feel that many of the platforms say they concerns have been addressed but not sure they really have.

Hippa compliance

I am disappointed that the AAMFT is not advocating for a multi state compact to allow clinicians to practice over state lines.

I appreciate the value of telehealth primarily for individuals. My experience with doing couples work is that it is hard to do well.

I do not use telehealth I feel it is far too ineffective unless it is a one time situation for an established client .

I don't practice telehealth

I don't believe its best practice as too much information gets missed. That said it makes sense in rural areas.

I don't do a lot of telehealth because I feel I work better in-person. That is a personal choice. I think telehealth should be offered because it is handy to have available during inclement weather events so people don't have to miss appointments. I know for our rural areas that telehealth may be the only way to bring therapy to some. While this is new, and there may be issues, I think that it should be kept available.

I have come to see how crucial it is.

I have not experienced any issues. It's incredibly helpful when needed.

I have not experienced or seen any concerns.

I have not, other than when I was working for Johnson County Mental Health they have a strict policy against telehealth. And I believe that policy is detrimental to clients' ability to access services.

I have not.

I have not. In fact, I am fully virtual and feel it has been an incredible blessing for myself and for those clients who are located in rural areas where they have little to no access to therapists.
I have noticed that I have to explain Telehealth ethics on how to present and where you are doing a session i.e. location
I have observed opposing opinions and/or statements about what is permissible for Telehealth across state lines. Specifically in the KC Metro area where the city is split in half by the state line.
I hear people often asking what state the client and provider should be in when doing telehealth therapy.
I love Telehealth. I not only work with individuals and couples, but I also use EMDR successfully
I struggled with maintaining boundaries with clients when using email as a primary form of communication. Clients struggled to know when email was appropriate and when it wasn't. Clients struggled to do telehealth in appropriate places and sessions would be canceled.
I think we are adjusting to telehealth.
I will use telehealth with adults with whom I have an established therapeutic alliance. I will do parent training via telehealth. I rarely will do telehealth with children.
Issues I have experienced is not having flexibility in being able to travel and continue to provide support for my clients.
It would be very helpful to be allowed to see clients via teletherapy when they are in a state other than Kansas. I have had clients visiting family out of state wishing to have a teletherapy session and clients who are Kansas residents attending school out of state who wish to continue services. Being allowed to see these clients via teletherapy would provide continuity of services in the client's best interest.
Keeping track of hipaa related to telehealth
What insurance standards are
Lack of being personable with clients
Limitations with telehealth due to licensure.
No - I can't stand telehealth and avoid it as much as possible but I greatly appreciate having it as an option for when clients are ill, or if there is suboptimal weather or something.
<b>No (103 times)</b>
No however I rarely provide telehealth services
No issues have been experienced in using telehealth.
No issues noticed. I feel that in person sessions more effective for any therapist, but I'm glad that teletherapy is available for those who need it.
No, it has been a largely positive addition post covid to allow accessibility of services to our rural people receiving services.
No, telehealth has been a positive experience as it allows more people to have access to therapy.
No. I'm so grateful for telehealth, as it provides so much more accessibility for clients. I hope insurance will continue to reimburse for it at the same rate as in person sessions.

No. Before the pandemic, I had no intention of doing telehealth. It's now a regular part of my practice and has been a significant benefit for some of my clients due to location, anxiety, and work/ scheduling challenges.
No. I wish licenses were not state specific though. Clients move, travel, change colleges, go home for the summer, etc. continuity and access to care is important.
No--I continue to believe that telehealth is such a needed, and wonderful way that we are able to provide much-needed care to those who, would otherwise, be unable to access services.
None. I think telehealth is a good thing that came out of the pandemic.
Not all practitioners are equally able.
Not applicable
Not really. What I seem to be seeing is that telehealth has become a very important tool for helping client's access services more frequently. The downside of such practices seem to be managed relatively well.
Only technical issues
Only when there are technical issues.
Pervasive confusion on HIPAA regulations and what malpractice will or won't cover
Potential treatment dilemmas coordinating care between therapist(s) and online therapy platforms/med management, such as Betterhelp.
Practitioners not screening for safety concerns and not familiar with resources in the area the client resides.
See above
Also, hearing about therapist/patient relationships (physical)
State licensing is limited. Seeing other professions joining things like psypact (for psychologists) and having the ability to practice in multiple states. I've had to terminate many clients who don't want to terminate/aren't ready bc they moved or left the area for school, etc.
Telehealth appears to be mostly ineffective for anything other than short term behavioral modifications. Therapy over long distance makes it entirely too easy for clients to obfuscate and withhold information without appropriate challenge. When intuition is cloudy, then counseling successes suffer.
Telehealth has been amazing for me as a provider, however, asynchronous messaging sessions are harder to navigate. Most insurances are now dropping that service, but it has caused communication errors.
Telehealth has made services and trainings more accessible. While I do appreciate this as an option, one issue that I see is less investment in the community.
The consistent barrier I see in the utilization of telehealth is technology impairment, when the screen freezes or information is lost due to poor Internet connection. This can be incredibly impairing to a client, revealing traumatic incidences in which is why I prefer doing in person sessions primarily.
The rules and expectations around telehealth are antiquated and interfere with clients progress and treatment.

Therapists who practice close to the state line are limited with telehealth if they are not licensed in both Kansas and Missouri. They may be able to see a client in their office, but cannot offer telehealth if that person is unable to come in person, if that person resides in Missouri.

Also, from talking with other clinicians, telehealth guidelines seem to vary depending on the presenters of various trainings.

Therapy platforms like BetterHelp possibly misleading therapists and clients around unrealistic expectations for telehealth therapy.

There are concerns that Psychiatrists and APRNs are meeting with clients mostly online through telehealth. However this is not helpful for my clients. Telehealth is helpful to stay connected however it should be the last resort after meeting in person. All of my clients prefer in person unless they are sick and need to meet online.

Uncertainty about guidelines

Using telehealth as an option to benefit the clinician more than the client.

While most practitioners I know use HIPAA compliant platforms, I believe some still use platforms like FaceTime

Would be very nice to continue to offer services to clients that move out of state or go to college.

Would like ability to meet with tele-health clients across state lines after they have moved

**Yes (2 times)**

Yes sadly. I'm in a therapist facebook group, and I'm amazed at the therapists who have posted that their OWN therapists were checking emails, playing candy crush, etc. while in session as they could see the reflection in the screen and tell therapist distracted. In one post, over 500 comments of others noting colleagues have done this or that they have fired their own therapist.

ALSO--I am appalled. There are therapists who see CHILDREN, who do not want to return to the office. So, they are in office some days and offer tele the other. For children, this is NOT supported by research. Rural areas due to lack of providers or specialty, or if illness--maybe. But the severely traumatized kids or kids who need games, co-regulation, etc... telehealth is not okay. It is done for therapists who don't want to come in to the office. I was asked to write an article for this for APT, but I have no time and know that it will be met with push back.

\*\*\*Licensure issues: therapists don't make much money--we just don't. I'm licensed in MO/KS because I provide supervision. Now with telehealth: therapists must be licensed in both KS and MO in order to provide it. Since in KC and close to the state line, this is impacting therapists and clients. Even if a therapist sees clients in person, it is now common practice that if a client needs to they switch to telehealth (sick kid at home, etc.) Cost is high, and the reciprocity rules of moving to KS and MO can be a road block. Just making you aware, not sure if there is a way for MO practitioners to just get a telehealth pass, or limit the telehealth pass to a certain number, or if close to KC and Stateline, etc...

Yes, poorly trained or inexperienced clinicians,

Also, policies regarding clients with dx related to suicidality or duty to warn. I do not believe all clients/dx are suitable for televideo.

Yes, practicing across states and safety planning.

Yes. There is a gap in training for professionals who entered the field prior to 2020. There seems to be less adherence to issues of confidentiality and privacy when it comes to other members being in the home and to my knowledge, there is no "best standard of practice" clearly laid out for this.

<b>LMFT Q15. Over the past two years, have you experienced any negative issues involving supervision? If so, please explain. (56 responses)</b>
7 yrs ago, yes
Hard to find in western ks
If there is a supervisor the specializes in a particular area they may lack in another and feedback may be limited. I think if I would have known this barrier I would have ensured to see a different group supervisor to broaden my opportunities to learn more and provide optimal care. Collaboration helps !
My supervision has been the best part of my work experience. I have had no negative issues at all.
<b>No (41 times)</b>
No supervision has always been great. I feel like it's very encouraging but also just important to have the connectivity to talk with other therapists about things we are noticing and clients we have. There's a real benefit in networking and just sharing experiences so that we do not feel like we are out on our own because so much of our job, particularly in private practice, is isolated.
No, other than it being incredibly expensive over time and you aren't really told this will be the case when you're in grad school. But I still think it's a wonderful way to learn and grow.
No. I love my supervisor/ion and have had a wonderful experience.
No. Over two years ago, I did have to change supervisors due to the lack of state approved training for my supervisor.
Not directly. I love my supervisor!
Since the 2024 election, I have observed supervisors insert their personal bias into individual supervision and group settings, and this has created an uncomfortable environment for the supervisees.
Two issues have happened in other states where I am licensed as a supervisor. I provide supplemental supervision for specialty credentials, so I am always working as an outside supervisor.
1. Supervisors refusing to sign off on hours at the end of the supervision period, stating concerns but having provided no guidance, remediation or notice to the supervisee about concerns.
2. Supervisors charging supervisees for signing off on their final hours report and licensure paperwork, charging either a flat fee or their hourly rate.
Yes finishing affordable supervision
Yes, when my supervisor does not understand my therapeutic model of choice.
Yes. I outlined it above in my previous answer. I feel very unsupported in this profession. Supervision is too costly, MFTs are too sparsely found in the Midwest, & mental health clinicians in general are not paid at all enough to meet the level of expertise, emotional strain, etc. that this profession demands. I love what I do...but I cannot keep working like this - particularly with my independent license financially out of reach.
Yes. In the past, I have had supervisors who were not accessible in times of client emergency, who were not prepared, and had little interest in supervising.

<b>LCMFT Q15. Over the past two years, have you experienced any negative issues involving supervision? If so, please explain. (175 responses)</b>
A supervisee forgot to submit a training plan addendum because of COVID stressors and was required to redo about half of their hours.
Confusion with seeing clients while waiting for clinical training plan approval. Also not understanding the role of "emergency supervisor", when an amendment is needed, and that they can have multiple supervisors.
Difficulty finding supervisees after becoming certified
Difficulty helping supervisees adjust to CMHC system
Don't do supervision
FYI... To the question 14 (how many people do you supervise), zero was not an option so I selected 'prefer not to answer' as none of the other answers would have been accurate.
Getting supervisee's
I am in a solo practice
I am independently licensed. I have had issues with my supervisees. It seems that the upcoming graduates have very little distress tolerance and struggle to find a work/personal life balance. Many of them who come to a CMHC think that seeing more than 4 patients a day is too stressful.
I am not a supervisor
I am not a supervisor nor do I need supervision
I am not trained to provide supervision. Because I am a senior therapist at my workplace, others sometimes seek my input on interventions I use that they are also using.
I do not have current supervisees
I do not provide supervision at this time
I do not provide supervision to anyone at this time (no choice for zero)
I do not provide supervision.
I do not supervise
I do not supervise any person.
I do not supervise anyone directly. I participate with colleagues in case consultation.
I don't supervise anyone
I don't supervise anyone.
I don't supervise non am I in supervision
I hated doing it, so I no longer supervise, but that's about it
I have not actively provided supervision as of this date.
I personally didn't have supervision issues. However, I was able to find a supervisor that I felt comfortable with. I think I was lucky.
I'm not a supervisor.
I'm not currently supervising.
It's a lot of time and investment
N/a don't supervise
n/a- I do not offer supervision
No - I do not supervise
<b>No (110 times)</b>
No as I am not a supervisor.

No not In last two years. However I did not renew my board approved sup status because during and after Covid I could find a refresher training
No, I am not a supervisor
No, I have not. I continually seek out consultation groups post-licensure. I wish there were more options
No, no supervisees
No. I currently do not have any supervisees.
No. I have had a very positive experience providing supervision.
None presently as I am not doing any supervision currently.
None. I do not provide supervision.
Nope. Eric Parks LCMFT is the best supervisor ever!! And beyond required supervision, he is such an amazing professional to continue offering support To his students and past supervisees
Not a supervisor
Not a supervisor. No negative issues.
Not in supervision
Not in the last two years. Previous to that I did have an issue with the difference between a supervisor vs an AAMFT supervisor.
Not over the past two years. As with my practice, it has been a wonderful addition to the profession that we can supervise virtually.
Only the fact that the requirements for an LCMFT become a clinical supervisor are drastically different than that for an LSCSW. MFTs appear to be regarded as "the ugly stepchildren" in this state with social workers being the "golden children". However, in most states, MFTs are the primarily providers of clinical therapy work, while social workers work primarily in case management and community programming. It is consistently disheartening to see how MFTs are treated versus other licenses in the state of Kansas.
Other supervisors not willing to interact with location manager regarding their concerns.
question 14 is poorly worded. No choice for 0. I do not provide clinical supervision, nor do I receive it as I am clinically licensed.
Students seem unprepared for how challenging this work can be.
Supervisee now showed a few scheduled supervisions. I have addressed the issue and assured that she was not doing the same to clients and the issue is now resolved.
Supervisee struggling to be self-sufficient and asking me to do all of the work (create contracts, make calls, etc.) I have had discussions about assisting them yet also encouraging autonomy.
Supervision is a lot like any other relationship. There will be negative issues if you are providing supervision. I do not provide supervision due to the observed indoctrinations of the incoming interns.
Terminations are never pleasant. Managing difficult personalities among professionals.
The red tape of being a registered supervisor. Get rid of it.

There is a lack of CEU options for meeting the requirements of ethics and supervision training courses for our State Board Approved Supervisor status. The continued issue of therapists just starting out and affording to pay for supervision. A way for therapists to find supervisors and the areas they specialize in.

There is not enough opportunities and individuals providing clinical supervision training in the state.

There seems to be a trend of newer supervisees not being proactive about their own supervision requirements.

This was not in Kansas it was in Utah but I had a clinician come through who was an LCSW, she went to the University of Utah and I know they typically turn out really great therapists, but she was just woefully unprepared to be a therapist and her ethical instincts were poor. It felt like it took a lot of work to help her get to a place that I felt comfortable signing off on her getting her license. I feel like we got her there, but I still worry that she was just placating me.

Where is the option to mark zero hours for supervision? I provide zero hours of supervision. I would like to eventually, but I still need to take the class.

Yes

Yes, lack of clear guidance in graduate programs or in general and harsh consequences for new graduates that don't do their training plan at a certain time/don't understand that part of the process.

Yes, unprofessional conduct

Yes. I'm amazed at the graduate school level how many programs are not following ethical code. One school had ZERO paperwork to inform clients that they student is under supervision. That is for intern at graduate school level. For post graduate: please please please re-evaluate the rules around when a post-grad can take the licensing exam. Currently, if they don't pass at the clinical level, they must then WAIT to take it until all hours of post-graduate completed and ready to apply for clinical licensure. While I believe in this test, for a post graduate to remember the specific details that must be memorized for sometimes YEARS is soooo hard. (I have a current post graduate who had a baby and worked part time, it's been 6 years and she is now ready to take it and done with hours). Many times, once clinical work begins therapists sharpen their clinical skills and use the theories they align with the most and also begin to pursue advanced trainings in their area. I've had so many post graduate amazing therapists, who have struggled due to memorization and being so long after the program. Please, please reconsider this rule.

\*\*This has not occurred yet, but I have concerns due to being in the KC area, so we have supervisees on both sides of the state line, and if they switch jobs then they are impacted. Reciprocity: thank you for lowering from 4 years to 1 year. I want to understand, and perhaps KS can communicate with MO, moving forward: for now, MO has honored reciprocity in Kansas. However, now that KS has lowered the hours requirement, supervisees are trying to practice on the KS side so that they save thousands of dollars in supervision. Now, if/when they want to move to MO side or get a job there: will MO continue to honor reciprocity? Or will they come back and say no, because the hours of KS are too low. While currently saying it's fine, I am curious if this will change because supervisees are just now applying since the rules changed. Not sure if KS needs to be aware of this or can do anything, but I've reached out to local supervisors and the MO board so that we can best support and guide or supervisees, as it impacts their finances and ability to be employed on the MO side.

Yes. A general decrease in the quality of supervisees

**LMFT Q16. Do you currently use artificial intelligence (AI) in your practice? If you do, in what areas do you use AI? (69 responses)**

I do not. I do know others that do and provide positive feedback.

I have used AI to make templates for treatment plans.

I use AI to help with social media ideas

**No (51 times)**

No, but I am interested!

No. I have a weird feeling about how AI can conflict with my client's privacy. I would be interested in more information about this from the board.

Use Simple Practice and I think there are some AI systems in place

Yes I definitely use AI in my practice. I have used it to help me complete and design new paperwork. I have used it to help improve my website to make sure that it appeals to my market. I have even used it when I'm trying to flush out a thought in terms of viewing a client through multiple different therapeutic modalities. I can find it helpful to come up with some interventions, particularly with my younger clients that are geared to each one of them specifically. I'm very interested in some of the newer AI that would help with things like taking notes and summarize meetings.

Yes! I use AI to assist with treatment planning and notes. I am very careful of clients information and do not use names or personal information.

Yes, to create letter templates to run private practice.

Yes.

- Developing written marketing materials
- Psychopathology research
- Researching aspects of HIPAA compliance in business processes
- Legal research related to LLC formation
- Business accounting & taxation research
- Insurance credentialing process

Yes; my company contracts Eleos, which is an augmented intelligence system created by mental health therapists for mental health therapy. It assists in summarizing and labeling interventions and client's response, progress and next steps in therapy.

<b>LCMFT Q16. Do you currently use artificial intelligence (AI) in your practice? If you do, in what areas do you use AI? (227 responses)</b>
Do not currently use
Evaluating for helping with generating notes
For quick references on medications, books clients are reading, various statistics, and generalizations of complicated topics. No AI is used in therapy or progress notes.
I do not use AI in my practice.
I have used it less than 5 times to complete emails.
I only use AI to occasionally generate ideas for marketing. After generating ideas, I create my own marketing content.
I think AI is most helpful when writing a treatment plan, It can be very helpful to give it a list of symptoms and the diagnosis and ask it to write up a paragraph justifying the specific diagnosis. It's good at writing but not good at diagnosis, it definitely needs a lot of guidance. Its also really great at coming up with a long list of interventions that I typically pear down and make more applicable for my client.
I use AI to generate first drafts of letters for court, ESAs, and invoices.
I use AI to outline a list of symptoms per the diagnosis and then I remove or adjust what my client experiences as a quick way to complete documentation.
I use AI, specifically Autonotes for progress notes. I recently experienced something very unsettling that Autonotes generated based on the information I entered and will be addressing that with an Autonotes representative.
I use Grammarly.
I use the Upheal platform. I use it for case notes. It's been very helpful in reducing the executive functioning load.
I will use AI when righting letters on clients behalf.
Insurance companies are using AI for compliance checks on documentation, to ensure sessions include evidence based practices and insurance contract stipulations are being upheld.
Clients are provided informed consent informing them of the likelihood of AI assisted reviews and they can request to opt out/decline. However, the insurance company can compel the client or the practice to turn over documents based on the agreement the client has with the insurance company. So this informed consent is mostly to inform clients that AI is being used this way with progress notes and treatment plans
<b>No (147)</b>
No hate that idea
NO, and I do NOT think AI should be part of the therapy process. Clients deserve a human interaction.
NO, and while it is popular this is truly scary to me. I understand therapists wanting help writing a note if they are billing insurance and due to time, but wow--the current AI out there adds stuff, and what about legal/ethical of us monitoring our own cases?
No, but I am considering this for documentation
No, but I am interested and believe more could be done to educate providers on ethical practice in this area. I want to keep up with the "technological times," but have anxiety over making sure that I am doing it well.
No, but it would sure be nice if AI could be used to generate my progress notes.
No, but looking into it.

No, however our agency has considered integrating an AI program that helps with sentence structure.
No, nope, no way. (To be fair, as of now, I don't understand the ethics of using this, especially around privacy and confidentiality and need to learn more)
No, this is dangerous for us to be using.
No. but it would be nice to have help with paperwork.
No. I don't believe AI needs to be utilized in this field. There are too many privacy concerns at this time.
No. Prefer not to use AI. I believe in the personal therapeutic relationship of human to human.
None reported
Not currently but will be moving to the use of Eleos for documentation for therapy sessions
Not that I am aware of.
Not yet but hopefully will be piloting one soon.
Not yet but the agency is discussing implementation of AI
Not yet, but we are working to implement Bells AI
Note keeping
Note-taking
Occasional use to improve my clinical language in notes.
Occasionally I may use it for document writing examples.
Occasionally I might ask a client to create an image using AI generated apps.
Occasionally when I can't find the office copy of the DSM. I like to look up stuff for clients. I am playing with using AI for writing notes, however, I have not actually written a note using AI.
Occasionally, but only for marketing and social media things.
Oh my goodness no! I can't even imagine how that is a thing. I'll have to research that.
Psychotherapy note transcription; summarization/editing
Sometime for ideas when writing
The only time is getting outlines for email contact with clients - I'll use GPT for "type a quick email template to a therapy client to help schedule ongoing sessions", it saves a lot of time. Other than that I do not use it
We have just contracted with our EMR to utilize AI in completing progress notes.
We utilize Eleos Augmented Intelligence as a notetaking assist.
Within EHR software (Therapy Notes). I would like to explore more with note-taking/transcription software
Yes in our medication management program.
Yes, HIPAA compliant software to help with case notes with consent form
yes, note taking
yes, telehealth
Yes, to aid in marketing, processes, and generating letter templates
Yes. Assisted note taking.
Yes. Help with wording.
Yes...autonotes ai to help generate progress notes

**LMFT 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? (49 responses)**

Again with my experience of 34 years, be grandfathered in as LCMFT.

Answering phone calls or returning them would be helpful.

Consider reciprocity with others states

DCF clinicians are not paid at all enough for the traumatic and laborious work that they have to do. Also, the call takers for DCF child abuse and neglect reports are typically quite uneducated and illiterate. Children deserve better protection than this. Therefore, I believe that we need to direct our efforts to increasing funding toward these services.

Do the multi-state compact and continue to make the licensing process online.

Do you have any pull with insurance practices such as recouments for insurance errors that are made more than 6 months after payment? It seems that practice is highly unfair to the clinician whose financial management is affected and often cannot collect from those clients who are no longer active.

Free mental health to other lmhp practioners

Get more involved in getting the word out about MFTs so the public has a better understanding. Maybe open a registry the public can access to find MFTs. Not require so many hours for LMFTs to gain Clinical Licensure. There is a large need and very limited resources. We need freedom to do our job. We are highly trained and should be recognized as such without so much regulation. Also, offer programs to eliminate student debt as we are public servants and should have some help there.

Having some way of asking questions that are difficult to find answers for that aren't always directly addressed in graduate school or training. Maybe a chat or easier helpline than through email.

I believe clinicians practicing in cities/areas within 20 miles of a state border should be permitted to provide telehealth to clients who live in that bordering state (without paying for an additional license).

I believe the BSRB needs to employ and train more investigators to provide a more thorough and efficient process for investigations. Investigations should never take over a year to resolve, especially since it is the role of the BSRB to protect the public.

I can't think of anything ay the moment.

I feel there should be more protection of licensees by the state, particularly those in independent practice. I don't think licensees feel the state will protect them as much as regulate them. I think this is preventing licensees from keeping their licenses or getting them at all. Nurse practitioners are more available than doctors. Who will the consumer turn to as burnout and therapist abuse continue to rise?

I think feedback on the use and ethics of AI for notes/admin would be helpful. I have avoided it due to ethical concerns, but since it is unlikely to go anywhere guidance would be helpful.
Maybe do more supportive marketing with family doctors throughout the state, so that they know to tell their patients that most MFT's can work through teletherapy, even if they live in a big city hours away.
Maybe providing more updated information on issues.
More online services when it comes to licensing and admin tasks. (I love the new continuing ed services!)
<b>No (25 times)</b>
No AI
No, I feel like Kansas does a very good job.
Opening up the multi-state license option would be great.
Please do what is possible to ensure that mental health professionals saying they are seeing couples and families have sufficient training and supervision to do so.
Portability
See above
Yes-My experience with the BSRB getting my license was unfortunate. My phone calls to the office are seldom returned. I find the workers in Topeka to be of no help. It is frustrating to want to follow guidelines and have no response.

**LCMFT 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? (161 responses)**

Add a statute to hold licensees accountable to professional conduct in the community as well. A licensee connected in any way to a murder, abuse, negligent acts resulting in death should have a consequence and require steps to regain public trust.

Advocacy - legislation / insurance

Advocacy when the legislature is proposing laws that violate professional standards.

Advocate through written or in person testimony against harmful legislation ie - trans youth medical care proposed bill; I would like to see MFT voices speaking to the systemic impact of these types of harmful legislation. Or seeking licensees to act as testimony writers/expert witnesses on various issues so when things come up, we can have our perspectives heard.

Agencies need to allocate more resources to training and support for individuals

Allow for more options and support for clients who need to make a complaint but want to do so anonymously.

Any help breaking the monopoly the insurance carriers hold would be useful.

As a licensee, I feel completely supported at this time I offer no additional insights to improve consumer services.

As mentioned above, I have concerns about licensed professionals not understanding their role in DCF reporting and wonder if more education and clarity would be helpful. If a situation meets DCF reporting criteria, I do not think a social worker should be able to tell a mandated reporter not to report.

Become a strong lobby for our profession with the insurance companies.

Collaboration with other states

Communicate with legislators regarding the importance of DEI and diversity education

Consider peer consultation hours as requirement for license renewal.

Continue to support expansion and permanence of telehealth services.

Easier reciprocity when extensive experience

Encourage certification or evidence of education for specialized therapy for evaluation/ diagnosis/ treatment of conditions such as domestic violence, sexual abuse, PTSD, etc.

Expand our ability to virtually see clients in states we are not licensed.

Faster licensure approval times

Feedback to each profession from their advisory committee's activity.

For the MFT profession, the BSRB does a fantastic job and is very responsive. I have noticed in the past 1-2 years that the committee that handles complaints, sanctions, etc. seems to be moving slowly in their processes. I have a client (also a clinician) who has been waiting over a year for a resolution to a complaint(s) filed against them. Of concern in this particular case is that they are still seeing clients in the interim.

From my personal experience, I believe it would be beneficial to have some type of regulated oversight of large clinical operations (group practices) in addition to those provided for individual, private practioners.

Get out of the politics. Neither confirm nor deny the gender issues and legality of marriage equality.

Give actual consequences to those who break ethical code and harm consumers. Put it in the ethical code for therapists to not have non-compete clauses in contracts.  
Allow LMFT's to rightfully file reports on LMFT's who are doing harm to consumers.

I am licensed in the state of Utah and they require suicide prevention CEs with every license renewal and I think that Kansas should also make that a requirement.

I am new to KS so I don't really have a good handle on the process here. Everyone seemed impressed that I had gotten my full license as an LCMFT, but in other places I have lived that is just a standard expectations. It would be weird for me to have practiced even 5 years without getting fully licensed. That does not seem to be the practice here and I am confused by that. I think I was also told that you can supervise and work to get your full license. It just is a surprising way to go about it, and it seems like making sure that people are prioritizing getting supervision so they can get their C would be an important way to increase quality control.

I am very unaware of the role the BSRB plays outside of when I renew my license. I would love more information on the ways the BSRB works to advocate for our profession.

I believe that BSRB investigations should actually result in more-severe consequences for therapists who have violated ethics.

I have concerns about AI and the security of client information. I hope this is an area in which the BSRB will provide ethical guidelines and regulations.

I love the idea of there being more high-quality trainings around ethics and diagnosis.

I often review enforcement actions to maintain a perspective on the trends of errors that clinicians make. The ability to sort enforcement actions by date would be a great tool to allow us to continue to stay up to date vs having to sort through all of the enforcement actions, looking for the most recent actions. It's a small thing but I think it would help us all stay informed on how we can avoid harming our clients.

I think clearer lines of communication from the BSRB to its licensees would be hugely beneficial. While there is a phone number and email available, it's not uncommon to have to follow up several times for a response.

I think communication has been excellent of late from the BSRB. Shout out specifically to Lois Prudhomme!

I think educating the public on our work would be helpful.

I think more oversight on all credentialed programs regardless of licensing. As someone who supervises and interviews, I can say that WSU graduates a lot of social workers who have no idea how to diagnose or treat and they have a terrible pass rate on their licensing test.

I think that consumers of services by providers don't often understand the difference between coaching and services by a licensed clinician. An increase in awareness surrounding these difference might help consumers find a better fit to suit their needs.

I trust our board and their processes. I do wish the board would allow approved Clinical Supervisors to supervise supervisees from other professions. For example, I am a LCMFT but I cannot supervise my LPCs practicing in my office. They are meeting with supervisors outside of the city due to limited matches in approved clinical supervisors. I believe the trained, BSRB approved clinical supervisors could supervise well providers from other BSRB licensed professions. At least to open up the option and choice for the Supervisee and supervisor.

I worry sometimes that clinicians are able to immediately open a private practice while still being under supervision. No support, no supervisor in office..etc.

I would like to see more regular communication from the BSRB. I feel like we get emails when something changes, however I would like to see more updates. I would also like for the BSRB be seen as more of a partner instead of a "punisher". So somehow more collaboration with licensees and proactive strategies.

In order to provide therapy to children under the age of 8, to have had at least one course (typically 15 CE hours) in play therapy.

Include the concepts of self sufficiency and resiliency in training programs.

Investigations take way too long. I have been told it can take up to 9 months or even more for complaints to get adjudicated. This is too long. If these are serious violations, the person being investigated has WAY too much time continuing to work with the public. Also, it is very hard on the accused to be just waiting all that time to find out the results of the boards decision.

Join a telehealth compact so telehealth can be provided to people physically in other states
Join an interstate compact
Lobby for reciprocity with other states
Make all states available for the LCMFT to service if we are willing to pay the fee and keep up the license
Medicare reimbursement
More availability for questions. It is difficult to reach someone at the office and wait long times for any responses.
More consideration for rural areas. I'll explain in length on question 18, as I believe it falls on MFT code of ethics.
More effective dissemination of law and changes within law and practice.
More regulations for online therapy platforms like BetterHelp
More supervision and practice helps
My only concern is the length of time it takes to process and adjudicate complaints. It's the worst it has ever been in my 20+ years.
<b>No (79 times)</b>
No, my interactions with the agency have been positive.
Offer more flexible reciprocity status for counselors coming to the state.
On the one hand, I think that the system covers all the basics and it works. On the other hand, I'm surprised that some rule breakers I've heard about in the community are still in practice. I think it's nice to give people second chances, but here we are following the rules while there are various stories about rule breakers that show a very different set of values and ethics than the rest of us follow and there they are still in practice. I'm not sure that needs to be changed. Second chances do have value. It's just annoying to those of us following the rules. But to be clear - I think the processes are generally very good.
Other license boards are slow to respond to applicants

Please provide some general guidance on how to implement AI appropriately. There just isn't a lot of certainty on what constitutes "best practice" regarding AI implementation due to its novelty. Some people think that any AI at all is not allowed (but given the insurance example discussed above, that isn't the case.) Some people think having the client sign an informed consent regarding AI completely alleviates their professional accountability if the client's information is mishandled by the company providing the AI. Is it ever the case where we aren't accountable in some way if a client is harmed? Example - Am I required to select an AI tool that offers a BAA and is certified as HIPAA compliant? Assuming everyone "should" know to be extra careful with AI, then the answer would be yes, but does everyone know this? Assuming isn't enough because this creates opportunities for unformed or less technically savvy clinicians to inadvertently risk consumer's privacy. Just like when televideo became an option, initially there was a lot of confusion surrounding its use and many practices dissuaded clinician's from using it. That left us scrambling to implement it appropriately when COVID restrictions occurred. Once we had clear guidelines, we felt more comfortable using it and televideo became a valuable tool that allowed the general public greater access to mental health services. Guidelines would go a long way to helping us all implement AI correctly.

Possibly some sort of survey of those in the state upon what they would want to see in regards to what therapy consist of and what their expectations are.

Protect the human relationship

Reciprocity

Require MFTs to do a half of their clinical hours treating couples, families, and children. This is the requirement in many states. I can't tell you how many LMFTs don't feel comfortable with/ don't want to treat these populations. We have a waitlist for couples and family work that goes on forever at our clinics, yet no one wants to provide these services (especially since the insurance companies pay so much less for these services than they do for individual sessions).

Right now, I want to learn more about using AI in practice.

Sadly I will say that professionalism within private practice has taken a hit.

Send more MFTs out west, provide incentives for family therapists in rural/frontier areas. Highly concentrated in urban but not rural scenarios.

Streamlining CEUs digitally; notification of roll-outs on new guidelines or laws concerning Medicare or any relevant expectations for clinicians in private practice.

There are several people with LMFT's practicing without supervision. I think that should be regulated in some way.

There could be a better awareness or informational campaign to let the courts, lawyers, or agencies understand that therapists cannot engage in dual relationships by making recommendations about custody or visitations.

They have been very helpful and prompt with license renewal.

This is a difficult question to answer. On the one hand, I think there could be changes in continuing education requirements that go beyond learning, such as participation in consult groups.

Often the protections that might be available by the regulatory board are not used by consumers/clients due to a number of factors pertaining to the relationship between the client and the therapist. These Svengali-like abusers of power often create a complicated relational dilemma between the client and the therapist, leaving the client to avoid reporting to protect the therapist.

On the other hand, more requirements regulations from a regulatory board would not necessarily inhibit, poor judgment or bad behavior on the part of the licensee.

Frankly, it's just responsible to hold the value that if you are practicing in this profession, you should be receiving your own consistent therapy as well as mentoring for case consultation. These stopgaps may not entirely prevent harm although could be significantly reduced.

This is a good question and at this time I do not have feedback.

This may not be what you are asking. But I really miss the yearly training Conventions that were local. I Want to network within my state with other clinicians who are doing great things that I can refer to and learn from.

To encourage higher standards for reportable issues, shifting the focus away from newer clinicians and minor concerns (i.e. did a clinician misuse a word on their website or social media, did they turn in their training plan late/not understand the process -- and instead make these warnings as to not bog down the BSRB's process with other more important, timely matters like approving those plans and licensure requests), and instead prioritizing creating "offenses" and a whole investigation process out of more serious matters such as genuine harm to clients, safety risks, and therapists neglecting their own well-being.

**Unsure (5 times)**

Update the laws regarding parental consent and ensure that parents are party to all treatment, with an exception for abuse risk (from parents). Parents need to be involved on all levels, for the vast majority of clients. Practitioners should facilitate this readily or be compelled to do so.

Update website to make it easier to utilize and more timely responses to questions.

When I look at the discipline page I am shocked by how many practitioners have committed a sexually inappropriate act with clients and are only required to do supervision to keep their license

Yes. While I understand the board is very, very busy. If a board complaint is filed, even if it is 100% false it can take 9 months for it to be investigated, reviewed, and dismissed. I had a false complaint, found innocent. And--because I teach and hold multiple certifications, it impacted my practice. Organizations like EMDRIA, APT, AAMFT, NBCC (approves trainings), all ask if you have a board complaint. My own liability insurance asked, and sadly it had come right when my renewal due. Because of this and needing to report allegations, my trainings were on hold (income, and resources provided to the community--many free), and it was stressful. Also, therapists need more information on how they are protected in a case of a board complaint, that if gross and un-ethical issues yes they will be held accountable. But what are the potential consequences? And how are they protected from false complaints? In my case, it was an abusive partner who had never been a client, false claim. Also, clients must be willing to file a complaint and sign a release of confidentiality--totally understand. And, we hear of massive ethical issues a lot--yet cannot file or protect the public in any way. For example, a teen client who a therapist came onto sexually. The male therapist has a bad reputation among others for many issues, but this therapist will continue to practice as no one will file, including clients who don't want to deal with this.

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.

**LMFT 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 marriage and family therapy profession? (44 responses)**

Being able to practice in other states would be awesome.

Easy reciprocity to near by states needed.

I understand that it is my (and all other clinicians) professional responsibility to read and know the statutes and regulations in this state. However, due to multiple observations over time of clinicians seemingly not understanding what they are bound to or what regulation they are breaking, I feel that it would be helpful to have some sort of a regular attestation to these saying that they have been read and understood. Adults in this profession have to hold themselves to the highest ethical standards for the good of the public, and it can be too easy to claim ignorance in these areas and continue on with questionable professional practices.

I'm curious to know where things landed with aligning the MFT code of ethics with the Social Worker requirements around dual relationships, specifically the waiting period before entering into any other type of business relationship following the conclusion of therapy. I heard that was potentially an area of discussion but did not hear more.

Make us multiple state licensed

MFT's and their clients, who live 50 miles from state lines, or in urban cities like KC should, automatically be given reciprocal licenses in both states if they sign up for one or the other. Or States bordering on other states should all have reciprocal licenses.

More leniency with LCMFT applications and regulations. I have all the experience of an LCMFT but don't have the letters due to BSRB rigidity on training plan amendments. Had all the proof of my hours and experience, but due to not filling out one form it was a complete waste of time money, and personal resources according to the BSRB.

**No (28 times)**

Not at this time. Thank you for reaching out! Would love to help more if possible!

Not at this time... unsure how/who to contact though if I did.

PhDs not required to complete additional clinical hours under supervision to become licensed in KS.

Please help find a way for someone like me with years of experience outside of KS that falls through the cracks and cannot get licensed (yet) as an LCMFT. I have many years of full-time work as an MFT under my belt, but because I stepped back from clinical practice and was "only" supervising for some years, I am still unable to license as an LCMFT. I understand that it's important to have assurance that a clinician's skills are current, and feel actively supervising a specified number of supervisees (I was carrying 6-12 supervisees at the minimum for some years) could also count toward the clinical service requirements, especially for AAMFT Approved Supervisors. Thank you.

Please work on a multistate licensing compact.

Also when a resident of a state you are licensed in is traveling out of town or even out of the country for any reason and is able to do telehealth but is constrained because of the rule that they always have to be physically in state for every telehealth session this poses an unfair burden to both provider and receiver.

Pleeeeee continue pursuing compact licensing!

Since the pandemic, I believe the need for mental health services has increased exponentially and the demand exceeds the amount of trained, licensed professionals available. I am dedicated to high standards in our profession, however, they not equal among states or similar professions. I believe this is causing our field to fracture. I can practice more effectively in Mexico or Canada because they are less restrictive and support the professional, lifting them up instead of seeming imposing. I do not speak Spanish. I am a Registered Marriage and Family Therapist in Canada and I have considered moving there. I am excellent at what I do but have faced unfortunate issues with only my supervisor and a small, local Facebook group to support me. Find a way for our state to empower the licensee in word and/or deed. I feel like sharing my experiences and opinion puts me at risk-of what I don't know. Graduates fear "The Test" and it's common knowledge it is designed and expected to be failed. The entire country, except California, all use the same test and use the scores differently. As I stated before, making an additional level for independent licensure does (hypothetically) seem to make the standard of care higher but it's not necessarily the case. I hear that as making fewer qualified licensees, increasing the next level's (LMFT's) financial and time burden greater. That is not desirable when one can go to another state or country and earn the same license with less stress, time and financial strain. We do have a duty to keep the consumer safe. Excluding qualified graduates based on a test score alone is not a good thing. I have asked every client if they know the difference in the designations of mental health providers. Almost all of them did not know the difference. I had one of the highest gpa's in my graduating class. I have excellent client feedback and reviews. Yet I am only evaluated by a single test. Narrowing the margin for independent is exclusionary in a time when we need to be more inclusive. I am part of a new group of people who feel invisible and abandoned by healthcare, friends, and even family because they have Long Covid. I have survived but too many are excluded to the point of being suicidal. I have read hundreds of accounts of individuals who feel mental health cannot or is not capable of helping them. Other families have lost loved ones to Covid but there are

~~virtually no support groups and 'no one wants to believe Covid was real'. Adding tertiary levels~~  
The KS BSRB maintaining an up-to-date list of the current KS LCMFT licensed clinical supervisors on the website.

There should be more opportunities to waive fees for beginning therapists. It is an extremely expensive process to becoming licensed and there are little to no resources to make it financially feasible for new therapists fresh out of graduate school

**LCMFT 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 marriage and family therapy profession? (149 responses)**

\*There needs to be better wording on "under direction." This is very confusing and I feel it needs to be monitored better.

\*There needs to be an opinion on telehealth and more guidance by the BSRB.

\*There also needs to be an opinion on AI and more guidance in this area.

There needs to be an allowance to provide services in the surrounding states to allow for easier access to care for clients on the border areas. OR we need to participate in a national certification that would allow us to provide care to all of the USA.

A disciplinary complaint was filed against me and resolved. However, because of the manner the complaint is recorded, I've been limited in expanding my practice. I would like to discuss this situation with the advisory board.

Accessibility has been so helpful for people receiving services, are there ways for new therapists to be able to submit forms online vs sending via snail mail?

Again, my biggest complaint is the lack of timeliness brought to important issues, like clinician's licensure which is likely caused by being bogged down by "offenses" that really better deserve a warning and 30-day check in vs. a whole investigation. I encourage higher standards for reportable issues, shifting the focus away from newer clinicians and minor concerns (i.e. did a clinician misuse a word on their website or social media, did they turn in their training plan late/not understand the process -- and instead make these warnings as to not bog down the BSRB's process with other more important, timely matters like approving those plans and licensure requests), and instead prioritizing creating "offenses" and a whole investigation process out of more serious matters such as genuine harm to clients, safety risks, and therapists neglecting their own well-being.

Allow student therapists to be paid for their time in internships as other mental health students from other disciplines are. Not allowing this is like gatekeeping so only people with enough resources can enter the profession. It is like gatekeeping. My facility would like to utilize student therapists, but because we insist on paying interns, MFT students are blocked from our agency. Now we only have student social workers and student professional counselors.

As above

Ban gender-affirming care. Return to classifications and recommendations that are not endorsed by political entities but that are agreed upon by a contingent of strong, research-minded clinicians. It is no longer evident to me in my various consultation groups that the average clinician reviews literature when making decisions. They seem to just follow social trends.

Build in more time for practice and mentoring

Clarifying the KC Metro area/ state line / Telehealth issue would be helpful. Or perhaps it's clear and I am uninformed. I hear so many conflicting interpretations (all from clinicians I trust and respect) that it's difficult to be sure I'm practicing ethically based on up to date information. Thank you!

Consider how changes can impact all types of practitioners - agency, private practice and public sector.

curious if the interstate compact will be done in ks and with which other states. How will it be governed to make sure qualified people are working.

Do more surveys like this - nothing is more frustrating than policies being changed by the people who will not be consistently impacted by them.

Educate legislators about sexuality, orientation, gender identity, systemic issues, and diversity appreciation

Education of the public in terms of what constitutes ethical and effective therapy.

Figure out tele-therapy across State lines.

Has the statute or regulation regarding getting licensed after attending an online school been changed? I feel like licensees are getting approved for licenses but maybe it hasn't been officially changed???

I always hope for MFT continuing education that is well done and at a low cost that meets the boards approval. Any endorsements or creation of such events would be wonderful!

I am not sure if this is applicable, but a form of communication that describes what is going on in the legal world of MFT and even perhaps some advocacy news so that we as a populus can get involved to affect change for the good.

I appreciate the work of the advisory committee for MFTs. Thank you.

I feel pretty darn lucky to be practicing in Kansas! Keep up the good work!

I have been struggling with how adults are not a protected class. We have to report any abuse or neglect of a child, elderly, or disabled person, but we are not able to make reports for adults. This may just be a hipaa rule, but it is really hard to stomach as a therapist.

I love that MFT is the highest trained and has the highest standards. Do not waiver from this.

I served in Kansas City for 6 years, finding it very easy to avoid conflict of interest. If a conflict did arise, I could very easily find alternative resources. It is vital to me to uphold our ethics strongly, and I take it very serious. After moving to Jackson County, KS this has become a significant issue for me. My family and I are actively involved in our church, extracurriculars, and community service. I have no problem turning an inquiry away if I know them. The struggle arises in having "multiple relationships". I have taken on clients as strangers, and then as I'm involved in my community they end up (very naturally) attending similar events, go to local events, or were invited to a same wedding. It feels impossible to not run into clients in small towns, and I often leave early or take myself out of event to respect client. It comes at the cost of myself and family not participating in strongly valued events. I wish there was more clarity on boundaries and leniency for small towns. We don't have the resources to always refer out or avoid these conflicts

I think more direction when it comes to the current state of the world and LGBTQIA+ issues now that KS is attempting to pass a bill eliminating the ability to treat and diagnose.

I think that insurance companies need to be held to account for all mental health practitioners. The best way to have good practitioners is to have practitioners who get paid a decent wage. I'm not looking to get rich. Just to pay my bills with my degree and licensure.

I think the BSRB is completely out of touch with what it is to actually do this work. Even with the questions on this survey - just couldn't be more out of touch- and therapists need support that's what they need, it's very difficult work and the BSRB just feels like another punitive system that doesn't get what it is to do the work or care to offer support to the practitioner.

I want you to add to the professional conduct- that any licensee who conducts themselves in the community in any negligent way that results in harm or death to a member of the community shall be at risk of license loss, revocation, fines, mandatory counseling period, and required apology to community. As it is worded now licensees are not held to a community protection standard and let's remember we are mandated reports, not just to our clients.

I will switch to private practice next year when I retire from the military and give supervision a break for a season. At that point I will seek reciprocity with MO and serve primarily Leavenworth area.

I wish there was a way of reporting persons practicing providing therapeutic services, without having a license at all. I have come across two of such individuals who provide therapeutic services, without calling it "therapy", and they are operating without a license and have never owned a license to practice.

I wish there was a way to collaborate with Missouri so that we could see Kansas/Missouri people here in Kansas City. Also, Psychologists have a compact that allow them to see other clients across state lines. I wish our marriage and family therapists could do the same.

I worry we will be replaced by online therapy entities such as Better Help and/or AI initiatives.

I would encourage that we reevaluate social media therapy groups with clinicians and therapists, they tend to be on the cusp of revealing too much information and personalization of their experiences, reminding all colleagues of the importance of professionalism and upholding the ethical standards.

I would love to learn more about what role the advisory committee plays and how they can be an asset/benefit to me within my practice.

Increased work to improve telehealth access for services provided by Kansas clinicians across state lines, particularly in bordering counties.

I've been surprised that the BSRB seems to collect information, but generally does a poor job of disseminating it. I think my expectation of the Advisory Board was that it would advise Kansas clinicians of relevant issues (such as BOI filing, Medicare opt-out, etc). It seems that a regulatory board should provide information on how to maintain compliance with state and/or federal laws and guidelines.

Join a multi-state compact or at least allow telehealth to be done if a client is not physically in the state of KS.

Join the MFT compact (or however that works) to allow us to practice in other states, so that I don't have to prematurely terminate my clients.

Stop selling my contact info to every Tom, Dick and Harry bc the amount of spam I get through this method is ridiculous. Protecting my privacy (if that even exists in this world these days) would be nice.

Just on this survey. Some of the answers should be 0, such as #14. Or are you assuming I am a supervisor?

Legal information for client/therapist protection.
Licensure portability with other states would be a huge step for MFTs--I know AAMFT has been working on this for years, and I would love to see more states get on board with a compact or something of that sort to help with clinicians who need to relocate out of Kansas or are moving to Kansas from other states.
N/A thank you for all you do
<b>No (80 times)</b>
No, thank you!
No. I think this survey is a great first step.
No. I do not do telehealth and think the survey should have none as an option on that question.
No. Thanks for all you do to protect consumers and providers!
no....thanks for all you do
Not at this time but thank you for doing this survey!
Not at this time. Thank you!
Not currently. It would be helpful to have surveys like this more frequently.
Not sure
Pay does not meet the responsibility level causing people to quit. I fight more with insurance companies that seem to take advantage of treatment.
Perhaps this already takes place and I am not receiving notification of such, but I think it would be nice if licensees received an email notification when there are changes to statutes and regulations. I know there have been times when I was unaware of a change that I think would have been good for me to know.
Portability across state lines. Very helpful for clients who travel, move, spend time in rural areas to keep continuity of care
Reciprocal Status with border states: I hope the BRSB will consider developing an ethical and legal system whereby LCMFTs could practice with the border states.
Requiring passing of the National exam before awarding the LMFT license. Then submitting a training plan for the LCMFT before the LMFT is given.
So very, very grateful for your contributions and valuable time donated for this. here are 2 more ideas: 1. Advertise when the meetings are, or how therapists can reach out to share concerns like this to the board so you can be aware and get feedback. 2. THANK YOU for sending emails when changes are made. While we are taught that it's up to us to learn and know, other states don't email at all, and it's hard to navigate websites. 3. If the current training standards for CE's could be in the same place on the website, that would be great. Example: we know we need ethics, Diagnosis, etc. but when I send supervisees to the website, these are not noted in the same places, we emailed and then spent forever finding the original places this was posted. 3. Thank you--again. Truly Kansas is great, and our board does so much. Appreciate your time and talent and you taking the time to do this

Sometimes it's hard to meet the requirements, but also in the state of Utah when we do our ethical CE's, we also required to do laws and policies. They have to be laws and policies that are happening in Utah. I think that as a profession, we should know more about what's going on. Could be helpful to have a CE requirements of Kansas laws and policies so that everyone's on the same page. Also, I think that that helps us become aware of issues that exist where we can be together to create new laws and policies that will help the citizens of Kansas.

Standardize licensure names/ lettering to make it easier to work across state lines. The rest of the US thinks Kansas is "slap happy" with their excessive application of useless letters... Like why does the word "specialist" need to be in the title for a clinical social worker? The multi-level licensure concept is difficult enough for many to grasp, we don't need to throw a bunch of other random letters in there! ;-)

Thank you for taking the time to gather feedback!!

Thank you for your work!

The staff at the BSRB is always incredibly helpful! Thank you!

The survey did not allow me to answer N/A to questions regarding supervision, questions (9 and 14).

The wording on these questions is at times confusing and may impact the data you collect.

This isn't about the statues and regulations specifically, but I wish we were able to contact someone at the BSRB for help or clarification on things if we needed to.

**Unsure (2 responses)**

We deserve to have full support to protect our profession so we can continue to help our clients.

We have an amazing educational platform for our profession. I believe we should continue to uphold a particular standard which makes our profession continue to be protected/ respected in the community. Too many stories about people abusing their power in the therapy room to manipulate and/or harm consumers. This should not be a occurrence in the marriage and family therapy profession due to the nature of our profession. These people need to be held accountable and stopped. I wish the board would take action over the 10 years of continued stories.

We need an organized place to voice concerns or thoughts.