

Behavioral Sciences Regulatory Board

Survey of Addiction Counselors

February 2025

Version 2

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 addiction counseling. As of February 2025, Kansas offers three levels of permanent licensure for the addiction counseling profession: (1) a level of license for bachelor's educated professionals called Licensed Addiction Counselors (LACs); (2) a level of license for master's educated professionals called a Licensed Master's Addiction Counselors (LMAC) license; and (3) a level of license for individuals able to practice independently called the Licensed Clinical Addiction Counselor (LCAC) license. LMACs and LACs must practice under supervision. To assist the work of the Board, the BSRB utilizes seven subcommittees, called "Advisory Committees," which are comprised of the Board member for the profession (serving as Chair), a public Board member, and between three and ten other licensees for that profession.

In 2024, members of the Addiction Counseling 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 addiction counseling 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 addiction counseling profession in Kansas totaled 1,546, including practitioners with a LAC license (520); LMAC license (433); and practitioners with a LCAC license (593). From January 24, 2025, to February 23, 2025, all LCACs, LMACs, and LACs under the BSRB received an e-mail from the BSRB informing them about the optional survey and notifying them a survey link would be sent directly from SurveyMonkey. While the survey was optional, licensees were encouraged to complete the survey. Adjustments were made to the SurveyMonkey system to ensure responses remained anonymous and a series of targeted reminders were sent to licensees who had not yet completed the survey.

Over the 31 days that the survey was open for responses, 422 individuals completed the survey, for an overall response rate of 27.3 percent. For the LAC level of license, 127 individuals completed the survey, for a response rate of 24.4 percent; for the LMAC level of license, 107 individuals completed the survey, for a response rate of 24.7 percent; and for the LCAC level of license, 188 individuals completed the survey, for a response rate of 31.7 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, references to specific individuals or companies was removed, but otherwise language in this report reflects responses as they were provided in the survey.

Question 1 (LACs, LMACs, and LCACs). In what Kansas county/counties do you practice the profession of addiction counseling?

One hundred and twenty-six LACs answered question 1.

Full responses are included in Appendix #1 on page 39.

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

- Sedgwick (40 responses);
- Johnson (10 responses);
- Shawnee (7 responses); and
- Saline (4 responses).

One hundred and six LMACs answered question 1.

Full responses are included in Appendix #2 on page 41.

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

- Sedgwick (18 responses);
- Johnson (18 responses);
- Douglas (7 responses);
- Shawnee (6 responses); and
- Saline (5 responses).

One hundred and eighty-six LCACs answered question 1.

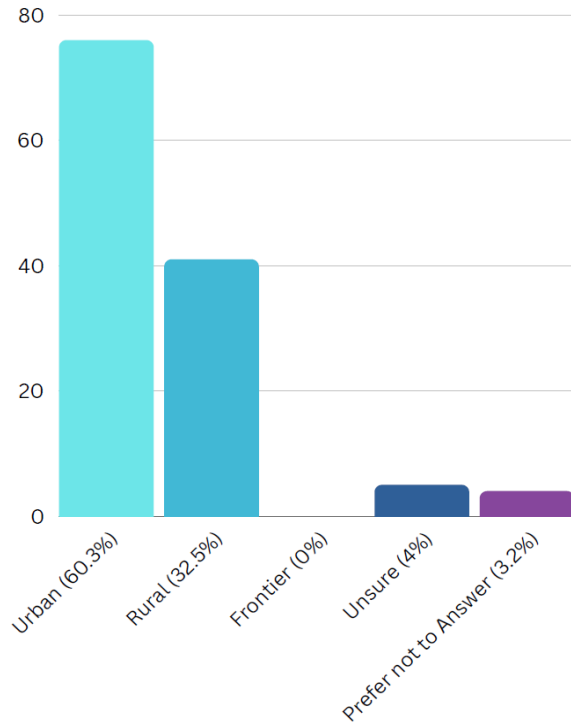
Full responses are included in Appendix #3 on page 43.

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

- Johnson (27 responses);
- Sedgwick (25 responses);
- Douglas (17 responses);
- Shawnee (10 responses);
- Riley (7 responses); and
- Lyon (5 responses).

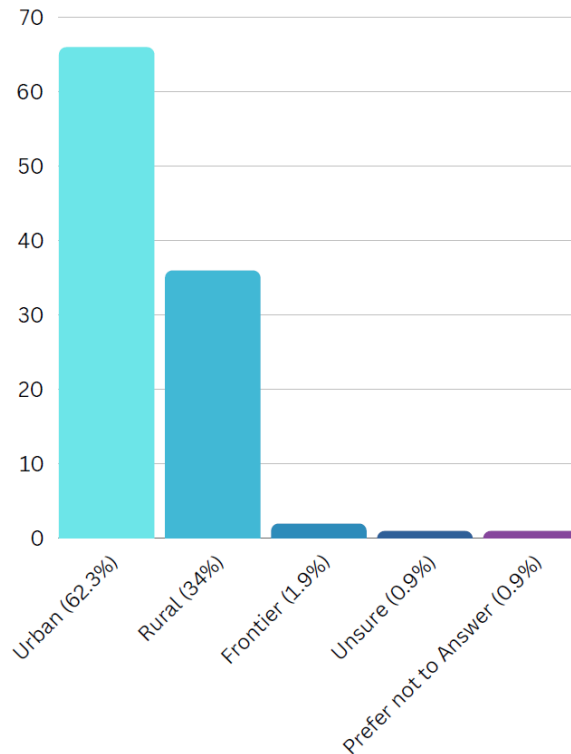
Question 2 (LAC, LMAC, and LCAC). Do you practice in a predominantly urban area, rural area, or frontier area?

LAC Responses



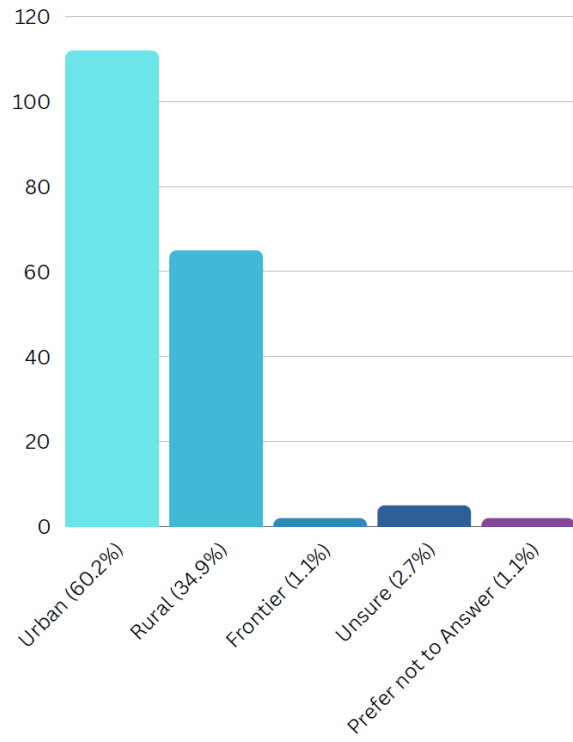
Of the 126 LACs that answered question 2, 76 reported living in an urban area (60%) and 41 reported living in a rural area (33%). All other responses were less than 5%.

LMAC Responses



Of the 106 LMACs that answered question 2, 66 reported working in an urban area (62.3%) followed by 36 individuals working in a rural area (34.0%). All other responses were less than 2%.

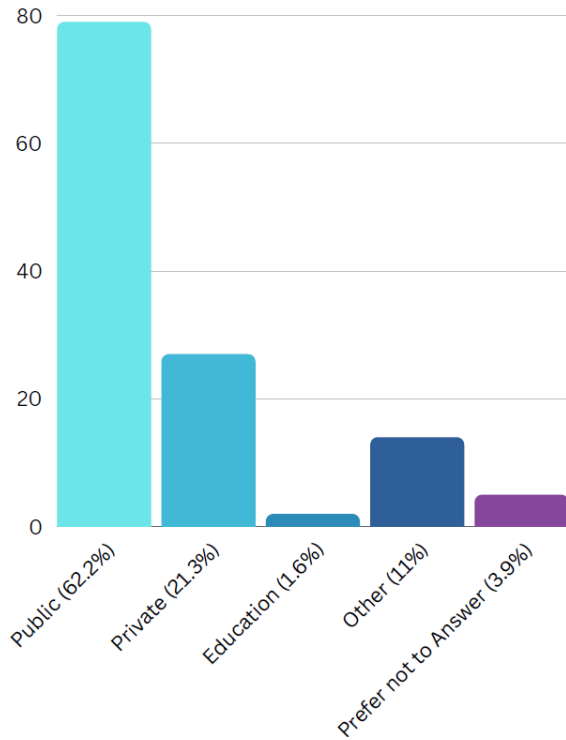
LCAC Responses



Of the 187 LCACs that answered question 2, the largest number of respondents, 112, reported living in an urban area (60.2%) followed by 65 individuals living in a rural area (34.9%). All other responses were under 3%.

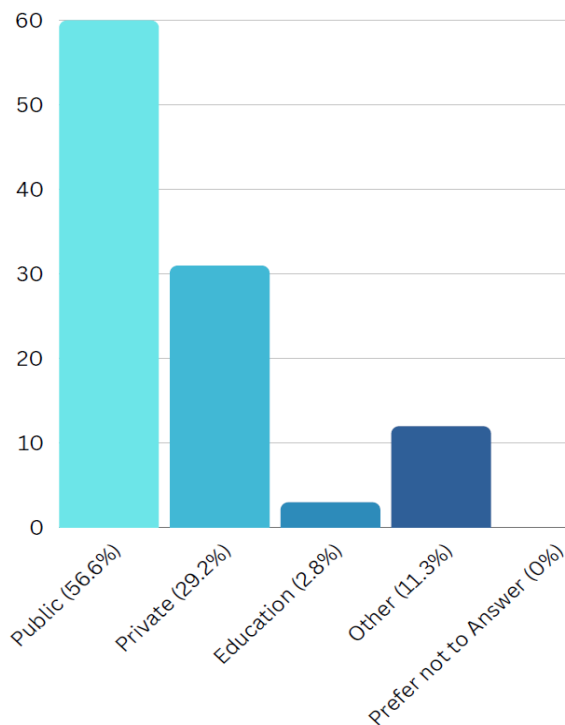
Question 3 (LAC, LMAC, and LCAC). Do you primarily work in a public practice, private practice, educational setting, or another setting?

LAC Responses



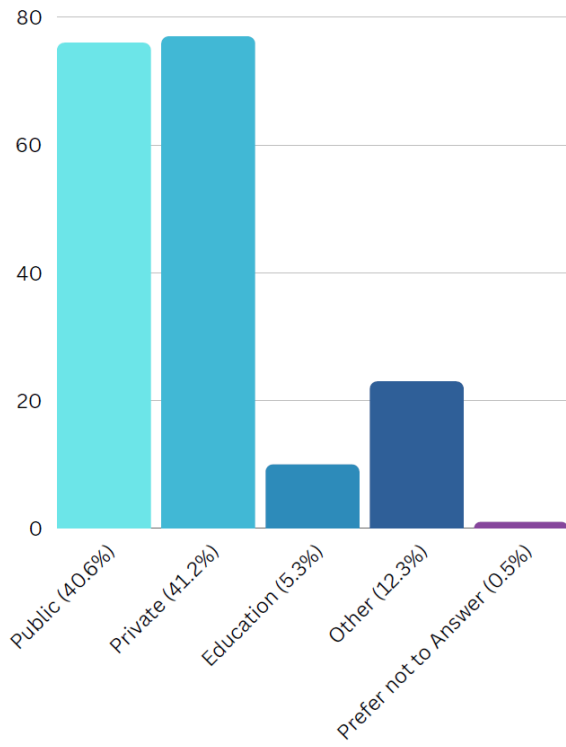
Of the 127 LACs that answered question 3, 79 worked in public practice (62.2%); 27 worked in private practice (21.3%); and 14 respondents selected “other” (11.0%). All other responses were less than 4%.

LMAC Responses



Of the 106 LMACs that answered question 3, 60 worked in public practice (56.6%), followed by 31 individuals working in private practice (29.2%), then 12 individuals who selected “other” (11.3%). All other responses were under 3%.

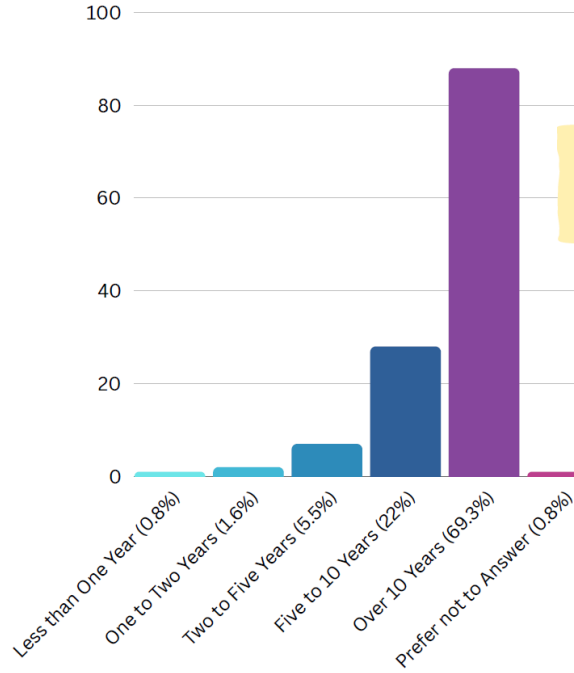
LCAC Responses



Of the 187 LCACs that answered question 4, 77 individuals were working in private practice (41.2%), followed closely by 76 respondents working in public practice (40.6%), and 23 individuals selecting “other” (12.3%). All other answers were less than 6%.

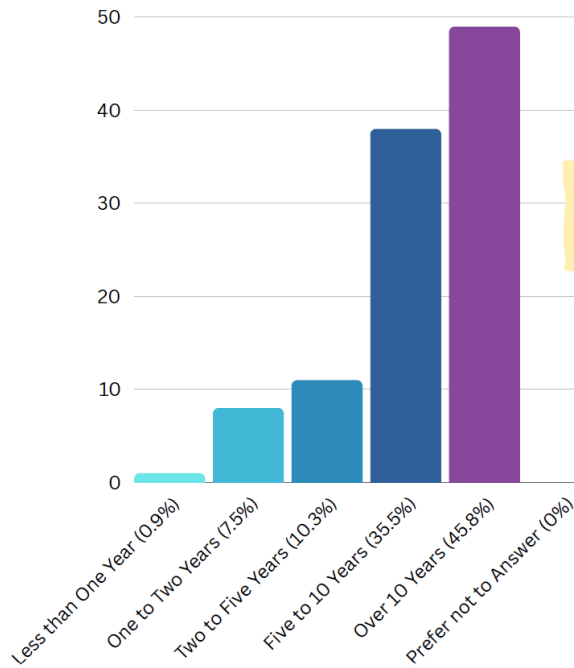
Question 4 (LACs, LMACs, and LCACs). How many years have you practiced the addiction counseling profession (if applicable, you may include years practicing in other states)?

LAC Responses



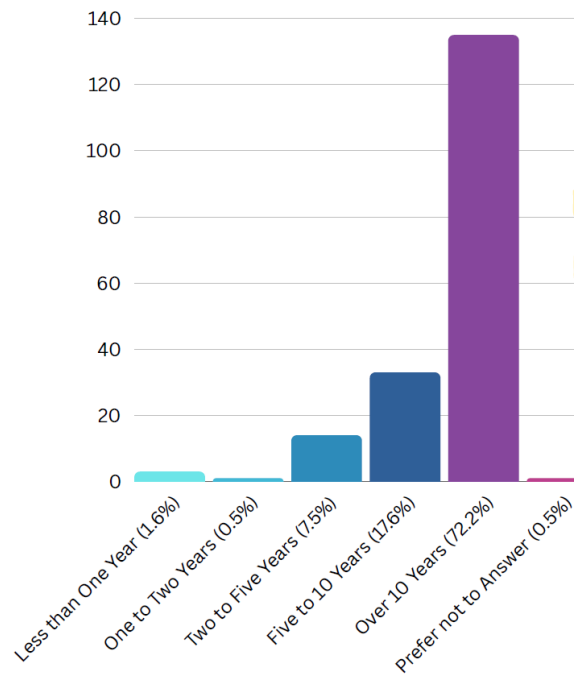
Of the 127 LACs that answered question 4, 88 individual worked more than 10 years (69%), 28 individual worked between five and 10 years (22%). All other responses were less than 6%.

LMAC Responses



Of the 107 LMACs who answered question 4, 48 respondents reported practicing addiction counseling over 10 years (45.8%), followed by 39 individuals practicing five to 10 years (35.5%), then 11 individuals selected between two and five years (10.3%). All other responses were under 8%.

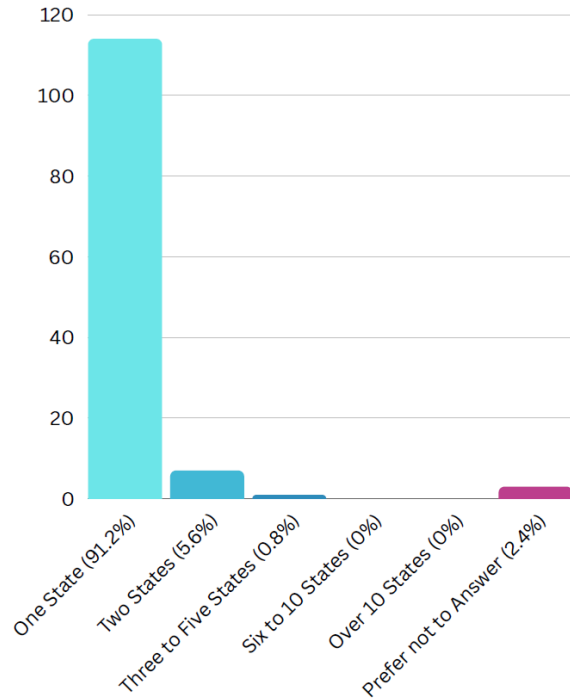
LCAC Responses



Of the 187 LACs that answered question 4, 135 individual worked more than 10 years (72.2%) and 33 individual worked between five and 10 years (17.6%). All other answers were less than 8.0%.

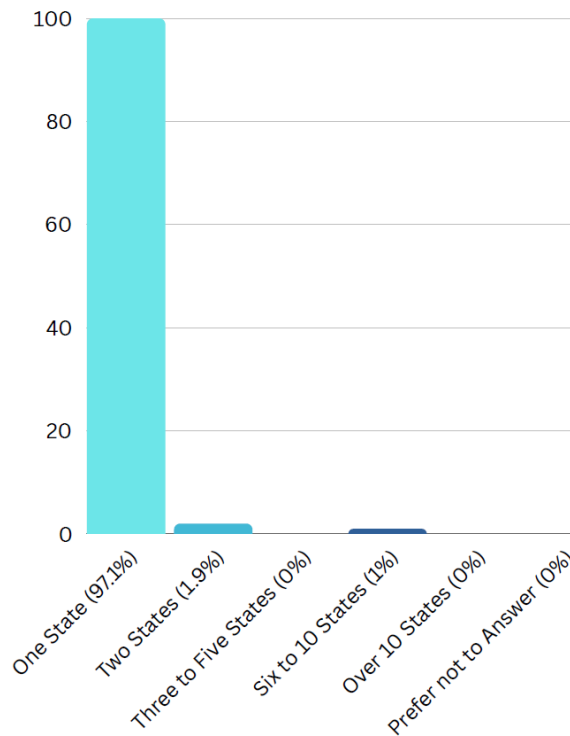
Question 5 (LACs, LMACs, and LCACs). Including Kansas, in how many states are you licensed/certified/registered to provide addiction counseling services between all states?

LAC Responses



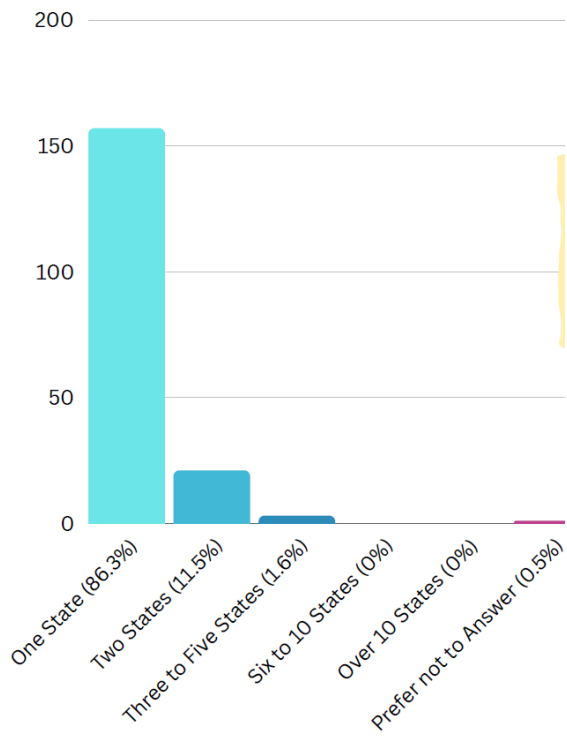
Of the 125 LACs who answered question 5, 114 individuals reported being authorized to practice in one state (91%). All other responses were less than 6%.

LMAC Responses



Of the 103 LMACs who answered question 5, the most popular responses were from 100 individuals licensed to practice in one state (97.1%). All other responses were less than 2%.

LCAC Responses



Of the 182 LCACs who answered question 5, the most popular responses were from 157 individuals licensed to practice in one state (86.3%), then 21 individuals who selected two states (11.5%). All other responses were less than 2%.

Question 6 (LAC, LMAC, and LCAC). Do you maintain an active license, but no longer work as an addiction counselor? If so, please explain why you are not providing services currently.

LAC Responses

Ninety-two Licensed Addiction Counselors answered this question, identifying reasons why individuals might maintain an active license but not provide services. (Responses for all licensees can be found in Appendix #4 on page #45).

The most frequent survey response (sixty-two responses) was that this did not apply to respondents. One respondent, however, is considering changing careers due to a lack of opportunities for LAC licensees.

Twenty-nine respondents indicated maintaining an active license but not providing services, with the most frequently reported reason (seven responses) being that providing services is not required with their current job. Other reasons reported included:

- The pay is higher in other careers;
- Provide services only when needed or short-staffed; and
- Work in private practice with a different license.

Additionally, two respondents stated that while this currently applies to them, they plan to return to the field soon. Four respondents also indicated being retired, and they maintain their license in case they decide to start working again.

LMAC Responses

Eighty Licensed Master's Addiction Counselors answered this question, providing insight into why individuals might maintain an active license without providing services. (Responses for all licensees can be found in Appendix #5 on page #47).

The most frequent survey response (fifty-nine responses) was that this did not apply to respondents. Of those who did report maintaining an active license but do not provide services, the most reported reasons for doing so included:

- Providing mental health services under a different license;
- Providing services is not a requirement of their current job;
- Providing supervision but not services; and
- Addiction counseling licenses are too limited.

LCAC Responses

One hundred and twenty Licensed Clinical Addiction Counselors answered this question, providing insight into reasons why licensees might maintain an active license but not provide services. (Responses for all licensees can be found in Appendix #6 on page #49).

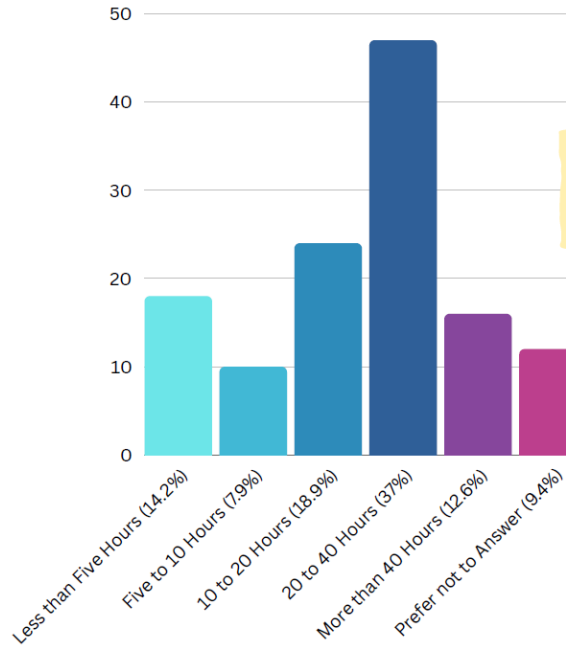
Seventy-six respondents reported that this did not apply to them. Of those who reported that the above scenario applied to them, the most frequently reported reason why (seventeen responses) was because providing services is not required with their current job. Some common jobs included those in administration, consultation, management, and jobs in educational settings.

Other reasons why licensees reported maintaining an active license but not providing services included:

- Primarily does mental health work under a different license (twelve responses);
- Provides supervision (six responses);
- Retired but maintains in case they decide to return to work (four responses);
- Use license only in disasters or emergency situations (three responses);
- Too many issues with insurance billing (two responses);
- Too low of pay in the field (two responses); and
- Live in another state (two responses).

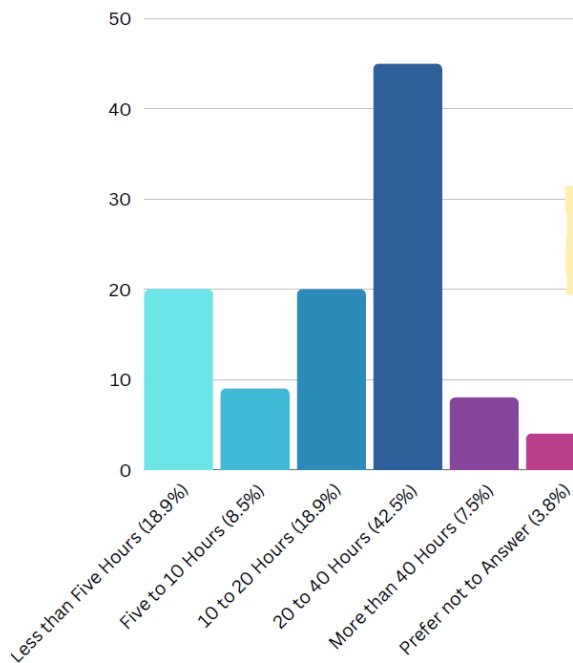
Question 7 (LAC) In a typical week, how many hours do you provide in-person services to clients?

LAC Responses



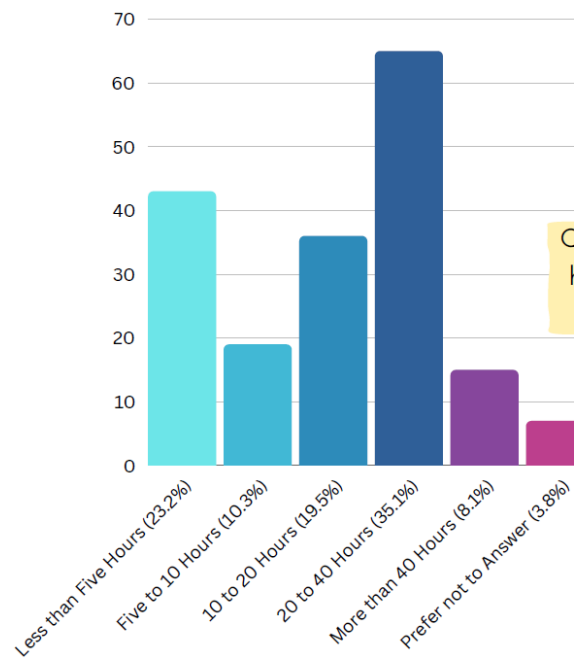
Of the 127 LACs who answered question 7, 47 individuals reported providing between 20 hours and 40 hours of in-person services per week (37.0%), followed by 24 respondents who provide between 10 hours to 20 hours of in-person services per week (18.9%), then 18 individuals reported providing fewer than 5 hours of in-person services per week (14.2%), and 16 individuals reported providing more than 40 hours of in-person services per week (12.6%). All other responses were less than 10.0%.

LMAC Responses



Of the 106 LMACs who answered question 7, 45 individuals reported providing between 20 hours and 40 hours of in-person services per week (42.5%), followed by 20 individuals who reported providing between 10 hours to 20 hours of in-person services per week (18.9%) and 20 individuals providing fewer than five hours of in-person services per week (18.9%). All other responses were less than 10%.

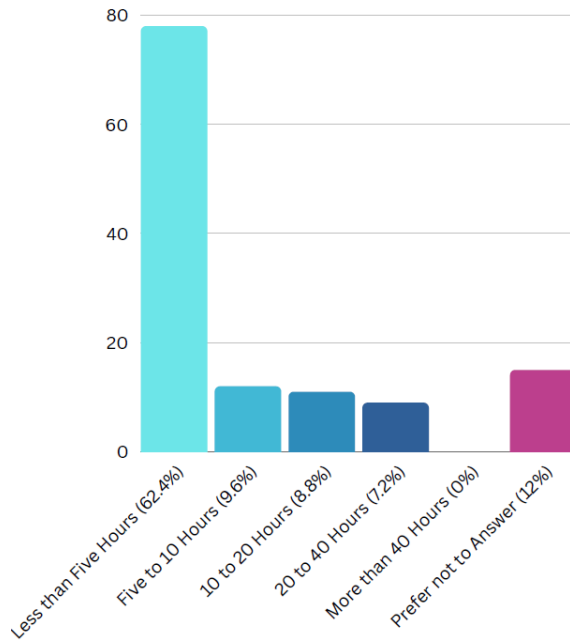
LCAC Responses



Of the 186 LCACs who answered question 7, the most popular responses were from 65 individuals providing between 20 hours and 40 hours of in-person services each week (35.1%), followed by 43 respondents providing fewer than five hours of in-person services per week (23.2%), then 36 individuals providing between 10 hours and 20 hours of in-person services per week (19.5%), and 19 individuals providing between five hours and 10 hours of in-person services per week (10.3%). All other responses were less than 10.0%.

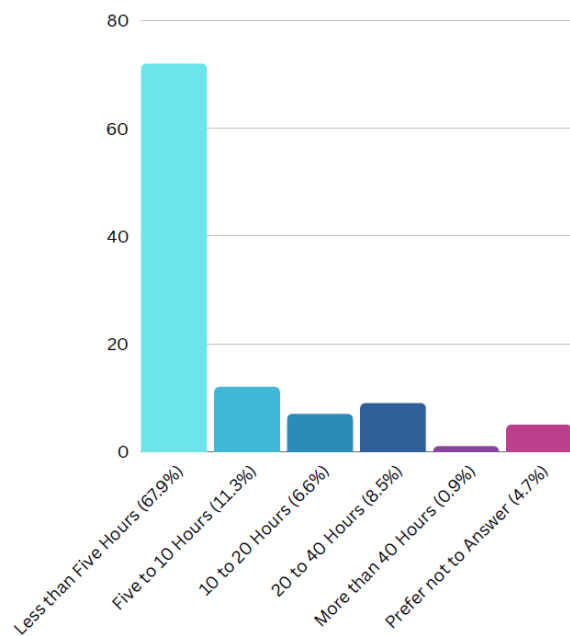
Question 8 (LAC). In a typical week, how many hours do you provide telehealth/remote services to clients?

LAC Responses



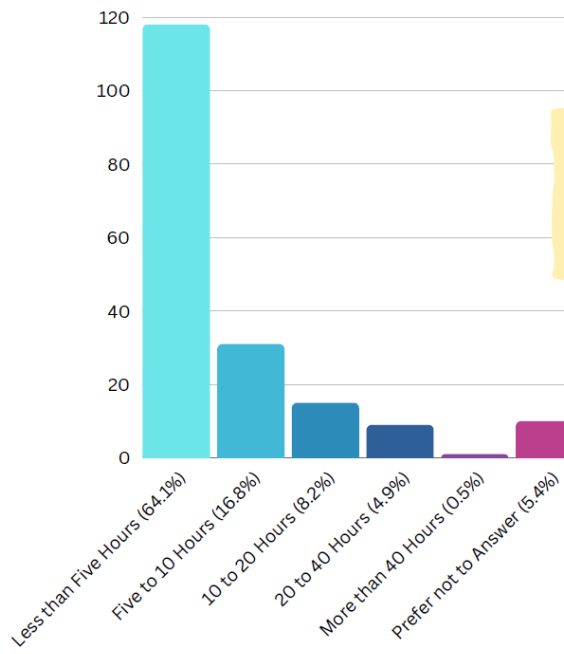
Of the 125 LACs who answered question 8, 77 individuals reported providing less than five hours of remote services per week (62.4%) and 15 individuals preferred not to answer (12.0%). All other responses were under 10%.

LMAC Responses



Of the 106 LMACs who answered question, the most popular response was 72 individuals providing fewer than five hours of remote services per week (67.9%), followed by 12 individuals providing between five to 10 hours of remote services per week (11.3%). All other responses were less than 10.0%.

LCAC Responses



Of the 184 LCACs who answered question 8, the most popular response was 118 individuals providing less than five hours of remote services per week (64.1%), then 31 individuals providing between five to 10 hours of remote services per week (16.8%). All other responses were lower than 10.0%.

Question 9 (LAC). Are you currently working towards attaining a Licensed Master’s Addiction Counseling (LMAC) license in Kansas? / (LMAC) Are you currently working towards attaining a Licensed Clinical Addiction Counseling (LCAC) license in Kansas? If you are not taking steps to receive such license, please explain why you made that decision.

LAC Responses

One hundred and seventeen Licensed Addiction Counselors answered this question. (Responses for all licensees can be found in Appendix #7 on page #51).

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LMAC Responses

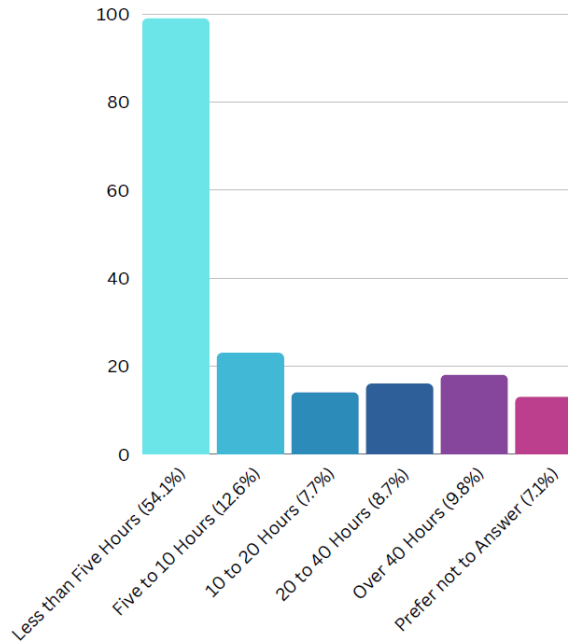
One hundred Licensed Masters Addiction Counselors answered this question. (Responses for all licensees can be found in Appendix #8 on page #54).

The most frequent survey response was

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

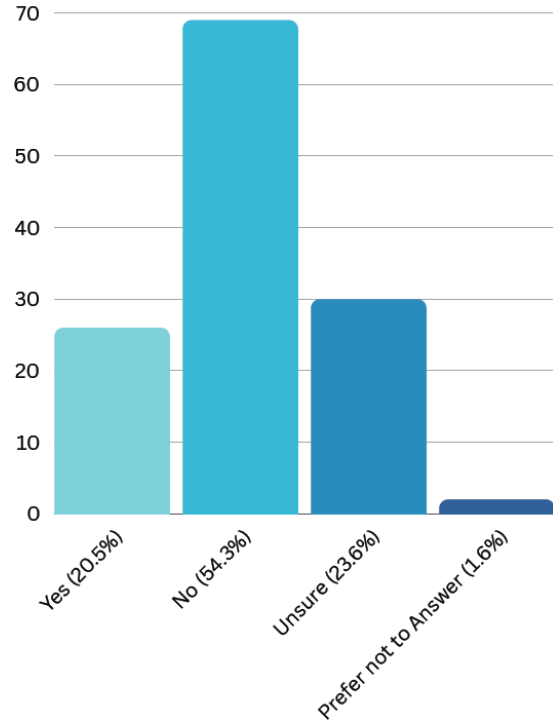
LCAC Responses



Of the 184 LCACs who answered question 9, 99 individuals reported less than five hours per week (54.1%), followed by 23 individuals reporting between five and 10 hours per week, then between 20 to 40 hours (12.6%). All other responses were less than 10.0%.

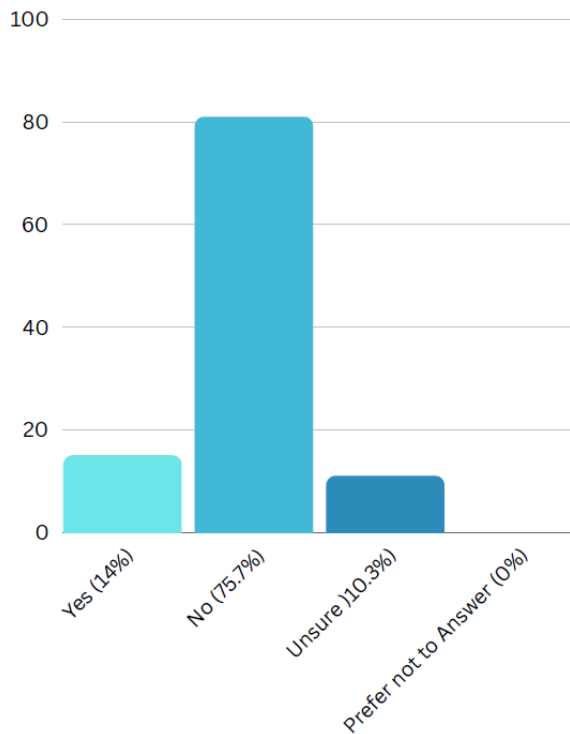
Question 10 (LAC, LMAC, and LCAC). Do you anticipate retiring from the addiction counseling profession in the next five years?

LAC Responses



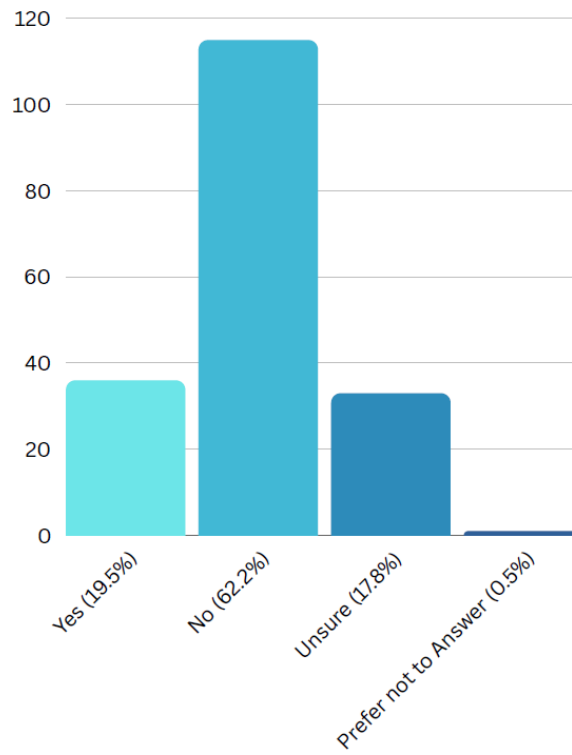
Of the 127 LACs who answered question 10, 69 respondents answered “no” (54.3%), followed by 30 individuals selecting “unsure” (23.6%), then 26 individuals selected “yes” (20.5%). Other responses were under 2.0%

LMAC Responses



Of the 107 LMACs who answered question 10, the most common response, 81, was “no” (75.7%), followed by 15 individuals selecting “yes” (14.0%), and 11 individuals selected “unsure” (10.3%).

LCAC Responses



Of the 185 LCACs who answered question 10, the most common answer, 115, was “no” (62.2%), followed by 36 respondents selecting “yes” (19.5%), then 33 individuals selected “unsure” (17.8%). Other answers were less than 1.0%.

Question 11 (LAC, LMAC, and LCAC). Currently, no multi-state compact exists for the addiction counseling 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.

LAC Responses

One hundred and eighteen LACs answered this question. (Responses for all licensees can be found in Appendix #9 on page #57.)

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LMAC Responses

One hundred and two LMACs answered this question. (Responses for all licensees can be found in Appendix #10 on page #60.)

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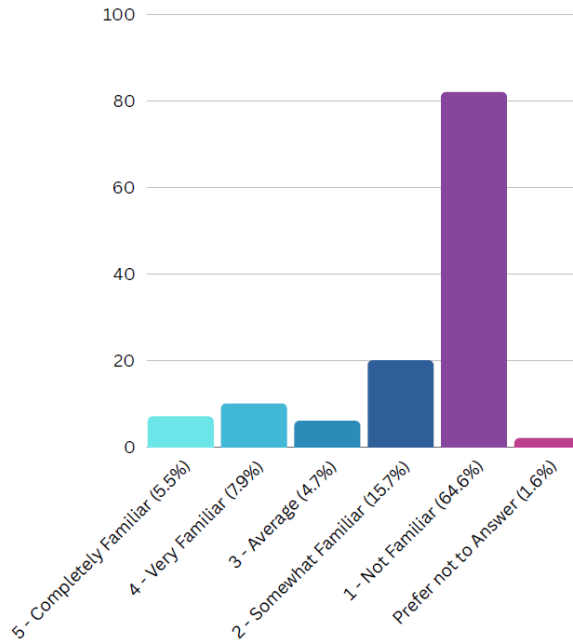
LCAC Responses

One hundred and seventy-nine LCACs answered this question. (Responses for all licensees can be found in Appendix #11 on page #63.)

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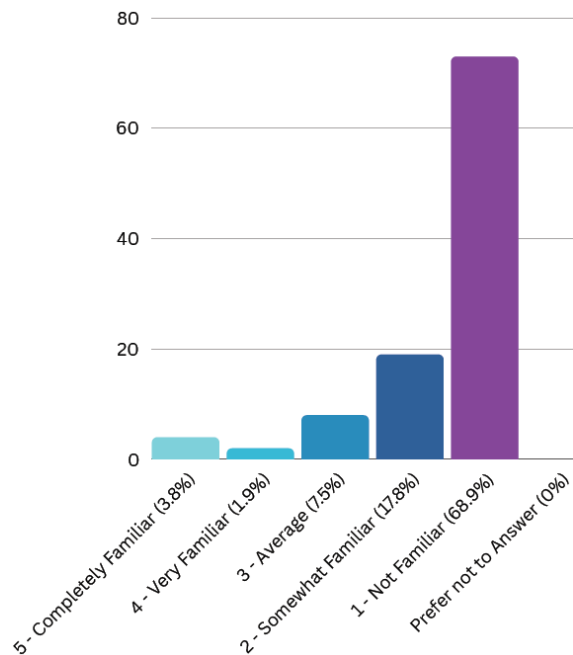
Question 12 (LAC, LMAC, and LCAC). To assist the work of the Board, the BSRB has seven standing Advisory Committees (one for each profession regulated by the Board), which are primarily composed of licensees in each of the seven professions. Advisory Committees discuss topics relevant to the work of the Board and make recommendations back to the Board on potential changes to statutes and regulations governing the profession. These meetings are broadcast on the BSRB YouTube channel every-other-month. On a scale of 1 to 5, how familiar are you with the work of the Addiction Counseling Advisory Committee?

LAC Responses



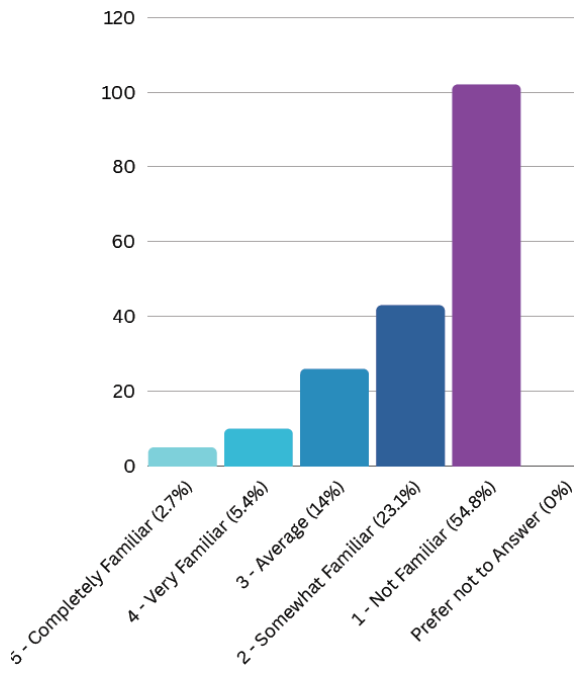
Out of the 127 LACs that answered question 12, 82 individuals selected “not familiar” (64.6%) and 20 individuals noted they were somewhat familiar with the work of the Advisory Committee (15.7%). All other responses were under 10.0%

LMAC Responses



Out of the 106 LMACs that answered question 12, 73 individuals reported no familiarity with the Advisory Committee (68.9%), followed by 19 individuals noting they were somewhat familiar with the work of the Advisory Committee (17.8%). All other answers were less than 8.0%

LCAC Responses



Out of the 186 LCACs that answered question 12, 102 individuals noted no familiarity with the work of the Advisory Committee (54.8%), followed by individuals noting they were somewhat familiar with the work of the Advisory Committee (14.0%), then respondents who noted an average level of familiarity (14.0%). All other answers were less than 6.0%.

Question 13 (LAC, LMAC, and LCAC). Over the past two years, based on your observations and experience practicing the addiction counseling profession, could you share information on any practice-related issues you have seen, such as areas where practitioners appeared to need more continuing education or training in a certain area? Please explain.

LAC Responses

One hundred and eleven Licensed Addiction Counselors answered this question, identifying practice-related negative issues that they have seen. (Responses for all licensees can be found in Appendix #12 on page #69).

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

Of the practice-related negative issues identified, the most commonly reported (twenty-one responses) was the need for more education and/or training in certain areas. Specifically, the following areas were reported to need more education and/or training in:

- Co-Occurring Disorders
- Cultural Competence
- Diversity
- Working with the Incarcerated Population
- Medication Assisted Treatment
- Evidence-Based Practices
- Treatment Plans
- Harm Reduction

While less commonly reported, other practice-related negative issues included:

- Directors not having degrees or licenses
- The LAC license is not recognized by private insurance
- Burnout
- The pay for the profession is too low
- There is a severe workforce shortage
- Lack of clinical support
- Education requirements for licensure are too restrictive

Additionally, fourteen respondents pointed to a number of ethical issues, including inappropriate/unethical relationships, poor boundaries, bias, and treatment centers providing services without proper licensing to do so.

LMAC Responses

Eighty-nine Licensed Master's Addiction Counselors answered this question, providing insight into practice-related negative issues experienced and/or observed. (Responses for all licensees can be found in Appendix #13 on page #73).

Nineteen respondents indicated having experienced no practice-related negative issues.

Of those who reported practice-related negative issues, a recurring concern related to the belief that loosening addiction counseling licensing requirements for mental health providers to more easily meet requirements has increased the number of incompetent practitioners in the field.

Furthermore, there was a call for more education and/or training in the following areas:

- Medication Assisted Treatment
- Trauma
- Dual Diagnoses
- Ethics
- Relation Between Addictions and Mental Health
- Treatment
- Boundaries
- When to Refer
- 42 CFR (Part Two)

It is necessary to note that some respondents, while not citing specific areas needing more education/training, reported a need for more in-person training opportunities.

Other practice-related negative issues reported included scope of practice limitations, crossing ethical boundaries, “old school” practitioners, stigma, burnout, and the workforce shortage.

LCAC Responses

One hundred and fifty-nine Licensed Clinical Addiction Counselors answered this question, providing insight into practice-related negative issues that they have seen. (Responses for all licensees can be found in Appendix #14 on page #77).

Fifty-six respondents indicated having seen no practice-related negative issues.

Of the negative issues reported, they can be broken into five categories: areas needing more education and/or training, ethics issues, medication-assisted treatment (MAT) issues, ASAM issues, and other issues.

Respondents reported a need for more education and/or training in the following areas:

- Trauma
- Co-Occurring Disorders
- Harm Reduction
- Diagnoses
- Documentation
- Treatment
- Current Drug Trends
- Substance Abuse/SUD
- Coping Skills

- Aftercare Services
- Dual Relationships
- Sex/Pornography Addiction
- CFR-42 Part 2
- Tobacco
- Confidentiality/HIPPA
- Mental Health
- Video Game Addiction
- Gambling Addiction

Reported issues relating to ethics included:

- There has been a decline in ethical standards
- There has been an increase in ethical violations
- Practicing outside one's scope
- Boundary issues

Looking at issues concerning MAT, some respondents mentioned the valuable benefits and knowledge associated with MAT, while others believe that it is overprioritized. ASAM issues involved there being a lack of knowledge around ASAM and a lack of ASAM-certified providers. Other issues reported included:

- There is a shortage of addiction counselors (seven responses)
- Increased regulations limit counselors (six responses)
- New licensees are underprepared (six responses)
- Insurance issues (four responses)
- Lack of affordable CEUs
- Pay in the field is too low

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

LAC Responses

One hundred and ten Licensed Addiction Counselors answered this question, identifying a range of issues concerning telehealth. (Responses for all licensees can be found in Appendix #15 on page #83).

The most frequent survey response (seventy-seven responses) reported having experienced no issues concerning telehealth. After providing this response, some licensees mentioned their belief that telehealth is helpful and essential for rural areas.

Of the responses that pointed out telehealth issues, the most frequently reported statement was that telehealth should not be used for addiction or recovery services. These respondents also noted that in-person services should be used instead, and a few went so far as to call telehealth a “disservice.”

Other issues, opinions, and concerns regarding telehealth that were reported included:

- Telehealth is ineffective
- Internet/connectivity issues
- Telehealth should only be used in rural areas
- Telehealth has increased access to services
- It is good to have options for providing services
- Telehealth increases the potential for missed observations
- There are restrictions with providing telehealth to clients outside of Kansas.

LMAC Responses

Ninety-two Licensed Master’s Addiction Counselors answered this question, identifying issues concerning telehealth. (Responses for all licensees can be found in Appendix #16 on page #85).

Sixty-five respondents indicated having experienced no issues concerning telehealth. The following telehealth issues were reported being experienced by licensees:

- Technical difficulties (six responses)
- Do not like telehealth; prefer in-person services (six responses)
- More difficult to focus (five responses)
- People not being in private (four responses)
- Missed observations and body language (three responses)
- Telehealth is not ideal for addiction services and/or SUD treatment
- Difficulty in obtaining signatures and/or documentation
- Clients/providers being located outside of Kansas
- More difficult to build rapport

LCAC Responses

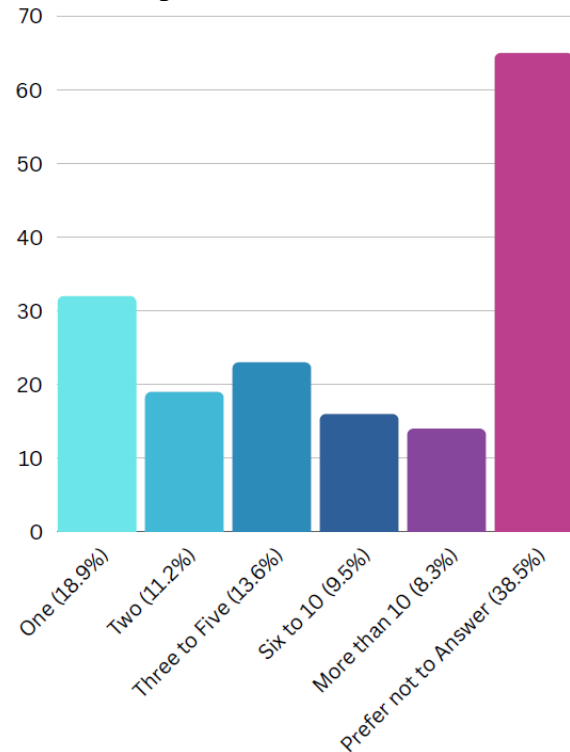
One hundred and sixty-four Licensed Clinical Addiction Counselors answered this question, providing insight into issues concerning telehealth. (Responses for all licensees can be found in Appendix #17 on page #87).

The most frequent survey response (one hundred and nineteen responses) was that respondents had not experienced any issues concerning telehealth. After providing this response, seven respondents reported supporting telehealth and its positive impact on access to care.

Regarding issues identified, the most common concerns focused on confidentiality, insurance, missed body language, audio-only services, increased distractions, and obtaining documentation. It was also reported that face-to-face services are better fit for providing addiction services. Reports of clients/providers failing to be in private settings and it being more difficult to build rapport with telehealth services were also made.

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

LCAC Responses



Out of the 169 LCACs that answered question 15, 65 individuals selected “prefer not to answer” (38.5%), followed by 32 individuals reporting supervision one person (18.9%), then 23 individuals noted they were supervising between three to five people (13.6%), then 19 individuals reported supervising two people (11.2%). All other responses were under 10.0%. *Note:* In a survey drafting error, the option of “zero” was not provided, which is believed to account for the high response in the “prefer not to answer” category.

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

LAC Responses

One hundred and ten Licensed Addiction Counselors answered this question, identifying negative issues involving supervision. (Responses for all licensees can be found in Appendix #18 on page #90).

The most frequent survey response (ninety-five responses) was that licensees had experienced no negative issues involving supervision.

Of the responses that identified negative issues involving supervision, one of the two main issues is a lack of real, proper supervision. Specifically, licensees report having direct supervisors who are not addiction counselors, poor support from supervisors, and experiences with supervisors being unprofessional.

Staffing issues are the second main issue reported. Specifically, there were issues reported with turnover, the shortage of addiction counselors, and providers being underpaid for the caseloads that they are managing.

LMAC Responses

Ninety-one Licensed Master's Addiction Counselors answered this question, identifying negative issues involving supervision. (Responses for all licensees can be found in Appendix #19 on page #91).

Seventy-five respondents indicated experiencing no negative issues involving supervision.

The most frequently reported negative issues involving supervision included:

- Unqualified supervisors
- It is difficult to find supervisors
- Supervisors do not seem to have enough time for individual supervision

Furthermore, respondents cite several supervisor-specific issues, including having supervisors who were unprofessional, disrespectful, overworked, unsupportive, unethical, and unwilling to provide solutions.

LCAC Responses

One hundred and sixty Licensed Clinical Addiction Counselors answered this question, identifying negative issues involving supervision. (Responses for all licensees can be found in Appendix #20 on page #93).

One hundred and thirty-nine respondents indicated having experienced no negative issues involving supervision.

Regarding negative issues identified, the most common issues with supervisees focused around supervisees neglecting self-care and having manipulation issues. Issues regarding supervisors focused on no-shows, last minute session cancellations, and untrained/unqualified supervisors. Other supervision issues reported included:

- It being difficult to find the time to adequately supervise
- Supervisors not being licensed in addiction counseling
- Employees engaging in unprofessional/unethical behaviors/practices
- Turnover
- Lying
- The belief that the hour requirement for clinical licensure is too low
- Supervision is inconsistent and lacking structure

Question 16 (LAC and LMAC)/Question 15 (LCAC). Do you currently use artificial intelligence (AI) in your practice? If you do, in what areas do you use AI?

LAC Responses

One hundred and twenty-seven Licensed Addiction Counselors answered this question, identifying uses of AI in practice. (Responses for all licensees can be found in Appendix #21 on page #95).

The most frequent survey response (one hundred and three responses) was that licensees do not use AI in their practices. After providing this response, some licensees mentioned needing to learn more about AI before using, and others reported looking into using AI in the near future.

Seven respondents indicated that they use AI in their practice. Specifically, areas of AI use included note-taking, treatment planning, and trainings.

LMAC Responses

One hundred and seven Licensed Master's Addiction Counselors answered this question, identifying areas of AI use in practice. (Responses for all licensees can be found in Appendix #22 on page #96).

The most frequent survey response (eighty-eight responses) was that licensees do not use AI in their practice. After providing this response, some respondents mentioned planning to implement soon, while others believe that AI use is unethical. Some licensees also expressed not wanting to use AI because their clients are not comfortable with use.

The uses of AI reported included using for notes, coming up with ideas, and documentation purposes.

One respondent noted that, while their practice has implemented the use of AI, they remain distrustful of it.

LCAC Responses

One hundred and eighty-seven Licensed Clinical Addiction Counselors answered this question, providing insight into the uses of AI in practice. (Responses for all licensees can be found in Appendix #23 on page #97).

Thirty-four respondents indicated that they do not use AI in their practice. After providing this response, four respondents reported that they are actively working to implement AI use and three reported being interested in AI. Other licensees followed up this answer by stating that best practices need to be established before they would be comfortable with using AI. Two expressed having no interest in AI use.

The most reported area of AI use (eighteen responses) was for notes purposes. While less commonly reported, other areas of AI use included:

- Treatment Plans/Reports

- Grammar/Formatting Checks
- Research/Information Gathering
- Documentation
- Generating Handouts/Educational Materials

Additionally, it was stated that insurance companies use AI to review documentation, so any clinician accepting insurance is exposing client data to AI technology. Furthermore, three AI platforms were named by licensees who use them; these AI platforms were Eleos, Adobe, and TherapyNotes.

Question 17 (LAC and LMAC)/Question 18 (LCAC). Based on your experience as a licensee in Kansas, do you have any recommendations on additional ways the BSRB could protect and serve and consumers of services offered by BSRB licensees?

LAC Responses

One hundred and seven Licensed Addiction Counselors 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 #24 on page #99).

Sixty-nine respondents reported having no recommendations to provide. The following lists frequently reported recommendations:

- Get more providers in the field to address the workforce shortage;
- Loosen educational requirements for LAC licensure;
- Limit the maximum number of clients on practitioners' caseloads;
- Limit group therapy sizes; and
- Make number of years practicing a component/pathway to clinical licensure.

Additionally, there were recommendations for more training in ethics, evidence-based practices, culture and diversity, HIPPA and confidentiality laws, and the long-term impacts of prescription drugs.

Some licensees also commented on peer mentors, recommending that the BSRB looks at guidelines and create clear boundaries regarding how they differ from licensed counselors.

LMAC Responses

One hundred and six Licensed Master's Addiction Counselors 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 #25 on page #102).

The most frequent survey response (fifty-one responses) was that respondents had no additional recommendations to provide. Of the recommendations provided, they can be broken into four main categories: BSRB-specific, application-specific, CEU-specific, and other recommendations.

BSRB-specific recommendations included hiring more BSRB employees, prioritizing more communication between the BSRB and licensees, and recommendations to create a multi-state compact.

Application-specific recommendations included requiring more professional references, getting rid of the examination requirement, and making the application process quicker.

CEU-specific recommendations included offering free or affordable CEUs. Additionally, it was recommended that CEUs be required in the areas of boundaries, dual relationships, co-occurring disorders, and professional conduct/development.

Other recommendations included addiction counselors needing more funding and resources, and loosening license restrictions and clinical requirements.

LCAC Responses

One hundred and fifty Licensed Clinical Addiction Counselors 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 #26 on page #104).

Ninety-five respondents indicated having no recommendations to provide.

Of the recommendations provided, examination-specific recommendations included making the licensing examination easier and providing study materials for it. Other frequently reported recommendations included:

- Creating/joining a multi-state compact (eight responses)
- Advocating for better/consistent insurance reimbursements (four responses)
- Addiction counselors need better pay (four responses)
- The number of licensed addiction counselors needs to increase (three responses)
- Ensure that professional boundaries and standards are maintained (three responses)
- Educate the public about services provided by addiction counselors (three responses)
- Reduce access barriers (two responses)
- Provide more clarity on scope of practice (two responses)

Furthermore, some respondents made comments about reducing licensure requirements, stating that such a move reduces competency, is a public safety issue, and is not the solution to addressing the workforce shortage.

Question 18 (LAC and LMAC)/Question 19 (LCAC). Do you have any other comments or feedback you think would be helpful for the members of the Addiction Counseling Advisory Committee of the BSRB to receive when evaluating possible changes to the statutes and regulations for the addiction counseling profession? Please explain.

LAC Responses

Ninety-seven Licensed Addiction Counselors answered this question, providing comments and feedback that they think would be helpful for the members of the Advisory Committee. (Responses for all licensees can be found in Appendix #27 on page #109).

Sixty-nine respondents indicated having no other comments or feedback to provide. Of those who did provide comments and/or feedback, some individuals expressed disappointment in barely missing being grandfathered.

Additionally, comments were made concerning the student LAC license, specifically that there needs to be quicker approval times and clear guidelines on what these licensees can and cannot do. There were also field-specific comments made, particularly the recommendation to explore creating an incentive program for entering the field to help in addressing burnout, the workforce shortage, and current unmanageable caseloads.

LMAC Responses

Seventy-six Licensed Master's Addiction Counselors answered this question, providing comments and feedback that they found helpful for the members of the Advisory Committee. (Responses for all licensees can be found in Appendix #28 on page #111).

Forty-five respondents indicated having no other comments or feedback to provide. Of those who did have comments and/or feedback to provide, one area of focus for respondents was on clinical licensure requirements. Specifically, while some respondents recommend reducing clinical licensure requirements, others say to stop loosening requirements that is, by extension, decreasing the quality of services and causing people to leave the profession.

Other comments and/or feedback reported included:

- Allow for easier dual licensing;
- Practitioners need more flexibility;
- Stop licensing uneducated/undereducated social workers as addiction counselors;
- Supervisors should have higher licenses than their supervisees; and
- Address the workforce shortage by creating incentives for entering the field.

LCAC Responses

One hundred and forty Licensed Clinical Addiction Counselors answered this question, providing comments and feedback that might be helpful for members of the Advisory Committee to receive when evaluating possible recommendations for changes to the statutes and regulations for the addiction counseling profession. (Responses for all licensees can be found in Appendix #29 on page #113).

Ninety-three respondents indicated having no other comments or feedback to provide. Of those who did provide comments and feedback, there was a reported need for more education/training in the following areas: dual diagnoses, treatment, competency, trauma-based therapies, de-escalation, boundaries, and scope of practice.

The following lists frequently reported comments/feedback:

- There is a need for a better trained workforce;
- Addiction Counseling licenses are too limited;
- Allow LMACs and LCACs to provide counseling services;
- Create a multi-state compact/license;
- Addiction Counselors need better pay;
- It is difficult to find and maintain good counselors;
- Create incentives for entering the field; and
- Provide clarity on the different levels of licensure and what each level is allowed to do.

There were also reports made about issues with the Kansas Department of Aging and Disability Services (KDADS). Additionally, while some respondents reported supporting the student addiction license and its support in addressing the workforce shortage, others share concerns and their view that this license type should not be offered.

LAC Q1. In what Kansas county/counties do you practice the profession of addiction counseling? (126 Responses)
All
Allen, Anderson, Bourbon, and Linn
Allen, Labette, Montgomery, Neosho, Wilson, Woodson
At
Barton
Barton, Ellis, and Russell
Barton, Ellis, Finney, Ford, and Seward
Bourbon
Brown, Doniphan, Jackson, and Nemaha
Butler and Sedgwick
Butler, Cowley, Greenwood, Harper, Harvey, Kingman, McPherson, Reno, Sedgwick, and Sumner
Cherokee
Clay, Cloud, Geary, Jewell, Marshall, Mitchell, Pottawattamie, Republic, Riley, and Washington
Cloud (2 responses)
Cloud, Geary, Marshall, Riley, and Saline
Cowley
Cq, Elk, Mg, and Wilson
Crawford (2 responses)
Crawford, Cherokee, Burbon, Labette, Neosho, and Montgomery
Decatur, Ellis, Osborne, Norton, Phillips, Rawlins, Rooks, Rush, Sherman, Smith, and Thomas
Douglas (2 responses)
Douglas and Shawnee
Douglas, Leavenworth, and Shawnee
Ellis (3 responses)
Ellis and Thomas
Finney
Finney and Lane
Ford (2 responses)
Harvey
Jasper City, MO, and Crawford County, KS
Johnson (10 responses)
Johnson and Wyandotte (5 responses)
Kansas
Labette
Leavenworth and Wyandotte
McPherson
Montgomery
Neosho County
None (3 responses)
Norton (2 responses)
Not working in the field
Primarily Labette

Appendix #1

Reno and surrounding areas
Reno County (3 responses)
Saline (4 responses)
Sedgwick and Butler
Sedgwick (40 responses)
Sedgwick County
Sedgwick,
Sedgwick, Butler
Seventy-Two
Shawnee (7 responses)
Shawnee and Wyandotte
Thomas

LMAC Q1. In what Kansas county/counties do you practice the profession of addiction counseling? (106 Responses)
Allen
Allen and Neosho
Atchison (4 responses)
Atchison, Douglas, Leavenworth, Wyandotte, Johnson, Crawford, Cherokee, Neosho, Labette
Barton
Barton and Riley
Bourbon and Crawford
Brown, Doniphan, Douglas, Johnson, Marshall, Nemaha, Shawnee, and Wyandotte
Brown, Doniphan, Jackson, and Nemaha
Butler, Crowley, Johnson, Riley, Sedgwick, Shawnee, and Wyandotte
Butler, Reno, and Sedgwick
Chautauqua
Chautauqua, Elk, Montgomery, and Wilson
Clay, Cloud, Geary, Jewell, Mitchell, Pott, Republic, Riley, and Washington
Clay, Cloud, Geary, Jewell, Mitchell, Pottawatomie, Republic, and Riley
Clay, Cloud, Pottawatomie, Riley, and others
Comanche
Cowley
Crawford
Dickinson, Geary, and Saline
Douglas (7 responses)
Douglas County and Johnson County
Ellis (2 responses)
Ellis, Graham, Phillips, and Thomas
Ellsworth, Lincoln, and Saline
Finney
Ford (3 responses)
Geary and Sedgwick
Harvey
Harvey and Reno
Harvey, Marion, and Sedgwick
I was primarily serving members in Shawnee County but will now be focusing on Lyon and surrounding counties.
Johnson (18 responses)
Johnson and Wyandotte (2 responses)
Johnson County primarily and a variety of counties via telehealth
Johnson, Leavenworth, and Wyandotte
Labette
Lyon (2 responses)
Many counties
Miami and Franklin
N/A
Pottawatomie
Saline (5 responses)

Saline—and across Kansas via telehealth
Sedgwick (18 responses)
Shawnee (6 responses)
SW Kansas
Wyandotte (2 responses)

LCAC Q1. In what Kansas county/counties do you practice the profession of addiction counseling? (186 Responses)

...

104

20 counties in the catchment area of High Plains Mental Health Center.

about 45 counties in central Kansas by telemedicine

All due to telehealth

All over kansas, heavily in western kansas (remote work)

Atchison (2 responses)

Atchison, Jefferson, and Leavenworth

Barber

Barber and Harper

Barton (2 responses)

Barton, Finney, Ford, Saline, Sedgwick, and Seward

Bourbon, Cherokee, Crawford, Johnson, Labette, Linn, Miami, Neosho, and Sedgwick

Brown, Doniphan, and Nemaha

Butler (2 responses)

Butler and Sedgwick (2 responses)

Clark, Comanche, Edwards, and Kiowa

Clay

Cloud, Republic.

Coffey, Franklin, Lyon, Shawnee, Osage, and several others for jail evaluations

Cowley and Sedgwick

Crawford

Crawford (In person) all other Kansas counties (tele)

Dickinson, Geary, Saline, and Shawnee

Douglas (17 responses)

Douglas and Shawnee (2 responses)

Douglas, Cloud, Shawnee

Ellis (2 responses)

Ellis and Graham

Ellis and Thomas

Ellis, Phillips, and Rooks

Ellis, Rush, Trego

Federal Govt

Finney

Franklin (2 responses)

Franklin, Johnson, and Miami

Ft. Riley

Geary

Geary/Riley Counties on Fort Riley

Harvey and Marion

Harvey and Sedgwick

Harvey, Marion, and McPherson (2 responses)

Harvey, Sedgwick, Shawnee, Johnson

I used to practice in Allen county, now in Pawnee County
Jackson
Johnson (27 responses)
Johnson and Wyandotte
Kansas
Labette (2 responses)
Leavenworth (2 responses)
Lenexa and Miami
Liberal
Lyon (5 responses)
McPherson and Sedgwick
Miami and Franklin (2 responses)
N/A - I'm in Nebraska but do telehealth with Kansas residents
N/A (4 responses)
NE Kansas counties
New York (2 responses)
Norton
Not currently practicing, but did work in Shawnee County
Olathe
Osbourne, Rooks, Russell, and Smith
Overland Park KS
Pawnee
Primarily Sedgwick County, but I offer teletherapy and have clients in multiple counties
Reno (4 responses)
Reno and Sedgwick
Riley (7 responses)
Saline (2 responses)
Sedgwick (25 responses)
Sedgwick and throughout via telehealth
Seward
Shawnee (10 responses)
Sherman
Sumner
Topeka
Wyandotte (4 responses)
Wyandotte County but services are available for 76 counties in Kansas

LAC Q6. Do you maintain an active license, but no longer work as an addiction counselor? If so, please explain why you are not providing services currently. (92 responses)

24
Active and currently work In the field
Active license and I work in the treatment field.
Active license, I work in the public sector of an addiction recovery center
Administration
Currently maintain an active license and am still working as an addiction counselor.
Currently working in the construction field. I've owned my own company since 1989.
Disabled
Employed as an LAC
Employed part-time
Had to take time off to care for a family member.
I am active and work in the field.
I am actively working as a LAC.
I am currently employed as an LAC
I am currently working and maintaining my license.
I am not working but looking for part time at this time.
I am over 65 and I have retired. I might want to start counseling again part time so I'm keeping my license active for now.
I am retired but I occasionally provide services as needed to a local treatment center when they are short-handed.
I am still practicing
I do not currently have a caseload, but I keep it so I can help with intakes, keep up with current SUD regs.
I have a current license, I took a break, currently not active but am ready to get back at serving, sponsoring others at this time.
I have a license and work as a counselor.
I have an active license
I mainly do private practice therapy as my primary work as I am dually licensed as a LSCSW.
I maintain my KS license in case I ever move back to Kansas or if I'm able to practice remotely, which is what I want to do.
I maintain my LAC in addition to my LMSW license and work primarily in private practice.
I practice
I still work with a license
I work in a prison as an institutional parole officer. The pay is significantly higher than treatment centers can offer. And there are so few providers in this part of the state anymore that I wouldn't be able to find a job anyway.
I worked in family services for years and only recently started back in addictions but I had to retest for MO because of no transfer rules. It's been so difficult.
I'm practicing
In the past, I kept my license up for 7 yrs while raising my kids. I am currently working in the field.
Maintain my license- worked too hard to obtain it, to not maintain it.

No (36 responses)
No- active license and currently practicing
No I still work in the field
No, but I'm strongly considering working in a different field that is unrelated to addiction counseling because of the lack of work. I've been working as an independent contractor in a licensed substance use program doing mostly telehealth-based treatment services for the past 12 months. I've applied for a couple of full-time positions but haven't has any job offers yet. Before this I worked full-time for four years in various positions and levels of care. During the pandemic I worked at an opioid treatment clinic. There just aren't enough opportunities for LACs where I live. Many of the openings are in either Missouri or another KS county which would require a commute of 40 minutes or longer each way.
No, still working as an addiction counselor and license is still active.
No, work in field
No. I have an active license and still practicing.
No. I work in the field
Retired (3 responses)
Retired from DCF in 2000 but still maintain my LBSW and LAC in case I would want to reenter the workforce
Still work
Yes - low pay options
Yes I am a director and oversee program improvement
Yes, I accepted a position a leadership position for an SUD provider. I maintain an active license but no longer do client facing work.
Yes, I have a job that doesn't pertain to addiction counseling, but allows me to still work with that population amongst others. Treatment doesn't pay as well and is harder to find jobs within my living area.
Yes, I have an active license
Yes, I retired last year.
Yes, It is not paying enough
Yes. I am currently employed with as a LMSW
Yes. I can make more money in the legal field. Better management.
Yes. Use only as needed.
Yes.

LMAC Q6. Do you maintain an active license, but no longer work as addiction counselor? If so, please explain why you are not providing services currently. (80 responses)

Active

Currently in a supervisory position and provide minimal direct service hours.

Currently work in SUD at VA under Mental Health Clinic as social worker

I am actively maintaining my license and providing services

I am currently only doing family nights because our KCK office was closed,

I am not currently working as an addiction counselor because the licensure is too limited. SW can provide addiction counseling w/o any additional credentials. Most practices are looking for a licensure that is more flexible.

I am supervising an evidence-based service delivery model to address parental substance use with a focus on child welfare. Although I do engage in client recovery supports, I am not providing treatment.

I continue to practice with an active license.

I have an active license, but my position is admission counselor. I primarily do assessments on incoming patients in a residential setting for a profit residential Treatment Facility .

I maintain licensure even though it is not required for my current job.

I maintain my license and I do adult therapy at my community mental health center. I do not provide exclusively addiction related services, but my knowledge and training in that area is used often with mental health clients.

I mostly practice in mental health but use the skills from my LMAC.

I mostly supervise

I still provide services

I work as an addiction counselor.

I work as an addictions counselor

I'm currently in private practice and do not hold an independent addictions license.

In private practice just recently and not billing in terms of treatment with LMAC however many clients have addictions. Only using LMSW to bill.

No (50 responses)

No I did not renew my license this year as I am retired from Drug and Alcohol Counseling

No, I remain active.

Opportunities, limited in my community.

Still working in the field

Supervising others. I'll cover a session here or there as needed.

The clinic I work for is not licensed for addiction. I use my expertise in addiction work at this location for dual diagnosis clients as we treat their mental health issues, and educate about how substances affect mental health.

Yes - administrative duties within my agency has increased

Yes - because I also hold a social work license and work as an outpatient therapist.

Yes, do not see clients one on one yet at new position and if i do see clients it's for the IDD agency I work at.

Yes, I live in Oklahoma where my licensure is not recognized. I'm not able to provide services with my current licensure.

Yes, Open Support more people with my clinical license

Yes, prefer behavioral health to addiction counseling. paperwork requirements for addiction are excessive.

LCAC Q6. Do you maintain an active license, but no longer work as addiction counselor? If so, please explain why you are not providing services currently. (120 responses)

Active (2 responses)

Active license and I practice

Admin role, provide supervision

Administration

Administrator and grant writer

Became a supervisor

Currently an active LCAC

Currently dropped out of state license and only work for state of Kansas where I reside. Cost and time is why I dropped the other state license.

Currently work on a military base with children

Does not apply

Educational setting primarily and clinical work aside from supervision is primarily mental health

I am a professor in the Counselor Education department at Emporia State University and teach addictions coursework. I practiced in addictions treatment from 1989 to 2014.

I am an LSCSW AND LCAC. I cannot bill for standalone addiction services.

I am an LSCSW at a high school and addiction counseling is a part of my job along with mental health counseling.

I am strictly a supervisor/manager of a team that provides addiction counseling.

I closed my substance abuse program, but still do evaluations and referrals.

I currently provide services, but I also am the CEO for the Breakthrough House in Topeka.

I currently work as an addiction counselor

I did not renew with KDADS in 2020 and since provide Cognitive Behavioral Therapy

I do maintain a license but do not work in an addiction specific agency. I cannot maintain my life on the salaries for addictions counselors only. I DO use my knowledge within my practice of mental health therapy.

I do maintain and plan to do so for a couple years past retirement.

I have retired, but am retaining my license in case I might want to work.

I maintain it and provide addiction counseling in addition to LSCSW counseling

I see clients in private practice with co-occurring disorders. I am semi retired now. Only offer telehealth.

I took a different job that had much better benefits but had nothing to do with addiction counseling. So that is why I am not practicing at the moment.

I use my active license

I work as a consultant in the area of policy, evidence based practices and workforce development.

I work with addictions and maintain an active license

I'm in a leadership position in the Housing/Homelessness space and use my subject matter expertise to direct policy.

LCAC and LMSW are current and in good standing thru 2026

My current job is in consultation and compliance, not direct service.

My role currently does not require me to work directly with addictions. I am in a management role.
NC does not recognize KS licensing
No - this is an oddly worded question
No (62 responses)
No, still providing services
No. I still practice Addictions Counseling.
Not needed. Moved to GA
Outpatient therapy primarily with some addiction counseling
Predominantly psych testing and client caseload, provide as need comes up
Providing mental health therapy and some addiction does overlap.
Retired. Maintain license and work PRN
Sold my private practice business and worked in other practice areas.
Use license in disaster related services
very occasional cases present with a primary addiction issue. insurances are much more likely to pay for mental health diagnoses
Yes (4 responses)
Yes I am able to provide dual diagnosis treatment in private practice but am not a licensed treatment facility just a provider with KDADS also LSCSW so primarily use this license
Yes I have an active license. I sometimes apply addiction counseling practice in my current role. Although, it is an inpatient psychiatric setting.
Yes, but no longer work as an addiction counselor. I was trained when I graduated 27 years ago in the state of AZ and worked as a dual diagnosis therapist for many years following. In private practice I don't believe I can offer the wrap around care needed to provide the care needed.
Yes, complaints to the BSRB
Yes, I work as a social worker case manager currently.
Yes, Temporary off, due to shoulder surgery, and soon to look for employment.
Yes. I am a clinical supervisor and manager of outpatient services. I see clients on a limited, fill-in or emergency basis.
Yes. Supervising staff.
Yes. We have specific staff that provide most services for addictions.

LAC Q9. Are you currently working towards attaining a Licensed Master's Addiction Counselor (LMAC) license in Kansas? If you are not taking steps to receive an LMAC license, please explain why you made that decision: (117 responses)

Age

Already have a master's

At this time, I am not pursuing a Licensed Master's Addiction Counselor (LMAC) license due to financial constraints, the cost of living, and my assessment of the degree value.

Because I'm scheduled to take my clinical exam. I would like to have the LMAC but feel that since I have been an LAC for so many years, it should be awarded without having to go through all the same hoops as anyone else with a master's that just wants to add LMAC to their LPC or MMFT.

Because it is not necessary for me to get my Masters to move up with my current company. I decided a long time ago that pay wise, it wasn't that big of an improvement. Luckily my company cares more about my 18+ years of experience working in the field and less about the letters after my name. Masters degrees do not necessarily make for great counselors.

Before my disability I was working towards the LCAC

Currently in school for LPC. After obtaining LPC I will be applying for my LMAC. I will say this will take a long time due to cost and time involved with working full time and returning to school. I intend to take six credit hours per semester.

Currently working towards

Don't have the time or money.

Have delayed returning to school.

I actually just have to apply a I should be grandfathered in...

I am 64 and use my LAC at work.

I am hoping to get my clinical license in addiction counseling as I have my clinical license in Social Work as well.

I am not because I am satisfied being an LAC

I am not currently working toward my LMAC. My personal life is extremely busy and I need to focus on family.

I am not currently working towards my LMAC. One reason is due to the cost of going back to school for my master's, the time away from family for school work. Also at this particular job and my location, an LMAC will not make a huge impact on my position.

I am not seeking an LMAC as I was grandfathered in with an associates degree.

I am not wanting to go back to school

I am not, I do not want anymore student loan debt.

I am older, no time or need for school. I'm doing what I love, helping others.

I am taking steps toward it. It will be a few years then I will have my degree, I am paying for my school on my own with a small tuition assistance from the company I work for

I am working on LPC currently

I am working on my LMSW.

I am working toward LPC in the state of Arkansas, which is where I'm currently living. I am attending UALR.

I can't afforded

I do not see the need for me to achieve a LMAC.
I do not want to accumulate debt at this time in my life. It would be interesting though.
I don't want to have to do schoolwork and work full time. I have a family I want spend time with them
I don't have a Master's degree
I have all necessary classes/education, however, the process of obtaining the LMAC is overly daunting.
I have an LCAC
I have been an active LAC for 39 years, working with over 17,000 people. I don't think I need another piece of paper to know what I'm doing.
I have my LSCSW but I don't want to have to take another exam to upgrade my LAC to LMAC
I have my Masters for my LMAC but you have to retest and expensive and I didn't do it.
I just applied for MSW. I am unsure if I will go on for LMAC or just switch to regular LMSW. I don't even know if I will be accepted into MSW program.
I retired
I sent in my application about a year or so ago and instead of being offered the LMAC test-I was offered the LAC, which I don't understand, I have had a MA since 2003. So unless someone wants to address that (there are new grads who just got their LMAC) then I will not go further beyond the LAC.
I thought about it, but I think the schooling would be too much for me in the position I am currently holding.
I want to get my master's DEGREE but I haven't found a school/program/degree that I am looking for and I have had a difficult time trying several different options.
I was graduated into LAC years ago. Without all the college credits I am not eligible to pursue LMAC. I had been a Level II certified counselor since 1987 under the old criteria and was only able to be given the LAC.
I was grandfathered in. Been a counselor for 30 years
I will attempt to take the test again, I almost passed it a few years ago.
It would not benefit me at this time.
It wouldn't make that much difference in my salary
It's a long story . I'm interested.
KSBSRB will not accept my masters degree though I have tried several times.
N/A
No (28 responses)
No, don't need it for my practice
No, additional pay in the field unless you also go on and get your clinical. Same responsibility and same pay.
No desire to return back to college
No- getting ready to retire
No I have a masters in professional studies and work more on program improvement and quality
No I'm not. I'm pretty close to retirement.
No I'm over 60 years old.
No, I am not working towards attaining a LMAC license due to my age and not wanting to further my education that would be required for this license.

No, I am not. I do not have a Master's degree.
No, the cost of going back to school to get my Masters Degree isn't worth it.
No, the pay for LMAC isn't enough to justify loans for schooling
No, the required amount of schooling and cost of tuition is not reflective of the average pay in this field.
No, too close to retirement age.
No, too old to go back to school for not much of a pay difference.
No. I waited for years for Washburn University to offer a master's program in addictions counseling. By the time they did, I was just too old to mess with it.
No. The program requires three internships which I think is Unnecessary since I have been in the field for 26 years. I am well aware of the Diagnostic criteria for SUD. The Pay increase I would get would not be worth the cost of the program.
No. Close to retirement.
No. Having my LMAC, as opposed to my LAC, doesn't feel like it serves any additional benefit and just has added cost.
No. I am close to retiring
No. I obtained my MSW, there were more employment opportunities and better pay.
No. I started but have health issues
No. If the State of Kansas offered and/or paid for classes I would strongly consider advancing to the next level.
No. My employer offers no incentive. There is no pay increase.
No. Not interested (2 responses)
No. Would retire before I had my masters.
Not at this present time as I would have to return to school to obtain a second Masters degree and not sure if I am willing to. My first Masters degree is no longer able to be utilized to begin the process of obtaining the LMAC.
Not going back to school
Not yet
Retired (2 responses)
The LMAC practices in medicating patience and not abstinence!
Too much student loan debt.
Will begin Master's program this year. Have not been able to start yet due to lack of time to focus on school. With the workforce shortage, it has been difficult to find the time.
Working on LCAC via LSCSW license
Yes (4 responses)
Yes, to continue to give clients care at a high level and to be more up to date with current practices to help in client care.
Yes. I am attending Walden University.
I want to be able to help individuals on an advanced level
Yes, working on completing the paperwork/application for a LMAC.

LMAC Q9. Are you currently working towards attaining a Licensed Clinical Addiction Counselor (LCAC) license in Kansas? If you are not taking steps to receive an LCAC license, please explain why you made that decision: (100 responses)

Age

Because it's a joke. Why spend the money to pay for supervision to become an LCAC when someone with less or no experience in the field of addiction can get a grandfathered LCAC? People who have absolutely no intention of working in this field who will then go on to provide clinical supervision to those with more experience in this field to get the LCAC. Its literally a joke.

Cost of supervision. Lack of supervisors certified in agency settings.

Don't want to take test.

Financial

Hard to find supervision in rural KS

Have clinical license in Behavioral health, no need

I am a LSCSW as well as LMAC. I don't need LCAC for my current practice. I do not want to take another test.

I am currently working on my LSCSW and after I obtain that, I may consider the LCAC.

I am not currently working towards clinical licensure. I am 65 years old and I'm not sure how much longer I will be practicing. During Covid, it was difficult to get supervision and I was very busy at a different position as an addictions counselor in an outpatient setting that was nonprofit and extremely busy.

I am not working in addictions at the moment, which hinders my ability to further my license.

I am not working on a LCAC license due to having a LSCSW license. I do not see a need to also have a LCAC license.

I am qualified to take the exam being an LCPC, but I just haven't done it yet. Yes, I plan on pursuing an LCAC.

I am working on my LCPC first, and have already passed the MAC exam. As soon as I obtain my LCPC, I will apply for my LCAC.

I am working on my Masters in Clinical Psychology.

I am working toward a clinical social work license.

I applied but did not take exam in time. I'm also not sure what the benefit would be that would justify another expense. It's expensive to be a therapist

I currently hold an LMSW and LMAC, and after I attain my LSCSW, do hope to work towards an LCAC.

I do not have the time as of now. I also do not want to spend the money for supervision at this time.

I have been working towards the LCAC and have taken the NAADAC Exam several times, only to find that some of the questions are not relevant to addiction counseling and the exam questions have no relevance to the material studied. This makes it frustrating and diminishes the desire to pursue a full license. It appears that the License exam follows the foot steps of the EPPP. These exams have handicapped me and several others. We work hard not for the salary but to improve the lives of those who have fallen into alcohol and drug use and who have comorbid mental health issues. There is far more devastation in our community than we know it.

I have LMAC and LCMFT. I don't want to take another exam to become LCAC. It's not worth the hassle to go from LMAC to LCAC.
I have my clinical social work license.
I have my LSCSW and if I don't have to retest then I will pursue my LCAC
I missed the deadline to be grandfathered in and is hoping something like that comes back around. Based on my circumstances, I believe I should be an LCAC
I started and had some hours then was terminated. Didn't want to start over again.
I want my LSCSW too, at the same time, but supervision costs too much.
I was but another supervisor let me down. I'm wondering if there should be some consequence for supervisors who sign the paperwork but then don't carry out their end of the deal. I lose money and hundreds of hours because they decide not to meet with me twice a month or skip a month. I receive no apology.
I was—but lack the time as a supervisor to obtain all the individual clinical hours toward licensure. It's an additional barrier that I just don't have time for.
I would like to get an LCAC
I'm not sure what's involved and how it would be beneficial.
I've been thinking about it!
I'll be testing for my LSCSW soon, and will transition to LCAC at that time.
It took so long and so much money for my LSCSW, I don't want to do it all over again for the LCAC.
My License is LMAC already.
My mentor passed away who I was working under and have decided to not go further because I'd have to start all over. I'm also near retirement.
N/A
No (8 responses)
No because I'm dually licensed as an LMSW and working towards my LSCSW
No because my current job doesn't offer any opportunity to meet the training requirements and I don't have extra time to work on this outside of my work and family obligations.
No increase in pay for having the LCAC.
No interest in obtaining a clinical license. I am nearing retirement age.
No my license expired and I did not renew so doing only therapy with my LSCSW until September when I will retire
No, but I am working on my LSCSW
No, do not need it to advance in role
No, I am currently working on attaining my LSCSW.
No, I am not planning on getting LCAC, not working enough hours to justify.
No, I do not want to supervise or work in private practice.
no, I have an LMAC and am content
No, I'm working on my LCPC and plan to test for the LCAC once I have completed my LCPC
No, no need for it
No, no one on the staff can provide supervision and I cannot afford to pay for it
No, not interested
No, seeking LCPC instead
No. Clinically licensed as an LCPC

No. Currently also an LSCSW so while I'd love the additional training I don't think I need the additional licensure
No. Didn't know it was available
No. I am too old and getting ready to retire.
No. I don't really see the point since I have an LSCSW and LMAC
No. I have been a LMAC since 2016. I have worked in the field for all but 1 year. I was not supported in clinical supervision until recently and I am unsure how long I will continue to work in Kansas. My team leader would love for me to get my LCAC. It just doesn't seem like it would advance my career. I wish my previous supervisor would have been more supportive; however, LCAC doesn't seem to hold much weight. I wish LMAC could test out to get dual credentials. Social work and clinical counseling seem to be the preferred. <u>Honestly I think addiction counseling got a raw deal.</u>
No. I'm currently satisfied with maintaining my current licensure for Kansas. I live in Oklahoma and have decided to maintain my LMAC only.
No. My focus is on mental health.
Not at this time, but I want to once I finish my LCPC
Not interested in clinical license
Not my primary license
Not needed.
Not sure
Not yet. The timing has not been right to start.
Planning on submitting LSCSW plan, complete it, then apply for LCAC.
The test, passed clinical exam for social work and not sure what benefit it would plus cost of testing
There's no incentive to do that.
Yes (19 responses)
Yes, but slowly due to the number of hours required.
Yes, just need to apply to take the exam
Yes, LCAC and LSCSW - I am currently LMAC
Yes. Current pursuing my LSCSW and then will test for my LCAC.

LAC Q11. Currently, no multi-state compact exists for the addiction counseling 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. (118 responses)

Absolutely if I could work remote to help more people.

Absolutely. It would open the door for Telehealth. To work in states that don't have enough services.

Absolutely. I have many calls from persons out of state requesting services and I cannot unless they have received a DUI or legal offense in Kansas.

Absolutely. Telehealth is becoming more popular, and I would like the ability to work remotely for different states, if possible, maybe through a contracted position.

Absolutely. I have had opportunities to leave Kansas and have chosen to stay due to not being able to get licensed easily in other states.

Being close to Missouri and Oklahoma it could help serve clients better. There are been some issues every now and then with MO residents not being accepted to KS treatment etc... especially when using grant funding.

depending on what States, I might be interested.

Depends on the time requirements to obtain it

I don't know at this time.

I might be interested. Would allow me to work in neighboring states.

I think that is a great idea and I would like to be able to work part time in another State upon retirement from full time+.

I would be interested, provided that the cost is not prohibitive to the applicant seeking the multi-state license and that the interpretation of "multi-" is clearly defined and reasonable.

I would consider it.

I would work with clients in other states if I could do it remotely.

If I was still working...yes

If it would be possible for someone grandfathered in like me yes. My youngest child is graduated KU in psychology. My wife and I thought about working in Kansas during the summer and Colorado in the winter.

No (12 responses)

No- distance to travel

No my kids are in Kansas

No need for me to look beyond Kansas.

No not needed

No thank you

No, but believe it would be beneficial

No, I work in a mental health facility that does not provide services in other states,

No, not if it requires more schooling, and more money.

No, only because I do not see me moving out of Kansas in the foreseeable future however, I would support such a compact.

No, probably not. I have worked in Kansas for 26 years.

No. I am not currently providing services as an addiction counselor but utilize the knowledge to assist clients I currently work with.

No. I don't have connections to other facilities out of state
No. I have no plans to do anything besides what I'm doing now
Not at this time
Not at this time in my life
Not at this time, I do not have a need to practice in other states.
Not at this time. I plan on just staying in Kansas.
Not sure (2 reponses)
Possibly (2 responses)
Possibly in the future
Probably. This would definitely give me options once I am able to retire from state employment.
Since I am not an LCADC I doubt it would benefit me much, if I was I would for telehealth.
Sure
Sure, if I'm able to work from Kansas maybe doing telehealth.
Sure. We get calls from other states seeking services.
Unsure
Yes (17 responses)
Yes as we receive many out of state referrals to conduct assessments but unable to treat these clients if they are recommended treatment.
Yes I am interested, would like to be mobile.
Yes- I could move to a warmer climate and possibly work longer.
Yes I currently provide services to clients in Mo and Ks my clients are Spanish speaking.
Yes, as it would be advantageous and allow for us to work well for the greater good.
Yes, but I would want it to be at an LAC level or have some offsetting cost to make it worth having to get student loans again.
Yes, but only if it was a painless process.
Yes, especially with the military population who move frequently, may want to keep their providers for continuity of care.
Yes, FHSU has students from other states...
Yes, I live close to NE and it would be helpful to be licensed in NE.
Yes, I think this would allow for more counselors to work a broader area without having to physically move (telehealth). This could help address the counseling professional shortages.
Yes, I would be interested in doing this because it would expand the helping profession of addiction counseling. This would give more people more options as to who or where they would want treatment and more people to pick from this way.
Yes, I would consider moving to another state.
Yes, I would like to have the ability to help out in states that area in need
Yes, I would like to have those options available.
Yes, if it were to happen in the next five to ten years
Yes, if it would be feasible and lucrative.
Yes, It would be beneficial
Yes, it would provide me with the freedom to move where I want to be!
Yes, living in Southeast KS I would be able to provide services for individuals in Missouri and Oklahoma.

Yes, maybe Missouri if I wanted to go somewhere else. I love where I'm at right now though
Yes, Oklahoma or Texas
Yes, so I could move to another state and utilize my license.
Yes, that would enable me to provide services to a larger area and potentially population of people.
Yes, that would make moving across state lines easier.
Yes, this would be nice in case someone wanted to relocate and continue working in this field without having to obtain other requirements of a different state's LAC license.
Yes, with services in the Kansas City Metro area it would be helpful to be able to provide services on the Missouri side.
Yes, would be able to expand resources.
Yes, would be interesting
Yes. I am so close to Missouri it would be really nice to be able to practice in Missouri as well
Yes. Being licensed in surrounding states would open up access to care for patients.
Yes. Client needs from predominantly rural areas could benefit from having additional access to quality care.
Yes. Due to how close we are located to the Missouri/Kansas state line, a multi-state agreement would be very beneficial.
Yes. I reside less than 20 miles from Nebraska. I have multiple clients who work across state line or reside in state line but then have to travel to state line to receive telehealth services when able to make full trip in person.
Yes. I work in Missouri and Kansas. I would be open to being able to help across more states.
Yes. I would like the opportunity to practice in other states.
Yes. I would like to have the freedom to move and practice out of Kansas.
Yes. I would think that would be helpful if I needed to utilize it. I live close to Oklahoma border and it would be nice to utilize my licensure there.
Yes. If telehealth is available
Yes. Interested in providing services in neighboring states
Yes. Missouri is right next door.
Yes. My wife and I will likely move out of Kansas once we retire but I would like the option to continue working part-time as an addiction professional in whatever state(s) we live or spend time in.
Yes. To be able to reach out and serve a bigger population would be transformative in the addiction field. Counselors are far and few between at this time, so being able to work in a bigger and much needed field would provide a huge fill in the gaps of services.
Yes. We are located along the Nebraska border so would be interested for at least that but possibly more.
Yes. Would like to relocate to another state

LMAC Q11. Currently, no multi-state compact exists for the addiction counseling 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. (102 responses)

Absolutely

ABSOLUTELY- that is a wonderful idea!

Absolutely!

Absolutely! Living and working in the KC metro area, this would open up many more job opportunities if KS and MO were part of the compact

At this time, I am not interested. I am very happy in my current position and work 40 hours a week currently. I do not anticipate working more than five years so I don't think it would be beneficial for me to have a multi state license at this time.

I don't know honestly. I would be interested in LMAC's with masters degrees in addictions counseling being able to complete limited additional college credits (such as 15-23 additional core specific classes) to become licensed as LPC's. I'm more interested in that. There is more financial benefit in that than a multi-state license. The decisions that the BSRB has made regarding the addictions field has just made a mockery of it. I received a masters degree specific to the addictions field and yet I'm paid \$20,000 less a year than someone who got an LMSW and qualified for a dual license and has less education and experience in this field simply because they are dually licensed. I am now looking to complete a degree in nursing because at least that field is respected.

It would be beneficial because of hoping to move to Texas or Missouri.

Maybe

No (6 responses)

No I am retired

No, but if the company I work for is interested in serving multiple states I would apply.

no, due to my limited time

No, I would not. The agency I work for, I am unable to provide services outside the state of Kansas.

No, only because I do not plan to move or need to work in any other state.

If I were in private practice or moving, then this would be a good thing though and I would do it.

No. I don't have any need. If I move at some point to a different state, I would be interested in pursuing it.

No. I don't want to take on more substance use counselling clients.

No. I have no need to see people in other states.

No. I prefer to practice in-person therapy.

No. I'm ok with practicing in Kansas only

Not sure

Possibly (2 responses)

Possibly but I'd be more interested in a multi-state for the clinical social work license that I'm pursuing which would encompass and surpass the clinical aspects of the LMAC/LCAC

Possibly interested, but it would require telehealth in other states.

Possibly, that would allow for a greater income potential
Possibly. I am 7 miles from Oklahoma border so that might help me assist people needing assessments etc. in Oklahoma.
Potentially but this isn't my active license I that utilize.
Sure, if it would benefit client care with us being so close to MO
Sure, if they accepted LMAC licensure for reimbursement
That would be amazing, Missouri, Kansas, Nebraska, Iowa, and Oklahoma.
Yes (24 responses)
Yes - my husband and I would like to move, we travel and will soon buy a house in a different state. I would like to establish a practice in more than one state and also perhaps provide telehealth services to my patients that reside in different states when I'm in my other locations
Yes because I spend three months in Fl. every year.
Yes because my LSCSW would also be part of a compact
Yes definitely-- I would like the option to move if I so desire and to already be licensed in other states. I also would like to be able to move more to telehealth, and this would enable me to see clients in the other states I held a multi-state license in.
Yes- I am also a nurse and have learned it is good to be able to practice in multiple places. The more options the better.
Yes I live on a stateline
Yes my sister lives in Missouri and wants me to move down there.
Yes- work close to Missouri
Yes! I'm bilingual and would like to work in other states to help those struggling with addiction.
Yes, because there is frequently co-morbidity
Yes, especially if it would be possible via telehealth.
Yes, expands client pool
Yes, flexibility in practice and wanting eventually to move to be where my family is, I would be interested in a multi-state license.
Yes, good to be available to assist more people.
Yes, however I could help!
Yes, I believe I would be interested in obtaining a multi-state license if it was Texas as my daughter lives there.
Yes, I have ties such as Business and family in other states and believe it would be beneficial to be able to practice.
Yes, I live near a state line so it would be helpful and beneficial.
Yes, I work with Military, college aged, as well as living close to the border of 2 other states this could help keep clients who move, go home and gain new.
Yes, I would
Yes, I would due to living in Kansas City Metro area, half approximately of the citizens and clients in my city are Missouri residents.
Yes, I would like to obtain equivalent licensure in Missouri.
Yes, I would, human life is precious, no matter where the addict lives. I will apply for such a license.
Yes, it would allow for tele-health services regardless as to where the client is located.
yes, opens up more clientele
Yes. I am from another state. My relatives want me to move home.

Yes. I live 11 miles from OK and would also like to practice there.
Yes. I would love to have an opportunity to apply for a compact to work in other states, specifically MO. We are close to the state line and that would have the potential to allow us more work opportunities. I don't love that we have state license barriers for both LMACs and LPCs.
Yes. If an opportunity presented itself to implement the evidence-based practice in other states, I would certainly be open to it.
Yes. If client's move, if I were to move, and when client's live close to bordering states they should have choice in therapists.
Yes. That would be very valuable to me.
Yes. I believe it will allow people to have more access and choices in terms of selecting providers. It would also have a positive impact on my earning potential.
Yes. I hope to work in the field after moving to area in lake of the Ozarks.
Yes. I think this would be very beneficial in reducing barriers to service provision in rural communities
Yes. I work in Kansas and live in Mo. I'd like to practice on both sides of the state line
Yes. I would like to be able to use my current licensure in Oklahoma instead of Kansas but Oklahoma requires me to go back to school to obtain an equivalent licensure. Having a multi-state licensure would allow me to continue to use my current licensure without going back to school while incurring extra debt.
Yes. I would. This open opportunities to widen range of services for consumers especially to match specialty.
Yes. It would be nice to have the ability to continue working with clients who relocate until they are able to start services wherever they move to. Plus, there is a jail in the neighboring state that is always hiring for a therapist to treat inmates a couple times a month
Yes. Location borders. Also telehealth
Yes. Once I have clinical licenses, I would like to do some telehealth as a side income.
Yes. The more freedom and flexibility the better.
Yes. Then I could expand my practice, or make more money.
Yes. Then I could help more people

LCAC Q11. Currently, no multi-state compact exists for the addiction counseling 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. (179 responses)

Absolutely I would be interested!! There should be no restrictions where we practice in the US. We all have similar training, master degrees, extensive training and experience and that should be valid in all states, not just our home state.

Absolutely! Our industry is rapidly moving toward a nationally competitive stage. In order for us to be able to compete with other licensures (LSW, LCP, etc.), we must have equal access to clients.

Absolutely! This would allow me to see individuals in other states and provide a service to patients that live in the rural areas.

Absolutely. Because of COVID, telehealth has allowed us to reach people in URBAN areas and I'd like to expand my practice.

Colorado

Definitely

Definitely. It cost too much money and too much time. It is already overwhelming and expensive to be a therapist and we do not make that much money. I do this because I am passionate about lifting people up but I also have to be cognizant about taking care of myself and family. My health insurance alone just for myself is almost a grand through the Market Place and I have a HUGE student loan that I will most likely die with.

Depends on the cost

Don't think so. My current role only serves Kansas.

I am in the middle of the state, it would not benefit me. I could see how it could benefit others who live near the state lines

I have clients present from adjoining states present for services. This can get problematic if they have state insurance because this will not cover out of state services. We live in a college town and have a fairly transient community.

I have LSCSW and LCAC in Kansas and LCSW license in Missouri. It would be nice to have my addiction license recognized in Missouri.

I think a multi-state license is a great idea. I am retired so I am not personally interested in the license. Ideally, it would be amazing if there could be a national license/certification, like the MAC.

I would absolutely seek licensing with a multi-state license. This would increase my virtual services as well.

I would be interested depending on the additional cost.

I would consider it depending on the status of my career at the time.

I would love this! Yes!

It could be beneficial for telehealth services.

Maybe (3 responses)

Maybe, although I don't plan to leave Kansas any time soon.

Missouri, I live on the Kansas/Missouri border

Most definitely

Most definitely. Colorado has some of the most progressive opportunities in the field, yet will not acknowledge Kansas licensure for any sort of reciprocity.
No (10 responses)
No as I am not working with individuals from other states, but rather exclusively Franklin and Miami counties.
No because I only practice in Kansas and will retire in 10 years.
No but I think it would be helpful in attracting individuals to practice in KS
No only because I plan to retire as soon as I can afford to do so. If I were much younger, yes.
No retired
No- unless a person is highly motivated, has a very strong support system addiction counseling from afar is not advantageous.
No, as I expect to be forced to retire
No, I have no intention of paying taxes in another state or work outside of where I am now.
No, I only see patients in Kansas
No, legal system is typically involved and that makes the practice more complex
No, the need is too great in my area to expand my practice outside of the state.
No. I don't need additional work. Multi-state licensing compacts are attempting to provide short-term answers to a long-term workforce dilemma. Not enough trained individuals and low compensation are not solved by interstate licensing compacts.
No. I don't plan to expand since I don't actively practice addictions therapy.
Not at the time, but I have lived in three states since 2017 and have successfully utilized reciprocity to obtain the new state credential each of those times. I do not believe reciprocity is a barrier.
Not at this time (2 responses)
Not for myself since I am near retirement. I would support joining a multi-state compact as long as it did not further reduce addictions-specific requirements for licensure.
Not sure. Given current political climate of our country, I might consider moving to a blue state, but nothing definite in terms of plans at this time.
Of course, which could be argued for most professional licensure and for a litany of reasons. Access to care/services would likely be the most agreed upon.
Only if there are possibilities of providing telehealth to clients out of KS
Originally, licensing for addiction counseling was done nationally with NAADAC, and KAAP oversaw the state level. Kansas decided to govern the field with their own licensing board. The question I hear you asking is whether anyone licensed long enough recalls this two-prong licensing/payment system. I will assume the change has not been successful and now infinite wisdom elects to eradicate the current system put in place interstate compacts for border states along the Kansas state lines.
Perhaps
Possibly (3 responses)
Possibly consider at some point
Possibly I definitely want one for LSCSW
potentially due to the proximity to MO
Probably

Probably not since I also hold an LP and am part of PSYPACT
Probably not. Don't anticipate I would benefit or that my clients would need the
The whole Substance field in Kansas is antiquated. There is no need for the addiction license. I have LCAC and LCP.. The LCP Supersedes and can DX/TX all DX's in DSM.
Uncertain
Unsure
Unsure, depending on distance - telehealth may not be as effective.
Very interested
Very interested. PSYPACT does not cover this license but there is a need for it.
Yes - potential of moving during the next 5-7 years and would still like to practice part-time
Yes (37 responses)
Yes as Beacon is the only connection to substance counseling in Kansas.
Yes as it would help me better serve those in other areas and potentially increase my profit margin in the private practice services I provide
Yes because I live in Oklahoma.
Yes definitely, I have my LCP and passed the EPPP w/ 80% above the doctoral level, we need to have Reciprocity at this level to practice in any state. I also have my LCAC and I am not aware of any compact agreements w/ other states
Yes for Missouri and Colorado
Yes for telehealth treatment
Yes I would, I think it opens up the ability to see more people via telehealth and could make more of an impact.
Yes since we live close to Missouri or to help in other states that need more counselors
Yes so I could provide clinical addiction counseling to other clients
Yes that would be helpful for plans eventually for telehealth only.
Yes- this is needed and not having it takes away from patients being able to receive services
Yes this would be a huge benefit not only to me but to the entire profession.
Yes- would be able to access more clients to help them.
Yes!
Yes! I live on the Colorado side of the state line and am only 10 miles from KS .
Yes! I would provide more options to move to other states
Yes! Living so near a state line a multi state license is attractive for both a clinician and the people we serve. Let's not let land be a barrier!
YES!! PLEASE!!
Yes, as it would expand client access to my services.
Yes, depending on the cost.
Yes, for purposes of expanding services within my current agency.
Yes, I have previously passed IC&RC licensure in another state as well as Federal requirements for DOT specialization in addictions and addiction assessment and those testings were quite comprehensive.
Yes, I might.

Yes, I think it would be extremely beneficial, especially for addiction counselors that work for treatment centers that cross over state boundaries in many directions Colorado, Nebraska, Missouri, Oklahoma, Iowa. I will be a huge proponent of it.
Yes, I would
Yes, I would be interested as I am clinically licensed in two other states.
Yes, I would like to be able to work in Missouri, Arkansas, Oklahoma and Kansas. I am currently licensed in Kansas and Oklahoma and work in Oklahoma.
Yes, I would pay an additional fee to practice in multiple states.
Yes, I would. It would make fulfilling traveling contracts easier if there was a compact instead of getting licensed in each individual state. It also would offer more opportunity in addiction treatment type settings (IOP, Inpatient, etc.)
Yes, it would be helpful for counselors who live near state lines. An example would be Kansas City, Kansas and Kansas City, MO.
Yes, it would ensure the clients in need received access to treatment.
Yes, it would make it easier to see clients in Nebraska.
Yes, it would potentially enable me to reach more individuals in need without over complicating the process.
Yes, just as social work
Yes, my program serves only Native Americans enrolled in a federally recognized tribe and many live in bordering states. Distance is a barrier sometimes and telehealth is not an option if the client lives outside of Kansas.
Yes, this could help if agencies have facilities in other states or the client moved back to a home state after treatment was completed.
Yes, this would allow for more employment opportunities
Yes, to expand service available in vulnerable populations with few providers
Yes, when we "retire" we plan to live in another state, but would like to be able to provide services to Kansans, as well as the surrounding communities.
Yes, would make it easier when current clients traveled or moved to continue continuity of care.
Yes. As I get older (next 15-20 years), I see myself offering more Telehealth services.
Yes. Being able to offer telehealth services or other options for assessment, treatment or clinical oversight would be helpful. But legitimizing our field of work and leveling our rates of pay as compared to mental health/social work because while we are 'specialized' in addiction we do a lot of care coordination and case management planning.
Yes. I am already a MAC through NAADAC and Board Certified in Addiction Psychology, but it would be beneficial to have a nationally recognized license, even with the MAC I am required to have an LCAC in KS and in CA my psychologist license outweighs any addiction credentials since they do not require a separate license for addiction. National licensing and/or reciprocity would be helpful to align treatment in this country for all levels of practice. I feel the same about my license as a psychologist even with license in 3 states.
Yes. I am licensed with LCPC in KS, LPC in MO, and LPC in Colorado and obtaining my license in NY currently, and I would love to add my LCAC to Missouri and Colorado and possibly NY, just don't want to pay the fees for licensing
Yes. I have IC&RC Credentials as ICCS and ICADC
Yes. I live in a border city

Yes. I live in the 4 state area- Missouri, Oklahoma licensing would be especially helpful.
Yes. I probably won't ever use it, but life happens and family is in different states. It would be nice to have the option of moving if necessary.
Yes. I provide services close the state line (Colorado and Nebraska) so it may be helpful for them to be able to access the services via telehealth while they are in their home state.
Yes. I see many in the military and students that relocate at some point and want to keep their current therapist
Yes. I work in a transient community with university students and family members of the military. I get many requests to continue my work with clients when they relocate to another state or are away for an extended period of time.
Yes. I would be able to provide additional services via telehealth. This would provide opportunities as a provider and services for clients.
Yes. I would be able to provide telehealth services to clients who are in Nebraska as it is close to where I practice. Just one example: In the past, I had a client who was a farmer that owned ground in Kansas and Nebraska. I always had to make sure he was on the Kansas side for our telehealth sessions.
Yes. I would love to have a multistate lid ensure because I live in an area where three states are together and I have to license in all three. The area is very limited in population and almost qualifies as frontier. Televideo work or travel is necessary for any provider because of satellite offices.
Yes. if it would allow for online groups and individual sessions would open up more opportunities for employment
Yes. It is my experience that some States change or rename licensure status. For example, in Virginia, it is a licensed substance abuse treatment practitioner (LSATP), in KS is a licensed clinical addiction counselor, and the clinical indicator matters to insurance companies. In Virginia, the attitude is that an LSATP appears to be lesser than other clinical professions such as social work, family therapy, etc.
Yes. It would allow for more cohesion across states.
Yes. It would allow me to expand my practice in a way that is reflective of the current model of treatment.
Yes. Our company also works in various other states, so being able to provide telehealth in other states would be helpful.
Yes. Requiring a separate license for each state is a completely unnecessary burden in terms of time and expense.
Yes. The company I work for is in multiple states.
Yes. This would be very helpful in case of moving or needing to do more online interstate private work in the future.
Yes. This would make telemedicine more accessible to rural populations
Yes. To do telehealth.
Yes. We are mobile society and I believe state only licenses could become obsolete.
Yes. Working so close to the MO border, having an interstate compact would reduce barriers for people seeking help.
Yes. Would allow for more remote work and increases flexibility.
Yes. Would be helpful to market skills across states

Yes...I would work with various individuals and agencies in other states already with behavioral addictions.

LAC Q13. Over the past two years, based on your observations and experience practicing in the addiction counseling 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? (111 responses)
Actually, the director at a local methadone treatment facility doesn't have any degree and the only reason that he even has that position is that he is married to one of the owner's daughters. Well, now she is the one running it under a power of attorney or something like that anyway.
As an LAC I cannot be a provider for private health insurances so my clients must pay out of pocket for any services. Private health insurance only recognizes LCAC credentials...not any less.
Being Lac is making it hard when everyone wants co-occurring and out license doesn't cover that.
Changes in Confidentiality laws
Co-occurring disorders
Co-occurring disorders, as a LAC I am limited on what I can do. Reason for continuing my education as an LPC.
Counseling as long as I have I believe the field has done a great job transitioning to a more work with clients rather than down at like when I first started. I see more professionalism now than ever
Counselor burn out is a consistent issue and has been the whole time I've worked in this field. 35 years. Paperwork and caseloads seem to be 2 big contributors.
Culture competence.
Directors should have to have a degree to be directors of facilities
Diversity training is sorely needed
Driven by insurance rather than patient care
Dually diagnosed and addiction within incarcerated/reintegration populations.
During site visits, auditors will ask for specific changes but give no examples of what they are actually looking for.
Evidence-Based Treatment and Treatment Plans
Fentanyl
High burnout, lack of agencies understanding what LAC are able to do. Low pay
I am not knowledgeable about this issue.
I believe Kansas ce training is more than adequate
I believe more training in harm reduction and evidenced based medications to treat addiction.
I believe people grandfathered in should be requires to have a minimum of a bachelors degree in psychology social work or addiction counseling
I believe that counselors need more continuing education in the areas of Medication Assisted Treatment, medical and social detox qualifications and funding, proper diagnosing and appropriateness for levels of care (i.e. clients that are dual-diagnosed and would benefit from a dual treatment center as opposed to a non-dual facility).

I don't see any deficiencies, I think the majority of Counselors currently working in the field, do a good job. There is always room for improvement though. I do wish there were more 2-4 day conferences in Kansas, I miss the old conferences we used to have. Some of the conferences that I have come across are just too expensive, especially with the cost of travel.
I have not witnessed any negative issues.
I have not worked as a LAC in the past 2 years. Based on reports from peers there is a high level of burn out and staff shortages.
I have noticed in recently hired employees having difficulty in understanding documentation practices, billing concepts, and lack of awareness of local community resources.
I haven't noticed anything negatively over the past two years regarding practitioners needing more CEU's or training.
I think Mental Health licensed clinicians allowed to work with Substance Use Disorder clients / providers could use additional SUD focused education.
I think the biggest issues I see is ethical issues related to having inappropriate relationships with clients.
I would love to go back to in-person trainings and workshops. I don't feel like on-line trainings are sufficient. An area where I think practitioners need more training is in learning more about some of the newer substances/drugs on the streets.
Leadership making poor choices with training funds
Major shortage of addiction counselors. Making it very difficult to have the proper amount of staff.
Management doesn't follow the rules they hold staff to. Lack of clinical support. Unlicensed staff promoted to manage licensed staff and facilities.
Many counselors need additional training Strengths-based approaches and motivational interviewing.
Many of the staff that I hire have a use history and don't have the best boundaries, often having too close of personal relationships with their clients. It is something that I address regularly with my staff.
MAT training should be required.
Mental Health
More professional development to minimize bias
More training in MAT would be helpful. One of my agency's med providers is completely against MAT, including things like Naltrexone.
More training in mental health and how it relates to addiction.
Most of us in this area could always use additional training on opioid issues as that seems to be a growing concern.
No (31 times)
Need better pay
Need more counselors entering the profession. Not enough qualified counselors, education requirements too onerous for the pay.
Need to learn to set boundaries and not have dual relationships.
New counselors have no idea about ASAM criteria.
New laws pertaining to DUI
No, as I have not seen any negative issues.
none at this time

None in the past two years.
None that I have personally observed.
Not a big fan of or seen much success with the Medication Assisted Treatment/Drug Replacement Therapy. All my clients report abusing it and getting a "buzz". Abstinence is the goal when I started.
Not a concern
Not applicable.
Not sure
Not that I can think of at the moment.
Nothing to share
Peer mentors not staying in lane
Professional burn out, ethics, evidenced based practices.
Retired for 4 years
See 18
Sometimes there is a lack of being able to identify with clients, because of experience not education.
The limited availability of inpatient treatment options for people. Wait time for services.
The new path for counselors in training needs to have more training in place prior to a professional getting to start working in the addiction field.
There are many great treatment approaches, I suggest providers get back to offering a Twelve Step approach from Inpatient and continue thru Outpatient. After years of Intensive Outpatient groups, I am under the opinion that 3- three hour groups three times a week is too much for todays addicts to focus on.
There is a need for more comprehensive training on harm reduction strategies, the use of methadone and suboxone medications, as well as the evolving landscape of cannabis.
To be more positive and uplifting to the client
TRAUMA INFORMED CARE, GENDER SPECIFIC ISSUES, FAITH BASED COUNSELING
Treating dual diagnosis patients with severe mental health issues. Too often the client is not in an office where Privacy can be maintained
Treating inmates in a group setting
Treatment Centers are skirting the law and providing services without the mandated LAC's.
Treatment planning and execution
Understanding how harm reduction works in an abstinence-based program. There is still a lot of stigma.
Unsure
We can all benefit from continuing education. I have seen people who are licensed who struggle with their own mental health.
When everything turned academic driven - people actually knowing what they are doing in this addiction specific field. We lost and continue to lose a lot of people that would be good addiction counselors but the academic requirements are difficult to obtain for people and are not worth what the work pays and requires.

When the licensing opened up to other licensure like marriage/ family and etc. it seems like a lot of individuals that I've worked with didn't know much about specifics in Addictions

Yes

Yes need more culture diversity

Yes, however, I believe that individuals who currently practice in the field of addiction are doing the best they can with the resources and support available. If requirements for continuing education are extended without additional resources or support in the field, it may be off putting to some. I firmly believe that continuing education and having awareness of the most up to date information in our field is important and would like to see additional resources offered in rural areas.

Yes, most LACs also do not have clinical counseling skills.

LMAC Q13. Over the past two years, based on your observations and experience practicing in the addiction counseling 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? (89 responses)
42 CFR and updates.
Addiction Counselors are needed in the Schools. There are Social Workers and School Guidance Counselors in the building. Social workers have a case load and will only meet with those on their case load. Guidance counselors do not have Mental Health or Addiction counseling training, there for the students in need of these services are overlooked or not getting their needs met.
Addiction Counselors need robust training in trauma.
Always need dual dx training and training about when to refer to a dual licensed professional. Always need updated training on dx of SUD.
appropriate treatment recommendations and subsequent treatment modalities
As noted before, the license is extremely limited compared to other master level counseling licenses.
Bachelor level clinicians LACs are working in dual diagnosis programs without adequate education and knowledge to treat all mental health
Being able to get a LMAC just because you have a LMSW and test. Not enough education and experience. I did it LAC then LMSW. I think those individuals are why more experienced.
Boundaries and ethical self disclosure
Clinical documentation
Counselors are not the ones that need more training per se, but the general public and our community partners.
Counselors should have education on how to address trauma experienced before, during and after active addiction.
Cues
Culture diversity
DEFINITELY need more local options for CEUs - usually I have to find online options.
Ethics, boundaries, Trauma informed care
Extremely high direct service requirements by agencies that result in burnout and decline in client care.
HIPPA and just needing more professionals
I believe additional training is always a need.
I can't think of anything off the top of my head.
I feel that practitioners are leery to use their license due to not being familiar with the substance use ethics compared to mental health practices.
I feel the states group requirements for Senate Bill clients is antiquated and needs complete revision.
I have had the need and interest in completing continuing education on medications to manage alcohol use disorder and opioid use disorder. A negative observation is noticing how behind we are in KS in treating these addictions, for example in comparison to practitioners in Colorado.

I have lived in Oklahoma for the past 3 years so my observations & experience would be prior to 3 years ago. If my observations are still allowed, then I would recommend more training on making ethical decisions regarding clients as well as other clinicians in the field and as an agency overall.
I have not experienced this in my area.
I have seen way too many LAC share personal information and cross ethical boundaries with clients.
I often see boundary issues and feel that a boundaries training should be mandatory with every renewal.
I would like to see a uniform assessment form being used. When I worked in WY the entire state used one assessment form.
In how mental health such as trauma caused addiction and that this must be addressed as well. Also- our audit regulations are old and not caught up with the times. We are going off super old regs for audits
In my area counselors have not progressed. I see lots of old videos and papers being used. Since starting my program I have had many good reviews with open concept where counselors are thoroughly trained in many evidence based curriculums.
In small practices, it is hard to find the time to do some of the CEUs.
LAC professionals are doing trauma work, which I believe they aren't qualified to do.
Legal side enforcing recommendations. More education on MAT.
Medicated Assisted Treatment
Medication assisted therapy
Mediocre professional development in representing the field, resistance to science supported practices and collaboration with academic institutions for outcome study partnerships.
More education on the different counseling modalities
More information on treatments for Opioid addictions and more training on dual dx's such as PTSD and SUD. ALSO, groups really need to be gender specific especially IIP.
More in-person trainings would be great, and having more location in Wyandotte, County to practice.
More training in system and somatic perspectives.
More training is needed in understanding why harm reduction can be beneficial at times while harmful at other times, depending on the severity of the addiction, substance used etc. Sometimes, total abstinence is the best for the client. Also, more training is needed to assist "old school counselors/practitioners" in understanding why mental health needs also need to be addressed in treatment programs at the same time the SUD issues are being addressed.
More training on current medication assisted treatments and therapies would be helpful
More willingness to consider person-centered work and less reliance on a "one size fits all" modality. More mental health training.
No (16 times)
Need more diagnosis opportunities of substances. These trainings are important and also require to maintain licensure.,
Need more information on the new ASAM criteria.
Need to have greater understanding of CBT, Neurochemistry, and Limbic System

No continuing education in agency setting. Staffing issues are significant.
No training for counselors who are not a person in recovery to understand how to teach 12-step programming
Not that I have observed.
Practitioners fighting each other, false complaints against people
Scope of practice limitations, 42 CFR part 2, and navigating client care when client is experiencing SI
Stigma
Stop letting LPC's and LMSW's with no education or training in this field to easily obtain an addiction counseling license. They are grossly uneducated regarding the dynamics of addiction and do more harm to the field than good.
Supervisor who has only LAC license overriding decisions of clinical staff
The biggest area I can see, would be to have some good resources especially in terms of overall treatment trajectory, important components for LMSW's who get their LMAC's by way of testing rather than LMAC specific courses .
The biggest area where more CEU's could benefit is MAT and its use in conjunction with traditional therapy.
The ever changing landscape of what substances people commonly use, their effects, etc. Kratom in particular
The loosening of educational and licensure requirements mean less competent people are working as providers. I don't want to continue to work with people who are supposed to be my peers, but are unprofessional and unprepared for the work.
The need for more training or CEUs is not the issue, The issue is the lack of providers and the burnout rate is taking a toll on how providers respond to patients just before giving up the profession.
The only challenge at times is the availability of BSRB.
The pay is super low for addiction. And it's hard to get into it with KDADS and clinical licensing not being applicable from one license to the next. It's all a lot of hoops with a lot of money attached for low ROI
The process of evaluations, making them congruent for all practitioners. Also, allowing private practice therapists to have less restrictions
The relation between mental health and addiction. It seems prior to a few years ago, there was more information and knowledge of this; however, it seems, at least within the area where I am located, this practice seems to be more separate.
There is still a lack of understanding in other professions of addictions
They need to practice ethics.
Too many client with very high levels of mental health issues and are unable to participate in our program.
Training in clients rights and being educated on what each level of care consists of to facilitate more appropriate referrals.
Trauma as root cause, SPMI population, recovery paths. LACs tend to see total abstinence and 12 step models as only way to recover.
Trauma related to addiction (co-occurring disorder treatment). I currently use Seeking Safety in my adult SUD group.
While all licensed areas can use more training in this area, LAC's still demonstrate issues regarding boundaries.

With the introduction of the new ASAM it would help if trainings were offered to help practitioners with applying the new criteria. Also there is an agency in Shawnee County that bars people with addictions for 30 days because of known symptoms associated with addiction. Stigma and sensitivity guidelines for licensees would help to prevent this type of agency behavior.

With the population that I've been working with there is a great deal of trauma that people have experienced. It would be helpful to have more trauma training on how to work with these individuals work past that. Mental health services and Kansas are lacking funding so being able to work with dual diagnosed clients is crucial.

Yes- the "non-profit" I started at when I first got licensed was all about the profit. I was told to push clients to peer recovery groups if their funding was not what SB123 paid, so I would have more spots for SB123 clients. It was unethical as clients were not ready to be completed but I was point blank told that my opinion did not matter. The "non-profit" needed money as they had bought a new building and were remodeling it. I complained the this board, to KDADS and to anyone that would listen and was told essentially that no one cared. Super frustrating. I was also being pushed to do everything via ZOOM as it cost less, and more clients could be in the group. The place I worked at was a mess, all about money. I have heard it still is

LCAC Q13. Over the past two years, based on your observations and experience practicing in the addiction counseling 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? (159 responses)

Actually practicing ethical standards

Addiction counselors appear to experience similar boundary-oriented issues and countertransference issues as other professionals in the helping professions, but they tend to be more readily apparent.

Aftercare services

As a practitioner that works indirectly with SUD treatment centers but worked collaboratively with these centers, it seems that there are challenges to be reimbursed for SUD treatment and a lack of adequate insurance coverage for people.

ASAM/level of care

Attachment trauma and relationship to addiction

Because of the lack of licensed addiction counselors, peer support services have increased. At time it seems as if they provide a lot of the care to patients.

Boundaries with clients. Appropriate use of self-disclosure.

Documentation of interventions utilized. Documentation of treatment plan.

Co-occurring disorders of all kinds

Current drug abuse trends related to drugs of choice for different age groups.

Diagnosis, MAT, and CFR 42-part 2

Differences of oversight/requirements for addictions work based on service location (e.g., private practice vs clinic vs inpatient)- for example, is it unprofessional conduct to be in private practice and require/request patients to get a UA/drug testing done vs in an inpatient/program it is a requirement and common place.

Documentation!

Education on assessing/diagnosis, harm reduction, medication assisted treatment for the actual counselors in the field- not just conferences for upper management.

Ethics

Ethics is always an important area for continuing education. I think more attention needs to be paid to training in tobacco cessation and in medication assisted treatment. The focus of some training (and treatment) programs on the 12-step model is very outdated. Twelve Step programs offer great peer support, but that is not the same thing as treatment!

Financial resources seem to keep some people from seeking addictions counseling in our area.

Guess was negatively impacted with automatic licensure for MH workers in order to help county government

Harm reduction strategies, benefits of MAT, enhanced skills in motivational interviewing, better understanding of co-occurring disorders.

Having taught graduate students who are interning in addictions programs (online program with students across the country), and staying on top of the addictions literature, I am saddened and concerned with what I perceive as a deterioration in addiction-specific knowledge in both the interns and their on-site supervisors (counselors at drug treatment centers). Ironically, this lack of knowledge I believe to be related to counselors who do not have personal experience with addiction giving bad advice and lowering expectations for abstinence. I'm observing these changes especially over recent years but also over decades, beginning with the arrival of managed care: (1) Insurance/ managed care requiring service providers with education/state credentials that may require years of college; (2) As a result, a lower percentage of counselors now have personal experience of addiction and sobriety; (3) "Harm reduction" and MAT models are prioritized over even attempts at sobriety; and (4) Licensure laws are gradually eroded to meet demands for service providers, so that even experience (internship) in addictions-specific treatment is not required/prioritized in grad-level licensure as long as one has a related counseling degree and can pass a national exam.

Heavy caseloads for counselors

I am a solo practitioner.

I believe we are very well trained.

I can only speak to my current workplace (school) that employs a worker for vaping cessation that now has also turned into screening for addiction issues. The person is an RN with limited training in the fields of addiction and mental health counseling who over steps boundaries by attempting to counsel rather than make the appropriate recommendations to licensed professionals. I believe someone in the role of identifying addiction should at least have more than a few hours of training. Then the person may understand how it does more harm than good to provide personal thoughts instead of evidence based recommendations grounded in theory.

I can't speak to this.

I can't think of any right now.

I can't think of anything at this time.

I continue to see people practicing outside their scope and causing harm to clients because they have not referred people to specialists soon enough - it is possible that clients do not always divulge relevant info so referrals can be made. It seems that the market is saturated with counselors and competition is high so counselors may be taking on clients they should not be taking on. For example, I have heard of people treating clients for addictions when they have no training or experience in addiction. And we need to expand the addiction license to treat more addictions than just substance use to help prevent this problem.

I could use more education on the use of AI in therapy as well as updated treatment modalities.

I feel like there is a lack of knowledge of MAT and how it works for people. It would be really great if people could be more informed on this type of intervention.

I feel training related to substance abuse and trauma is very important.

I have concerns with addictions counselors not being familiar with HIPAA, CFR 42, especially with regards to telehealth/remote work or emailing communication. As well, I know of addictions counselors who (with only an addictions license) advertise that they treat specific Mental Health diagnoses, not dual diagnosis. I think there is a lack of understanding with the medication assisted treatment as well.
I have heard counselors that have patients personal address and would go to dinner at their house with and then the family members would have their personal cellphone numbers to call them if they needed help when they relapsed. They were not friends before they were counselor/patient either.
I have not been in Kansas these past couple years
I have not.
I have noticed ethical violations such as confidentiality and professionals being afraid to report violations because it is not anonymous. I understand why this is designed in this way however there needs to be an alternative.
I have seen a decline and ethical standards and clear understanding of documentation expectations just at a regulatory state level alone
I have seen people with little training hold themselves out as "addiction counselors"
I practiced on the micro level in a clinic where I was the only clinician. I cannot think of issues at the moment related to this topic.
I served on the State of Nevada Addiction Licensing Board, where I first obtained my license. I served 4,000 as an Intern to an Intern Supervisor under a 'board approved' supervision agreement. The absence of this formal process in Kansas is alarming to me.
I think new clinicians need more training in diagnosis.
I think that many helpers treating SUD do not have the added credential of LCAC for state of KS and likely need different training creating less information, coping skills, or tools needed to help assist the different levels of care for substance use disorders.
I think that unless you have worked in CMHC services in your career you are unfamiliar with the resources available for those that are under or uninsured. Additionally, there are not enough treatment beds in our state and not enough aftercare services.
I think when covid hit and the need for more counselors was a problem, the requirements were relaxed. I believe that they need to have more of a balance now so that people are getting quality care.
I'm always in search of training in the area of trauma and also ethics (online)
In trauma
Insurance billing, administrative work
Issues of cultural competency. In particular working with people who are neurodivergent
It is hard to find substance use diagnosis and treatment specific trainings in Western Kansas. I have had to do online trainings.
I've lived in Virginia
Kratom and Delta-8 THC Vape and Vapes in general.
Lack of experienced licensed professional - overall number of providers
Licensure still has to get easier
Lost standing in NAADAC, social workers calling the shots for licensing.
Low to no cost CEUs

Management of Suboxone treatment, detox. pain management (chronic) and detox. narcotics and depression interface
Many come out of college and do not know what they are supposed to do and what to do. Ethics are a big issue.
Medication Assisted Treatment. Illicit substances interacting with psychiatric medications. Substance use and co-occurring medical conditions.
Medication management
Mental health
Mental health disorders, trauma informed care
More continuing education for co-occurring or comorbid disorders with addiction.
More continuing education that is not introductory
More education and diagnosis
More information on using tobacco use treatment.
More regulations and less pay
More training and education needs offered in general. Other states have more training opportunities and better structure.
More training in Co Occur9ng disorders
More training opportunities are needed for video game addictions, sex addictions, gambling addictions- basically all 'behavioral addictions' substance abuse trainings are very available
My primary focus is professional integrity and patient care
No (45 times)
Need more training in CBT approaches to addiction treatment. Also a solid understanding of the medical causes and treatments for withdrawal
No. We have a strong practice.
Not enough ppl licensed
Not sure
Not sure it's a training issue. The turnover rate seems to be high. A lot of hoops to jump through to get licensed, and generally low pay with lots of educational debt not a workable solution.
Not where I have been employed.
Overdosing and Harm reduction
Practitioners would benefit from SUD specific training opportunities and CEU's including new trends in addiction and treatments that are effective. Many practitioners I have supervised do not feel knowledgeable despite having their license.
Professional behavior training for all licensed individuals, including members of the Review Board
Professional boundaries
Professional Ethics.
Professionalism, boundaries with clients, dual relationships
Programs that do not integrate mental health treatment with the treatment of SUD. Inadequate professional skills and ethical issues from LAC's and LMAC's- lack of reliability/dependability, boundary issues with clients, unable to articulate therapeutic approach but are just "winging it".
Providers feeling incompetent to treat addiction, poor definition of competency, need for quality training

<p>Quality affordable or free continuing education is always a need. Most agencies do not provide quality free CEU and it is up to the licensed provider to ensure they get these CEUs and pay out of pocket for licensing and CEUs. We cannot claim these on our taxes as exemptions either why many of us work in private practice as 1099 employees to take <u>advantage of the tax breaks</u></p>
<p>Relapse prevention</p>
<p>Significant barriers to addiction counseling are the increased regulations above and beyond mental health counseling and availability of SUD-licensed staff. I have found counselors who are interested in providing SUD treatment to be burdened by the extra regulations, and <u>they do not pursue the licensure.</u></p>
<p>Since higher standards of education were adopted in the early 2010's requiring a Bachelor's level degree for minimum standards of addictions counselor certification at the state level, I have seen fewer and fewer instances of lack regarding what I would consider run-of-the-mill methods of engaging clients in 1x1 settings. Prior to those base Bachelor's level standards, I had noticed some shortcomings in practice standards exhibited by an individual who held a "grandfathered" addictions counseling license. The issue in question was exhibited by said individual practicing as an LAC in the state of Kansas who would sometimes leave clients frustrated from his lack of ability to listen to clients as well as tendency to talk over clients thus not allowing them to verbalize their own thoughts.</p>
<p>So much is needed here. There is a severe misunderstanding in how to treat this medical condition. With the acceptance of this as a medical condition, other professionals have not expanded their knowledge into areas of recovery. We do not have enough ASAM certified doctors, and psychiatrists, and it makes it hard for those trained as addiction counselors to apply those professions to recovery. I could talk about this and the neuroscience of <u>addiction for a long time.</u></p>
<p>Some addiction counselors do not seem to know much about the ASAM criteria and when <u>to recommend certain levels of treatment.</u></p>
<p>Still difficult to find LAC's/LMAC's to hire. Training needed around Harm Reduction and the Opioid Crisis</p>
<p>Substance abuse with adolescents</p>
<p>The addiction field is constantly changing, and I think it is important to stay relevant.</p>
<p>The impact of trauma</p>
<p>The master's level clinicians allowed to work with clients who struggle with addiction are not <u>getting enough training.</u></p>
<p>The regs were built when non-degreed mostly recovering indiv's provided tx with grant money as was no parity for MH and SUB. The State Oversight KDADS should be dissolved</p>
<p>There appears to be a disconnect between in-patient and out-patient settings.</p>
<p>There appears to remain a significant gap in SUD counselors being able to effectively practice in trauma informed ways. SUD license by itself places direct trauma work out of scope but a more informed approach would also improve the recovery system of care etc.</p>

<p>There seems to be a strong reliance upon peer recovery groups. This has been true in my 17 years of experience in the addictive disease field. It would be wonderful to see more practitioners using modalities that are more relationship/person centered. Peer recovery is fine and it is not for everyone. I use DBT and Narrative Therapy modalities to help individuals through their recovery journey. It takes more time and is currently only viable in settings that have resources (money). I understand the reliance upon peer recovery groups. It is practically free. The newer practitioners that I have encountered in my work have seemed as if they are relying upon older modalities. I am not sure if this is a negative issue as much as it is an issue regarding public investment in treating addictive disease.</p>
<p>Too many confusing license types - too restrictive for the lack of providers</p>
<p>Too many regulations that create paperwork log for us to practice</p>
<p>Training in non-chemical addictions. Not many providers that work with gambling, pornography, gaming, and food addictions.</p>
<p>Training's on specific evidence based practices, conflict resolution, coping skills, and practicing self-care.</p>
<p>Treatment planning and documentation</p>
<p>Unknown</p>
<p>We get plenty how to help clients, however, insurance companies has so much control how we provide counseling/therapy over reimbursement, notes, and sessions. I am considering only self-pay clients in 2026 to avoid spending so much time and headaches as a therapist.</p>
<p>We have a significant gap in providers, we need to be out there recruiting for alcohol and drug counselors seeking incentives to bring them into the field. Advocating for higher pay for our counselors in the field and ways to make the career more appealing to attract candidates. Always more training on ethics and safety; along with DSM 5 and treatment planning. There is just so much it is really hard to put in this box here.</p>
<p>We have more needs for teen substance abuse but we do not have many resources in the state, especially in western Kansas. Also, there are limited amounts of CEUs for the specific population.</p>
<p>What are private practice limitations, if any, addiction providers?</p>
<p>Yes (2 responses)</p>
<p>Yes, as I believe we do have a lot younger workforce entering the field and I truly believe the community as a whole has changed in the last few years as well as substances more readily available.</p>
<p>Yes. The new ability to receive an addiction counseling license through a social work program by only taking two addiction related classes has providers uneducated and unable to provide quality addiction counseling services. I think it's a mistake to allow this.</p>
<p>Young counselors need to attend AA and NA and especially Al-Anon so they can be more familiar with the 12 Steps</p>

LAC Q14. Over the past two years, have you experienced any issues concerning telehealth, either through professional practice or observations of other practitioners? (110 responses)

Clients have poor bandwidth/ connectivity

Clients stated having just Telehealth services is a convenient but is easier to lie regarding Substance use as Counselors have difficulty noticing symptoms of use such as weight loss, pupil dilation, and body movement. I have had Clients transfer to my services in which I utilize hybrid model of one in person group session weekly and one telehealth session to help with fuel costs

Haven't done any telehealth in the last two years and haven't observed any other practitioners.

I don't do telehealth now that Covid protocols are not needed

I don't do telehealth

I don't feel like participation is the same. I feel like telehealth services should be removed!

I don't provide telehealth services, never have.

I feel I've lost some normal cliental to telehealth. But it's also good for the client to have options.

I feel that telehealth does a disservice to people who are seeking recovery.

I feel that telehealth should only be used in rural areas where help is not closely available. Otherwise, I feel we are doing our clients a dis-service. There is too much that is missed on a screen. Too easy for clients to hide their behaviors and counselors are unable to see all the warning signs of use or mental health. I think it is dangerous.

I have not been closely connected to telehealth services

I have not experienced any telehealth issues. I use a state-approved website for that.

It offers a wide array of services to, sometimes, hard to reach places

I think some may conduct Telehealth groups with unmanageable numbers.

Just being able to observe the client closer, regarding gestures and things going on around them, such as distraction with children.

Just issues with system buffering or being down sometimes.

Just the restrictions placed to be able to practice in other states. Many referrals are from attorneys in Kansas whose clients received legal charges while in Kansas.

LACK OF AGENCY ASSETS FOR SUPPORT I.E. CELL PHONE LAP TOP

My personal opinion of telehealth for the A&D field is that it isn't too effective. In person contact and in person groups always have more participation and accountability. For rural areas this may be something that is needed to meet the needs but not in urban areas.

No (62 times)

No although I imagine few know best practices.

No problems. Telehealth has helped rural areas tremendously.

No, I have not practiced telehealth in the past two years.

No, I have not. It is done here but, it is rare.

No. It has been helpful for clients

None. I do not engage nor observe telehealth practices.

Not affective

Not being able to sign releases remotely.

Not good option for addicts. Too much freedom to not actually address their substance and isolate this feeding their use
Our company doesn't utilize telehealth
Retired 4 years
Telehealth does not seem to be affected for populations who are court ordered to treatment
Telehealth has been positive, especially with attendance and access to care.
Telehealth is a great tool for individuals with barriers that interfere with their ability to attend in person. That being said, there is a loss of person-to-person connection, and professionals may miss nonverbal cues due to sessions being conducted via Telehealth.
Telehealth is essential for patients in rural areas and those whom have barriers to attend in person
The only issue that I see is it needs to be utilized more. Not just a rural areas in Kansas due to transportation issues however also it's been effective for clients with anxiety and that has difficulty being in a group of people.
Through professional practice and observation, I feel that, when possible, in person is best for treating addiction.
Too often clients don't have a private office/room where Privacy can be maintained.
Try not to do telehealth
Typical connections issues when working with clients living in rural areas.
Unlicensed staff promoted to manage licensed staff. A lack of understanding of importance of releases being correct.
Very familiar with Telehealth.
We do not use tele health for substance abuse group as it seems to be less effective for the clients we work with . It seems better for 1-1 counseling, we have chose to not do it.
While I don't feel it's as effective as in person I think it is a very valuable option especially in rural setting where it can be a distance to treatment/counseling and a lack of transportation within our client base.
Yes one organization is mainly doing telehealth for outpatient and there is no checks and balances of ensuring clients are attending the entire time and engaged
Yes, addiction consumers appear to need the additional social interaction that in person services provide.
Yes, client's lack of video and or just the lack of in-person accountability.
Yes, I have noticed that many clients prefer telehealth
Yes, the biggest issue is serving clients that live just across the state line in Missouri but are involved in the Kansas court system so they are usually required to get treatment services from a KS practitioner. Many of these clients work in Kansas during the day but are physically in Missouri while off work.

LMAC Q14. Over the past two years, have you experienced any issues concerning telehealth, either through professional practice or observations of other practitioners? (92 responses)

Assessment of current use is more challenging.

Clients do not engage as well via telehealth, we can't provide testing via telehealth, and it difficult to build real rapport.

I am unclear on statutes or requirements regarding doing Telehealth across state lines. For instance, if I were traveling out of state would I be unable to meet with my Kansas clients during that time?

I have a hard time getting telehealth clients from rural areas because they don't want someone far away and they don't want telehealth. Our rural areas are still suffering

I really don't like telehealth. I find the client are very lax on who is around and often I have to decline services due to where the client has chosen to be or who they have allowed to be present.

I used it during COVID and did not like it much. I think it is an okay tool if you have no other options but prefer in person and also prefer gender specific groups.

It can be more difficult to tell if a client is abusing substances or actively under the influence during a telehealth session, as it's more easily hidden by clients

It is easier to become avoidant, can increase isolation and social anxiety. People have less privacy and it seems harder to focus.

It's difficult to conduct telehealth if client is impaired, therefore more issues with rescheduling. Higher risk for client being impaired by substance if they are not presenting in person.

Many of the concerns I have heard from others are obtaining signatures and documentation and having enough practitioners to fill the need

More when working with adolescent clients and younger. Attention spans and fear of adults overhearing the conversation is apt to keep them from being actively involved.

My biggest concern is that signs are missed on Telehealth. I prefer putting eyes in clients regularly.

No (61 times)

No, however it is not ideal for SUD treatment.

No, I believe this is much needed service to allow all people access to treatment

No, it's just harder than in-person.

No. I have only observed people having technical difficulties with the software such as getting both audio and video to work.

None I'm not an advocate except in extreme conditions.

Not personally. It spike post COVID and seems to be dwindling. My concern is if it wasn't ok prior to COVID, then what makes it ok now.

Not with addictions counselors

Other than technical difficulties, typically, I have not noticed any specific issues.

Poor signal often impacts visits

Telehealth does not work in Addiction Counseling

Telehealth makes it possible for me to work, as a disabled Kansan who needs to work from home. Aside from rare power outages or also rare network failures, telehealth has worked well for multiple therapeutic modes, and even co-regulation with clients who are struggling with regulating themselves.

The clients don't get a whole lot out of it due to too many distractions.

<p>The main issue I experienced when I was doing more telehealth counseling was having people show up for their scheduled appointments. Often times working in a rural community in individuals weren't able to get onto the zoom sessions due to lack of Internet or Not having Wi-Fi capability.</p>
<p>There seems to be problems with telehealth. Whether it's communication with the client, getting them to sign documents, or having somebody who is a community partner assist us with things on the opposite end if needed.</p>
<p>Working in KC near State Line- making sure patient's are Zooming in from the State of KS per my license. We have patients from both KS and MO.</p>
<p>Yes</p>
<p>Yes- some people just are not appropriate for telehealth. May not have a good environment or are unable to focus.</p>
<p>Yes- the company I used to work for was all about ZOOM. They could do a zoom assessment in 15 minutes and would bill for an hour. I was told if I just called and asked a client how they were doing, I could bill for an hour appointment telehealth. I am also a nurse, and I think telehealth has its place, but I prefer in person. I can do a better assessment in person and as a counselor it is easier to connect in person.</p>
<p>Yes, telehealth is only as good as the clients ability to connect through WIFI. The lack of grant funding available is an on-going concern for those practicing within the telehealth capacity.</p>

LCAC Q14. Over the past two years, have you experienced any issues concerning telehealth, either through professional practice or observations of other practitioners? (164 responses)

Addictive disease treatment is very relational. There is a greater emphasis upon "being real" with your patients. This can be difficult to develop this sort of rapport virtually with patients. I have no clue as to how one could develop rapport in a strictly virtual setting. I know many younger people are used to virtual and often prefer this mode.

Although telehealth is a great resource and makes treatment accessible to many who otherwise wouldn't get the services, it doesn't provide much accountability for the clients as face-to-face.

As stated above- I personally don't feel like tele-health addictions work is adventitious
Clinicians are the hard working professions, however, we struggle so much with insurance companies. I really hope there is an easier way to do private practice.

Confidentiality

Does not work well for some clients.

Don't believe in telehealth

Haven't used telehealth

I do not believe telehealth is a very good option for addiction work.

I feel that in-person counseling is the best fit when it comes to addiction counseling.

I get referrals via email regularly from other providers who send protected health information with no regard of privacy.

I have concerns about the validity of telehealth SUD groups, especially in IOP programs.

I have not observed anything specific. I anticipate need for clarifications in regulations on how AI technology should be handled in particular around informed consent.

I have not personally had issues concerning Telehealth, although if someone is actively using I have limited or stipulated that I can't see them via Telehealth, especially if they are being see for court issues, etc.

I have not provided telehealth, but I have moved from in-person to online teaching of my addictions class and find it a poor replacement. Students readily "hide" online and at the bottom line, I could not predict who will actually be a good counselor. This was not true in the classroom when we had small group practices in person, etc.

I have really worked hard to make telehealth effective. One of the biggest challenges is UDA testing with patients in telehealth.

I have very limited experience with telehealth in this setting. I did use telehealth in a hospital setting pre-COVID for rural areas and did not experience any issues.

I have worked solely in telehealth as an LCAC in private practice over the past year with several clients. Many of which I have only ever met via telehealth. After having worked in face to face settings for 11 years prior to switching to exclusively telehealth, I can say that the benefits far outweigh the risks.

I haven't experienced any issues

I occasionally did telehealth but mainly in person. I did not have any issues that I could think of.

I've observed a few practitioners use phone calls as a method of therapy which can be risky with SUD clients that could be under the influence or using during these calls where there is no direct observation of them.

I'm personally not a fan. I feel like I get too easily distracted using telehealth.
In public agencies like the federal government that I am familiar with, there is a lack of office space and privacy for therapist to provide telehealth services. Counselors need to be provided with the space and equipment to provide these services in a confidential manner.
In the rural and frontier area I practice, it is sometimes a barrier for clients to have access to wifi.
just concern over legislative regulations possible changing- limiting on line use
More training around confidentiality and ethics. Not just for the counselors but for other staff members within agencies.
My program does not offer digital signature capability so having a client complete an intake packet prior to the appointment has been complicated and cumbersome at times. As far as the professional practice of telehealth I have not observed any concerns.
No (104 times)
No concerns, a benefit to our agency/patients
No issues, telehealth is great
No remarkable telehealth concerns to date
No, I have found that telehealth increases access and is a great alternative during inclement weather, illness, etc.
No, telehealth since COVID has actually assisted being able to reach rural areas for assessments and treatment.
No. Where I work at we actually have a really good success rate with clients completion of treatment services and it all remote individual and groups.
None directly
None reported
None--I feel that it is one of the best things that came out of COVID-19. It allows those that are unable to drive due to physical health issues, financial issues, weather, etc. to continue to get their services.
Not currently interested in doing telehealth...
Only technical cliches.
Our clients do not always have access to devices and/or internet to complete sessions.
Possibly less reimbursement by health insurance companies.
Providers continuing to use telephone (audio only) services.
security
Seems equivalent, and safer from a public health perspective considering COVID, RSV, and tuberculosis
Substance use virtually is quite difficult in my opinion depending upon the substance of choice- there is a lot to be said about in person and the observations/smell and other sensory experiences with someone in the office setting.
telehealth is a good option, but face to face still works much better for me. I can read the whole body face to face and not with telehealth.
Telehealth is so vital to our business. During COVID the restrictions were lifted off where the provider or client were located both in the state of licensure. Afterwards chances were made again causing issues. The clients are having barriers to their treatment because of location.

Telehealth is usually better than nothing and preferred by some clients, but it's typically not as substantial.
Teletherapy has made counseling services more accessible to clients.
The lack of attentiveness by participants on virtual calls and laid back rules by professionals conducting the treatment virtually.
The limitations of or potential limitations of telehealth are rarely discussed. Its better than nothing and ideal for some situations but can contribute to missing data such as smells, seeing pupils with more detail, etc.
The only issue with SUD telehealth is it allows for another level of secrecy and deception from clients, since we sometimes can't see them, and can't smell them through telehealth. There are so many nonverbal clues about what and how a client in recovery is really doing. Telehealth just allows for more of a gap in that information. In person has its challenges, of course also. But this is one extra barrier to having all the correct data possible to help.
The use of telehealth has been really important, especially due to a lower workforce, less money and trying to assist people in more remote locations. However, access to internet, a good phone and an understanding of technology is sometimes a barrier.
There are always concerns whether it be bad connections, people coming in during sessions, or even difficulty connecting with clients.
There is always a concern of who is listening to the client on their end. Question the privacy/confidentiality of the session.
Yes, confidentiality issues
Yes, the BSRB appear to be promoting telehealth services, but rejecting of contacting clients between appts or for post-DC check-ins
Yes.
Yes. Getting ROI/Privacy Statements, and Homework back from patients using a virtual platform.
You miss facial and physical indicators. It is harder to form an empathic bond.

LAC Q15. Over the past two years, have you experienced any negative issues involving supervision? If so, please explain. (110 responses)
Complete lack of clinical supervision.
I did not receive any supervision my first year at the agency I was at
I have a great supervisor. No problems.
I left the treatment field full time due to being underpaid and unrealistic case loads.
I personally want to grow as a counselor, in my mind supervision is a place where one should be able to gain insight and constructive feedback. Some view supervision as a time to only discuss your caseload.
I was a director for 7 out of the last eight years or so. The biggest issue talking to other directors as well as I had was staffing. In Southwest Kansas it's difficult to have enough counselors so it was difficult for accountability when a counselor wasn't acting with best practices because the agency could not afford to lose them.
Lack of training required for people who are supervising
My direct supervisor is not licensed in addiction counseling which means she is unfamiliar with practices, paperwork, regulations, etc.
No (91 times)
No, I have been fortunate to work for two agencies and both provided excellent supervision.
No, not that I can think of.
No, we have supervision once a week.
Over the past two years my company has now had 3 clinical supervisors. Starting new in my opinion is hard. Giving grace to that person to gain their footing and overcome growing pains
Prefer not to answer (2 times)
Providers are overwhelmed with demands due to shortage of Counselors. Competent supervision may not be the highest priority for many individuals as they are trying to meet the gap with interns and new hires who could benefit from extra hands-on supervision.
Retired 4 years ago
Supervisor do not understand what LAC can or can't do. Poor support from mental health providers in this field.
Yes, my supervisor was not professional and has not treated other counselor very fair.
Yes. We struggle with keeping clinical directors sometimes. We have had 3 in the 2 1/2 years I have worked for this agency

LMAC Q15. Over the past two years, have you experienced any negative issues involving supervision? If so, please explain. (91 responses)

Absolutely. The last supervisor just walked away--like a client/patient. She would not return my calls.

Focus was more on meeting audit requirements over client needs

I have lived in Oklahoma for the past 3 years so my observations and experience would be prior to 3 years ago. Again, if my observations are still allowed, then yes I have had a negative experienced involving Supervision. The primary experience was related to how I was treated which was not very professional. I believe the Supervisor could have treated me with more respect for my position.

I was supposed to get supervision from one LSCSW as part of being involved in his practice. I received only a handful of the promised supervision sessions and I was also hoping for some of his guidance on my training plan but did not get that either. This would have been 2019-2020. I am currently working with another supervisor.

It can be difficult at times to find supervision in the addiction field.

Lacking in rural KS

My experience was the supervisor I worked with was hired to supervise counselors, and it ended up. We were short staffed and she had to take a caseload of her own and was overworked so she didn't have time to give me my individualized supervision. The other issue was when we did talk she was more consumed with talking about herself than helping me to solve my issues. That was part of the reason that organization.

N/A. Not currently using my license.

No (69 times)

No, I am very lucky to have an experienced and insightful supervisor who has experience with co-occurring disorders.

No, I have helped at another residential SUD provider that has unlicensed and students doing full time addiction counseling with without supervision

No, I've had great supervisors.

No. I'm a Board Approved Supervisor and haven't had issues with supervisees.

No. My supervision is great.

Not that I have experienced.

Poor availability.

Prior supervisor didn't support providing supervision for LCAC and didn't think I could do required work because most of my work was found assessments. She didn't discuss with her supervisor or board. I should have made contact myself but assume she was right.

Supervision is expensive and if you do it with an agency there's a lot of strings attached. And most of the time it's a joke.

Supervisor who has only LAC license overriding decisions of clinical staff. supervisor using personal opinions of clients to determine their success in an inpatient program

The treatment centers I worked for did not provide curriculum training, EHR system training, and the supervisor was never willing to provide solutions

Too many LACs were "grandfathered" in a few years ago, many of which do not deserve the supervision prestige and independence, by comparison to LMACs who completed superior education at the college level.

Yes- my old supervisor is the reason I quit. She was implementing a profit making approach to helping clients and it was totally unethical. I always did in person groups and I had a high success rate, but she wanted to overload my groups and then have me complete certain clients early as they were not making the "non-profit" company enough profit. That was and is a huge shady mess.

Yes. Those in positions to supervise are people with little to no experience in the field or hold only an associates degree. This leads to the perpetuation of misinformation about addictions and effective treatments.

LCAC Q16. Over the past two years, have you experienced any negative issues involving supervision? If so, please explain. (160 responses)

Difficult to have enough time to adequately supervise staff and meet other program duties

One agency's officer says she has a LPC license yet she is not licensed in the state of Kansas. She professes to have been a supervisor in Missouri prior to her position where she supervised those with the Missouri licensing board. She professes to have a license to practice in Kansas but I can't find her with the BSRB. She is deceiving her staff. Another staff member is a LPC in Kansas yet she does not hold a LCPC, and another employee has a LPC and does not hold a LCPC, and an employee has a restricted license and does not hold an independent license and yet she is making decisions that affect BSRB restricted licensed staff. These employees all make the final decisions for hiring, firing, and correction action and get to make the ultimate decisions on critical decisions such as safety of children, they interview staff when there are complaints turned into HR, they fire staff, and make decisions for those who are licensed as a LAC and LMAC. Yet, they get by with working in these positions and the BSRB is not censuring them when they have to renew their license every two years which specifically asks who their supervisors are and our CEO does not hold an independent license with the BSRB. There is no one higher than them in the company. Do you see the ethical's issues the officers are getting by with only having a restricted license? They create the greatest harm for lower level staff due to the threat of retaliation if you turn them in. I have personally seen our officer terminate staff and our supervisor stating that she did not have the ability to save them due to the officer having the ultimate decision. Our LAC in the office is not getting regular supervision and is ultimately out of compliance with the BSRB for the supervisor is located in Wichita, Kansas and does not travel weekly or provide telehealth supervision for her on a consistent basis. Supervision has been cancelled multiple times in a department in which we needed supervision badly but the supervisor would cancel at the last minute or not even show up leaving us with no one to provide the weekly group supervision. supervisors will go on vacation and not provide a substitute. Since our officer does not hold an independent license, she did not even try to assist in taking over the supervision when our independent license supervisors were both on vacation. This is abandonment of supervision responsibility. This creates a consumer danger for the safety of the clients in the residential and reintegration programs for

For those with dual licenses, outside agency supervisors claim to have access to other agency details, and would sign that they knew so very much about the practice upon seeking the next level license, and they actually do not have a clue.

Have not done supervision in past two years, no

I am not supervising others at this time.

I do not provide supervision at all, anymore. That would have been a good option on the previous question.

I feel that we have taken our supervision down a level with less supervision hours and standards.

I have not experienced any negative issues.

I have not had any negative issues beyond what I would consider normal supervisory issues. Overall very positive experiences.

I have not had the responsibility of supervision of others in the past 2 years.

I supervised a therapist who easily manipulated the BSRB and the place of employment to have me removed so she could move into my position

Ignorance of value of abstinence model
My supervisors in the past have not been licensed in addiction counseling.
No - I do not provide clinical supervision
No (127 times)
No issues that aren't remedied through additional coaching.
No, I am a LCP and do not require supervision No I also have an LCAC and do not require supervision
Not supervising anyone
Nothing not addressed above
Only when employees engaged in unprofessional conduct and/or had performance issues.
Primarily around diagnosis.
Quick turn over in staff. New counselors are trained then tend to leave for private practice or other positions with fewer regulations.
Role is a co-supervisor. Have encountered more challenges with other supervisors than trainees. Supervision frequently lacks structure and is inconsistent.
Some staff have not accepted me going from a peer to a supervisor.
Some who call themselves supervisors are not trained or qualified
Supervisee lied about supervision hours
Supervisees who neglect self-care.
Supervision of employees or of other licensed professionals/students?
The 2 people I am supervising are seeing me for gambling counseling certification.
The largest barrier is time for all participants.
With having to do co-occurring treatment there are sometimes issues around helping addiction counselor understand the need to communicate when the staff are new.
Yes- had to terminate supervisees due to unethical behaviors/practices
Yes, but I responded to this under the LP survey. I have not provided supervision under LCAC
Yes. He wasn't teachable.

LAC Q16. Do you currently use artificial intelligence (AI) in your practice? If you do, in what areas do you use AI? (127 responses)

Absolutely not.

Help with progress notes

I am still doing research on AI so no I don't. I need to learn more about this.

I have used AI to assist me in writing progress notes and intake notes.

No (95 times)

No, but investigating note writing...

No, not sure how I would.

No, not yet but we are looking at options for this as an agency practice.

No. We are specifically asked to not use any form of AI.

Not at this time, but may begin using for planning SUD groups and other evidenced based activities

Not yet but willing to try.

Only for training sessions and materials.

Sometimes.

Yes, assessments summary and treatment planning.

yes, for progress notes.

Yes. It helps create extra information for trainings.

LMAC Q16. Do you currently use artificial intelligence (AI) in your practice? If you do, in what areas do you use AI? (107 responses)
Game ideas and names for projects
I used it once to help give ideas for group therapy check-ins. Running a 5 day IOP program can be challenging to come up with creative ideas everyday.
It's a new initiative. Some practitioners are utilizing AI for documentation purposes. Sort of an AI scribe that captures a smart summary of the visit.
Just starting to within the past 30 days. I am distrustful.
My employer plans to implement it soon. I do not wish to use it.
No (82 times)
No I am interested
No, I prefer to not use AI and most of my clients are against this being put in place.
NO. I believe it's unethical.
No. I do not see it as ethical, given multiple areas where AI is deeply unethical and harmful (environmental, plagiarism from artists).
There should be no distinction between LMAC and LCAC.
They are working on it (work in a community mental health agency).
When completing notes
Yes, help with documentation
Yes, I use it to spark ideas if I'm stuck on a client case and am unsure how to proceed. It can also be useful in formatting notes.
Yes, with documentation.
Yes. Drafting email and text messages to clients
Yes. To help with notes.

LCAC Q17. Do you currently use artificial intelligence (AI) in your practice? If you do, in what areas do you use AI? (187 responses)

AI is used by multiple insurance companies to review documentation. Essentially any clinician who accepts insurance is exposing sensitive client data to AI technology. That bothers me, but the client makes that choice when selecting their insurance plan. I will use AI to help me write treatment reports. The information is completely de-identified and the AI is used more as a grammar check and wordsmith. Primarily, AI helps me comply with word count restrictions. For example, a program requested an update on a client but the box provided on their form only allowed a small number of characters. Using an AI program to help me create a succinct report that still provides all the important information was very useful. The time I used to spend on editing reports has been cut by at least half, probably more like 75%.

AI may be used on a limited basis but not routinely.

Center-approved AI use for completing progress notes.

Charting

Completing notes

For notes

I do not currently use AI

I do not currently, but am interested in exploring in the development of treatment plans.

I do not have AI in my practice. I have options to have AI notes but have not chose to implement.

I do not use AI at the moment

I do not. A recent article identified that only about 3-5% of MH apps are empirically tested and research based, with AI being just at the forefront of its development we will need to vet any use of AI through a clinical lens prior to implementation.

I use an EMDR platform that incorporates AI to modify the speed of the bilateral stimulation based on the client's response.

Never I hope-I can think for myself and do work so far, if I had a stroke or something else, then I might need it.

No (116 times)

No but I'm cautiously open to it

No, but I suspect my students use AI to write papers. The state universities are a bit behind on identifying policy about whether this is a good or bad thing. In my opinion, it is not the best way to learn in a lasting way.

No, I do not use it as I have concerns regarding AI and privacy.

No, would not understand how that would even apply to what we do.

No. I am not opposed to it. Just have not used it-no need for it. I think it could be beneficial for some circumstances.

Not at this time, however we intend on exploring the use of AI.

Not currently using AI actively. Investing best practices. Do at times suggest use of one of the CBT based programs if client wants additional practice and feedback on use of the specific tools

not yet but working on it

Not yet, but pending.

Not yet, but actively looking into the matter.

Note taking and progress note enhancement.
Notes and information gathering
Occasionally when doing internet searches an AI will provide me an answer, but I will scroll through to accredited and credible sources for evidenced based answers.
On some platforms such as Betterhelp or Talkspace
Only to research topics.
Our agency does utilize AI for dictation of notes.
Profile, informed consent.
Progress note writing
session documentation
Some predictive text
Therapy Notes incorporates it a little and Adobe does as well.
To generate handouts and psychoeducational materials for clients
Use it to help write notes.
We will move to in in 2025
While I was employed with a Community Mental Health Center, that ended in December of 24, they implemented the use of AI to help with notetaking.
yes
Yes editing documents
Yes progress notes
Yes- transcription of notes
Yes, AI is used as a note taking tool to gather spoken information in session and provide suggestions for notes.
Yes, assistance in documentation (with consent), providing a client summary and follow-up tasks, preparing handouts or written materials
Yes, for marketing and content creation
Yes, in session notes
yes, note taking
Yes, Note writing assistance
Yes. Eleos for progress notes.
Yes. Word documents
Yes. It varies from administrative applications to generating treatment plans and having interns practice with AI through roleplay. When SimplePractice creates a note AI, we will be implementing that.
Yes. We use AI to formulate progress note from our memo or notes.

LAC 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? (107 responses)

Additional trainings in ethics, evidenced based practices.

AGENCIES NEED MORE TRAINING IN THE DIFFERENCES BETWEEN HIPPA AND 42 CFR.

Allow license to be obtained through less education. We do not need gen Ed topics for the degree, simply core classes. Which would allow more people in to the field, more efficiently add to the field, and make the field more cost efficient for initial education required to enter

Better care coordination through Social Work and Addictions Counselors to better care for clients. Also with Mental Health workers/advocates to better streamline care through the different pieces of the puzzle.

Better checks of releases and consents during audits.

Better peer specialist training

By being able to engage clients in treatment sooner rather than having to wait several weeks or a month. When that client is ready to engage in recovery, treatment needs to be available sooner than later, or the client has a tendency to not go at all because of continued use.

Caution on the medications and long term effects of prescribed Psych meds.

Currently the only people that can diagnose are LMAC/LCAC. I have counselors that have been in place for 10, 20 and even 30 years that have a much better understanding of diagnosing than a newly graduated LMAC. There needs to be a time component with licensing as well. Many of the grandfathered LCAC's will be retiring soon and the pool of LMAC's are just not meeting the needs of the community.

Education around changes in confidentiality laws.

Enforcement of number of clients that a licensed counselor has on their caseload.

Ensure telehealth is more closely monitored if offering outpatient group telehealth services - cap telehealth groups at 10 for IOP and OP

Get people signed up for the correct license/test.

Having clear boundaries on what Peer Mentors and Counselors do that are different and providing free state training to help supervisors understand this difference.

I feel the BSRB does a great job as is.

I personally would like to be able to ask a question and get an answer not read... I am pretty sure most people have.

I think if there are practitioners violating ethical boundaries, such as having inappropriate relationships with clients, they should be banned from continuing to work under licensure. There have been multiple people with these specific violations over the years, and they have gotten very little repercussions and then even repeated the behavior, and still maintain in standing licenses with the BSRB to this day. It makes it seem as if there is no accountability for disobeying direct standing practices.
I think the required 40 hours of CEU is too much for every two years.
I'm not sure (3 times)
Increase staffing levels at facilities.
Limit the number of client's in groups and the number assigned to Inpatient Counselors.
Look at the guidelines for PM
Lower the educational requirement to be an LAC. Once it was raised people started starting away from it, which is creating a major shortage.
Make decisions for the greater good so we can serve more people.
Make it less complicated to get licensed. Many treatment centers have difficulty hiring because no one wants to go to the trouble of getting a license in Kansas; it is easier to get a license in Missouri from what I've been told. I got my KS license with an AA degree in 2006. It is a BA, now, right? For the cost of what we do mentally and emotionally, doubling the student loan is not good incentive.
Maybe more diversity training. How to appropriately ask for information about culture.
More conferences at reasonable rates and connecting with other states for licensure.
More continuing education requirements
More culture diversity trainings
Myself and others have talked about better definite responses by the BSRB. We've asked on a number of occasions if an MSW was allowed to diagnose in SUD without an SUD license. From what I understand and MSW could diagnose a mental health but not SUD. But if an MSW could diagnose mental health why wouldn't they be able to diagnose SUD? We've asked on several occasions and there seems to be a vague answer every time. So on this question and a couple of other occasions would really like more definite answers.
No (65 times)
No, I can't think of anything, especially with all of the changes and improvements made over the past 5 years.
Offer more services in rural areas
Offering more frequent surveys similar to this, but more topical.
Please allow LAC's to obtain the LCAC credentials based on years in practice. I have 40 years experience but not enough college credits because I always had to work to keep a family going.

Provide a job board and pursue agencies that are providing services without paying for LAC licensed counselors.

Referrals that are meet criteria for treatment.

See 18

The people that are teaching addiction counseling in the colleges - need to understand addiction specifically - not as an add on to other disciplines. However, I don't think that direction can or will be changed. Our field suffered a lot as far as having counselors that understand addiction and that would have been really good counselors when the academics became the focus vs. knowing what you are doing with this specific field.

To better serve consumers I think we need to figure out a way to fix the workforce shortage. This is a problem in the rural areas of Kansas.

We are seeing a proliferation of recovering advocates and self-help coaches advertising their services online. Not sure what can be done. The BRSB might consider licensing standards for peer counselors and techs, recovery coaches to help protect consumers.

LMAC 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? (106 responses)

As a Outpatient provider, we lack resources for the Level III clients. We could definitely increase the number of beds for Level III residential clients

Assist therapists that work for agencies in fighting the impossible direct services requirements that negatively affect the quality of care we provide our clients.

Audits of supervisors that oversee addiction counselors

Availability with questions and considerations- maybe hire more BSRB employees- I know that is probably a budgeting issue.

Boundaries training requirements for renewal.

By completing your due diligence by monitoring, and following up on all reports.

Create a compact

Dual relationships seem to come up often especially for addiction counselors who are also in recovery and attending 12 step mugs. I have witnessed blurred boundaries many times.

Educate clients/consumers on how to report if a counselor is behaving in an unethical or harmful manner towards clients. Clients often have no idea where to start to report such behaviors by professionals.

I do not have any additional suggestions?

I think you are doing a good job.

I was able to sit for the LMAC after my LMSW, So why can't I sit for the LCAC post LSCSW

I would like to see a national license be created.

It would be nice if we who have worked as an Addiction counselor for over 10 years could be grandfather into clinical like you grandfathered those with no education into be8ng an LAC

Maybe request more references of each applicant.

More funding for different types of substance abuse treatments, not just facilities centered around 12 steps.

More information provided to therapists/counselors regarding co-occurring of mental health and substance use.

More staff available at BSRB to help answer questions and move application process along

No (47 times)

No—maybe those that supervise in the field have other ways of obtaining requirements toward clinical licensure. Again, the hours required make it difficult to obtain, considering we have passed all testing requirements for masters level practice.

Not sure, to new to the field

Offer CEUs

Offer more free access to CEU.

Require professional conduct/development CEUs.
Restructure the relationship between corrections and counseling
Slow down the painless ease that allows basic social workers to practice SUD with ill-equipped and germane academics.
SO many- the company I worked for was so shady. The management is all about profit and recidivism creates profit, so if they do a half ass job at healing, they guarantee clients will be back. They were doing 3 hrs. 3 days a week and decided they get per diem so moved to 2 hours 5 days a week. It is a non-profit that is profit driven.
Stop grandfathering people into the addictions field. Stop allowing people in other states to easily get licensed here and then telehealth services for Kansans when working in another state, because they don't understand how services work in Kansas and are unfamiliar with our states resources
Stop loosening educational and licensing requirements. Professionals who take the work seriously are leaving because we don't want to work with untrained unprofessional people who are hired because they're willing to work for less pay than those of use who have put in the time and gone to the expense of an actual education and training.
The LMAC needs to less restrictive in practice most persons I serve have the comorbidity of mental health issues. Currently, I can only tx people with A/D issues. It is a mistake to silo addiction counseling because SUD don't exist in a vacuum.
Unsure
Update guidance to include the new ASAM criteria.
We need more in person trainings available, especially in rural areas
We need more of us. School loans are difficult to endure.
With the significant shortage of licensed addiction counselor's many clients have to wait extended times to be seen at the higher levels of care.
Yes, do away with the ridiculous exams that strangle the profession. In its place use, 1. the candidate for full LP license should have a Psy.D. or PH.D. from an APA school and internship, have been working in the field for 10 years and have a practicing LMLP license in Kansas. The addiction field will benefit from allowing those with LMAC and have been in the field for over 10 years to get the LCAC, so that the field of addiction counseling will have more supervisors who can supervise from experience and not from mere text books.
You're making it easier to navigate all the time and that's greatly appreciated!

LCAC Q18. Based on your experience as a licensee in Kansas, do you have any recommendations on additional ways the BSRB could protect and serve consumers of services offered by BSRB licensees? (150 responses)

A nationwide compact will open up doors for counselors and clients.

Adequate protections and service appear to be in place

Advocate for making reimbursement from Medicaid more reliable.

Already do a great job

Assist w/ reciprocity to other states

Make the CEU requirements the same as other master level professionals

Better trading for supervisors

BSRB is as busy as others and following the guidelines is complex. The outside culture too, affects the thinking in the micro...there is plenty going on that borders on unethical or is unethical, but the intersection of the regs/statutes is complex.

Continue effort to reduce barriers to access by clients. This may include regulation modifications to increase number of licensees

Create a formal training process for new counselors that require a demonstration of competence prior to practicing independently and reduce the number of license types, it's confusing. Professionalizing the field by demonstrating competence does not create a barrier to entry, however lack of competence is a public safety issue.

Create collaborative teams within the regions of 'working' counselors/mental health and social work programs to be able to collaborate for best practices and client care. Offer online meetings monthly for these teams or with the advisory board when things are changing/policy changes/funding changes that will affect our work/practices.

Encourage the state to reduce client caseloads for counselors who are working.

Ensure professional boundaries.

Expand the addiction license to treat multiple addictions (substance use plus sex, porn and love addiction, gambling addiction, etc.). Counselors should have licenses and extensive training to treat these issues.

Familiarizing the General Public more with the functions and Services provided by LCACs

Going out to facilities to view services and provide feedback.

Have more oversight on what programs are credentialed.

Help link counselors with the latest available resources and trainings. I'm concerned that there are many newly licensed master's level (not independently licensed) practitioners functioning as independent practitioners because they supposedly have supervision in place. In reality they are leasing their own space and have no one on site most of the time. Also on sites such as PsychologyToday.com there are a number of out-of-state providers who pay to be listed as local providers in Kansas yet they are not licensed in Kansas and are not part of a compact. People come into my office after seeing them and are surprised to find that there are a range of local providers who will work with their insurance companies and provide competent services. Tried filing a complaint with Psychology Today about one and they said the person technically hadn't done anything unethical. And...since you asked... there are a growing number of online "coaches" that cater to specific issues and charge hefty fees but they have no training or credentials in some very tricky areas including trauma, addiction, suicidality, etc.

Help me understand when insurances cover addiction issues

I am very concerned about SB63 being passed and the repercussions for people with gender identity issues and those providing services to them.

I believe we got enough regulation. The profession needs to pay more money so that we can keep license addiction counselors

I don't think so at this time.

I feel that the BSRB does a great job protecting and serving consumers.

I honestly believe the toughest issue right now for everyone personally is financial. Pay has not really increased but the cost of everything else has. I know the renewal fees were decreased a while back which was wonderful.

I think if more information could be disseminated about the regulations regarding professional conduct, supervision standards, and ways to become licensed in the different professions.

I think it is wrong that BSW students, who do not receive clinical training in their educational program, are able to get LACs by only adding courses in addictions treatment and pharmacology. This is not sufficient education in addictions counseling to safeguard the consumer.

I think you are doing a good job

In many cases, I refer back to the words of my college professor who was the head of the substance abuse program where I earned my Bachelor's degree. He related that, as a practitioner, one did not have to have suffered from schizophrenia in order to help a client who was suffering from schizophrenia. His stance remained the same with addictions, holding that one did not have to have suffered from an addiction in order to help one overcome an addiction. However, it has been my experience, many times, that the realm of addiction is it's own beast. And while I have worked with many practitioners with an LPC or LCP (or other) licensure who was not in their own right in recovery, there was something missing. Many times that something could be overcome with technique, focus on relationship and client centered interactions. However, there were also key and critical moments when a practitioner having had a history of overcoming addiction herself or himself was most likely a key factor in helping the individual in need to hang on and stay engaged in treatment. Definitely there are moments early in the treatment process wherein a client who may otherwise lean toward the exiting side of ambivalence has maintained engagement in treatment due to the fact his counselor was also a fellow in recovery, be that fellow a male or female. Having that common background in the field of addiction seems to carry more weight when addressing addictions than when addressing other MH disorders.

Insurance provide more details to consumers of coverage in a more easily accessed streamlined way

Inter-state licensure and any efforts for master's level psychologists to be able to work with Medicare, Tricare, and EAPs.

Keep expectations and standards high. This will keep our people, communities, and society safe and well.

Keep reviewing ways to improve field participation. We don't have enough qualified people

License art therapists

Like multi-state licensing for substance and mental health clinical licenses.

Make the test easier reduce cost for licensure order more evidence based educational opportunities allow continuing education to be more broad

More clarity on scope of practice

More co-occurring capable clinicians. Practice silos are detrimental.

more information available to general public regarding need to use licensed practitioners

More long term programs for people struggling with addiction.

More of mind and educational areas as of so many other states these days

More thorough investigations of complaints and not assuming the complaints are legit

More training on block grants

Multi-state license may be beneficial for underserved areas.

My belief is that the BSRB is doing the best they can with the limited resources provided.

No (83 times)
No. I think you do a good job.
Not sure (5 times)
Nothing other than ensuring we maintain awareness about compassion fatigue, boundaries/ethics, and scopes of practice.
Over the years the bar has been set higher and higher to get licensed creating an artificial shortage of workers (like the devastated child welfare system, and the teacher shortage in education) This isn't serving consumers at all.
Provide clearer guidelines around the implementation of AI.
Provide study material of some sort for the addiction counselor exam. Advocate for fair salaries for addiction counselors.
Required supervision plans for new counselors.
Signing up and advocating for any and all interstate compacts is critical.
social workers especially and other professions would benefit from further education in addictions. There are so many professionals that don't want to work with the addicted client that they miss recognizing it so it goes undiagnosed and not referred for services. Families then are destroyed because it goes untreated or addressed.
Support LCAC to practice independent of KDADS
Temporary licenses for Master students in their last semester could be beneficial. Then give them 12 months to take the exam but still be able to be a part of the work force.
The consumers are no longer a priority when salaries are not high enough to draw good counselors. The dumbing-down of licensure requirements is a sad way to have to deal with the scarcity of counselors.
The process of getting licensed in Kansas after being licensed in CO for a number of years seemed unnecessarily cumbersome and time consuming. Perhaps this could be streamlined by the idea listed above of having an inter-state recognized licensing board for both LCAC and LCPC level providers.
There are some restrictions for LCAC's due to what is believed to be a lack of training in the mental health field. LSCSW's are allowed to practice in that field and it causes some challenges with insurance companies at times.
Use of the ASAM criteria would be helpful.
When counselors are reported for having intimate relationships with clients, their licenses should be removed. I know of situations when the individuals have been allowed to continue to practice.
Would welcome chance to visit in person, by phone, etc. to further discuss observations & dealings with BSRB that impact service delivery.
Wrong question and wrong direction on what purpose of the BSRB should be in my opinion. How about how the BSRB could support and help licensees?
Yes, require that those with an LMAC and higher actually have plenty of education specifically in addiction counseling. I stated this concern in the above question.

Yes. Make your reciprocity agreement truly reciprocity, and not the circus of hoops that I had to get licenses in KS , after being licensed in MD for 20-years.

LAC 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 addiction counseling profession? (97 responses)

A union to represent and protect counselors.

Allowing out of state non-accredited schools be implemented into the program with proof of education.

BSRB needs to be more inclusive of other universities that are accepted for being licensed in the state of Kansas!

Could we figure out an incentive program for individuals who are interested in seeking and providing Addiction Counseling services in Rural Kansas or Just Kansas to help meet the needs? Maybe even incentives for individuals to purpose MSW or get licensed for LMAC/LCAC and stay in Kansas? Dane G Hansen Foundation has an interesting program that might be a good reference. Or an incentive program for a way that Peer Mentors can become licensed?

Extending the license renewal period to three to five years.

Have more opportunities for LAC. It seems there are more opportunities for social workers

I ask that the Advisory Committee consider what resources are available to all areas of Kansas before changes to the statutes and regulations are made.

I believe that people with past violations should be removed from being in good standing with the BSRB and licensure at this time. It makes everyone else look bad when we all have the same rules and regulations.

I could used ideas for ways to address counselor burn out that can be implemented in a small agency but busy agency.

I do not, but thank you for asking.

I think overall the BSRB does a fantastic job. I was turned in for an appropriate behavior last year and the process of accountability was transparent and I appreciate it that. I appreciate that due to the communication that was involved not because I had no action taken against me. If anything I would recommend more information explaining all the BSRB does to help the field. I'm embarrassed to say I was way too ignorant on just how much the BSRB helps.

I think these surveys are a great way to give current licensees an opportunity to provide feedback on various topics.

I wish that previously certified / licensed LAC's who also had Bachelor's degrees, who took the National test, would have been grandfathered to the LCAC license. At that time, I believe current LAC's without Bachelor's degrees who also hadn't taken the national test were grandfathered as LAC's. This was very disappointing to several who had worked in and supported the SUD field for several years and had paid association and membership dues for several years as well.

I wouldn't suggest making a Master's degree a requirement for addiction counselors to obtain - this field used to be oversaturated with counselors 10+ years ago and now many providers, from what I've seen in the last 5 years, are desperate to find, hire, and retain them.

I'm in favor of the 27 hour certificate returning.

In Arkansas substance abuse counselors are becoming obsolete, sadly. The field is moving toward Licensed Mental Health therapists. I do not know if that applies in Kansas, too, and it is frustrating. Maybe providing ways that would make it easier on those with an LAC to have more education in order to protect their jobs? Again, I'm not living in Kansas, currently.

It appears that opening up positions such as peer mentors has decreased counselor positions. Ut it has also decreased the impact of services because they can only provide "education". It seems like community sponsorship has been professionalized and financially incentivized.

Making sure there are clear guidelines on the use of ST LAC.

Working with colleges to encourage graduate programs easily available.

Reciprocity of out of state licensing.

Those you have extensive experience have an higher licensing than a LAC without having additional education.

Mental health and SUD are miles apart in regulation, why is that?

No - thank you for creating this survey and requesting our input/feedback.

No (62 times)

No more than I already recommended in #17. Thank you for asking.

No other comments. Thank you for helping us professionalize the addiction counseling profession. I have been in it 35 years and I feel it has been an improvement, and we are taken more serious as a profession

No. Thank you for doing this survey.

None at this time. My experience with the BRSB has been great.

Nope. Good luck with your survey.

Pt/counselor ratio needs changed.

Stop making it more difficult, cumbersome, expensive by increasing what a person has to do to work in this field - people will continue to shy away from it - it's too hard of work for too little of pay for what is required to do this work.

Take in consideration culture and language of clients for assessments.

That if an LAC returns to school for a master's degree they should be able to receive the LMAC without all the additional testing.

The LACs that were grandfathered in when certification became a licensure, hold valuable experiences and expertise on Recovery and life values of their clients.

The process for an ST-LAC to get approval to test for the LAC is apparently taking months to happen. I understand that the course review is what is holding it up.

The updated website looks better, and the links seem to be functioning properly.

This is the 1st I've become aware of this committee.

When looking to go to other states, and move to a LMAC. I miss the grandfather rule by 3 months. It's unfair.

When we had KAAP there were a lot more educational conferences being put on around the State. I seldom hear of them anymore.

LMAC 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 addiction counseling profession? (76 responses)

A counselor assistant program to increase workforce numbers would be great. Often addiction counselors are second career individuals who are not willing to return for a full 4 year degree.

Again I believe once you have a masters level there should only be one designation either LMAC or LCAC not both because your doing the same job and have the same expertise. More work load is just being added to get LCAC.

Allow dually licensed therapist who have the correct addictions education and clinical license level in mental health become clinical in addictions without taking another exam.

Allow for easier licensing to dual LCP license. Reduce requirements for obtaining LCAC licensing for those who have obtained a masters degree specific in addictions. If someone completed practicums in addictions under a masters program and has at least 5 cumulative years of experience in the field they should be allowed to obtain LCAC status without any further requirements being met. Do not allow current LCAC's to provide clinical supervision to those seeking such licensure if they don't have at least 5 cumulative years of experience in the field and haven't worked in the addictions field with the last 2 previous years prior to providing supervision.

Annual meetings for all addiction professionals

Ban gender affirming care in all behavioral health care settings

Consider letting those with masters and clinical level addiction counseling take clinical counseling exam. It would allow many to advance.

Curriculum training for counselors that's not a self guided computer training

Fair pay would be nice and attractive more talented professionals. I could make more money as a waitress. Idk if you can help with this. In lucky to be offered \$28-32 per hour for most agency work

How do you become a board member?

I have been addiction counselor 38 years. It seems the field has been dominated by mental health providers. I would like LMAC to be recognized as a specialty.

I love the multistate compact idea...very, very useful for provider in KC. Thank you.

I think that addictions counselors should be able to take less classes than another masters degree to be dually licensed, just as LPC and social workers are able to do little to be addictions counselors.

I work primarily with adult clients who have ADHD. The overlap of ADHD and addiction is well known but treatment modalities are not well covered or widely known in the addiction counseling community in my experience

I would recommend they go in as clients to see how things really are. Have a board member schedule an assessment and do it and see how it goes, etc. I am currently working in a kids facility and it seems a lot more ethical but when I worked at CKF there was so much going on that was not ethical, all about zoom and money. Talk to the probation officers in the area and ask them their opinions on the treatment their clients receive.

Make sure those supervising addiction counselors have higher licenses than those they supervise
Making it easier to get licensed means more professionals leave and service quality goes down. Changing regulations to require less education and training may mean more licensees, but will result in poor quality services and drive professionals out of the field.
More education and resources for medicated assisted treatment.
No (45 times)
Perhaps putting together a course or resources for LMSW's going into addiction counseling and working towards their LMAC's, even with the courses I had in under and graduate school that were addiction specific, they were very much broad overviews, and having some resources specifically oriented towards LMSW's would be helpful just for confidence and grounding while putting together all of the LMAC study materials for the test and making sure we have the basics and a sense of strong grounding beyond passing the MAC test.
Personally I take it serious when it comes to helping individuals who suffer from addictions or mental health issues not just here in our state of Kansas but around our USA. Getting ride of the red tape that stops professionals from getting fully licensed will allow a better availability for mentoring new professionals and serving our community without restriction.
Questions 1, 2, and 7 were not applicable due to telehealth program. Considering revising to include "not applicable" as an option. "Preference not to answer" is not accurate in these situations.
Read above answer.
Stop the flood of social workers given gratuitous access to a specialized profession. Soon, MSWs might likely be doing brain surgery
SUD counselors need to be able to dx and provide counseling in a more flexible manner.
Thank you for allowing feedback via survey!
Thanks for offering the license at a reasonable rate.
The structure of who is allowed to be an addiction counselor is confusing and I'm sure not clear to the general public or clients who would need it. I think in the past, people with nothing more than a high school education worked in the field as addiction counselors, but the general public isn't aware of the difference between that and a masters' or higher-level addiction license/practitioner.
To consider: Should the CEU count for LMAC renewal mirror the count for LMSW renewal?
To strongly consider creating a less toxic work environment and begin holding management & leadership accountable for their actions. Thank you for the survey.
We need other funding options for those who cannot afford treatment. Yes we have the federal block grant but at times that is not enough.
Yes, reconsider giving out our addiction credentials to social workers. They don't seem to understand the addiction field.

LCAC Q19. Do you have any other comments or feedback you think would be helpful for the members of the Advisory Committee to receive when evaluating possible recommendations for changes to the statutes and regulations for the addiction counseling profession? (140 responses)

Again I probably should get involved in the addictions advisory group. It would give me a chance to talk about things that I observe and want to help improve.

As I enter the twilight of my working life and can look back almost 30 years of working in addiction counseling from adolescents to inmates, I can see that the feeling of belonging in a professional community has disappeared. One can blame COVID in the recent past. I am curious to find a solution and motivation for folks to reengage with their professional community. I prefer to leave my home and attend trainings in person but my ability to miss work is a barrier leading to my disconnect. I may have answered my own question! Thank you for the survey, I look forward to the results.

As I noted before, I believe there has been a change in the community we are serving and I am definitely hearing more and more about aggressive and inappropriate clients. Maybe some education or requirements around de-escalation and creating boundaries.

Clarity on each of the AC licenses and whom qualifies for what

Consider local/regional customs as part of ethical and professional standards.

Current website is confusing for people seeking access to assessment tools

Eliminate the student level license. Require master's level licensure to provide assessment and counseling services similar to what is required for mental health.

Ensure non addiction educated individuals are competent...that ship has sailed

Feel free to contact me

Help put in laymen's terms what the different levels of licensure are able to serve

How many degrees is classified is valid I think is significant the state of Kansas. There are so many states that recognize online because they provide on ground practicum and residencies. You have to pass licensing at a doctor at level. All you have to pass a comprehensive examination and you have to do a dissertation with a board of certified psychologist. Kansas is very limited in what they accept which I think is a detriment to our profession. I know Kansas is very conservative which I am into but certain areas you've got a change with the times if they're in accredited institution, they should be given the same Approval. That's only been my one disappointment with the BSRB otherwise I think it's a wonderful licensing board

I admire your dedication when I know your hands are tied in many ways. Thank you for your service.

I am concerned for clients, as the therapists who are truly client-focused are being pushed out by others who are not

I appreciate that the BSRB allows for a simple process to maintain dual licenses. It encourages holistic treatment approaches and increased access in client care.

I can't think of any at this time as you all have done a great job updating them as needed.

I do not at this time.

I don't

I don't think a licensed addiction counselor should have to have four years of college

I really wish we didn't have to be licensed by KDADS to run addiction programs out of our practices but this may not be an issue for the BSRB. I'd really like to see more independent private practitioners who are able to provide addiction counseling and assessments.
I think it makes sense for those that are dually licensed to be able to renew both of their licenses at the same time as long as they have met the requirements, even if that means paying twice. I feel that the multi-state licensure is necessary for Kansas to stay up to date with the rest of the nation, as well.
I think it's a challenge to obtain and maintain great therapists when the amount of pay for SUD field whether private or state funded is terrible.
I would recommend addiction counselors be required to complete CEUs in mental health conditions, specifically trauma, as addiction and trauma are more often than not co-occurring. If the trauma is not addressed the addiction cannot be addressed. Affordable or free training in EMDR or Accelerated Resolution Therapy (ART) and other trauma based therapies is highly recommended.
I'm very grateful for the Advisory Committee and think they are doing a great job!
I'm still not clear about whether an LCAC in private practice can actually provide and bill for addiction treatment in a facility (i.e., a private practice office) that is not a licensed addiction treatment facility. I didn't think they could but it seems to be happening.
It would be good if the BSRB worked more closely with educational programs to help strengthen these programs to promote a larger, better trained workforce. These programs could use your help in gaining support and continued funding from University administration.
It would be nice to have more town hall type gatherings where we can talk about processes and struggles, more trainings or conferences, and more active groups promoting substance use treatment. SUD treatment feels very isolating at times and I don't think people see or respect this licensure like they should.
It's time for Advisory Committees to seriously consider reciprocity with other states (like nursing and medicine) or expect no one can get services on a timely basis. Non-reciprocity is just "fence building" and "closed shop tactics" in a supposedly "right to work" state. It hurts consumers and creates artificial shortages.
Keep doing a good jobs
Make the BSRB and KDADS websites more user friendly.
Match addiction counseling regulations with those for mental health regulations.
More incentives to get addiction license and what it means to be competent in practice. Many LMSWs have expressed concerns about working out of scope
No (87 times)
No recommendations for significant changes in the current statutes and/or regulations to date
Not at this time. Of note, Two questions need "not at this time" as an option, as am looking to return to the workforce soon following surgery
Not sure

One recommendation I would have is reconsidering (or advocating) to KDADS on the mandated required paperwork regarding treatment and clinical documentation on providing addiction counseling services in the state of Kansas. I am dually certified in the state of Kansas and was providing both addiction counseling services and behavioral health services. At one point, I considered removing myself from serving under the addiction treatment umbrella because it was far more work outside of the counseling session and I was not being compensated for the additional expertise of dual licensure. I understand the importance of having individuals sign treatment plans and the content within the treatment plans; however, it can be tedious and time consuming which takes away from the quality of service able to be provided. There were times that I would spend nights at home off the clock (I was salary) working on these treatment plans after a 10 hour day to make them as KDADS recommends and it takes a lot out of the clinician. I wanted to continue to serve that population as it was a clear need in Allen county; however, it was so much work outside of the actual counseling process. The way things are set up and the criteria in place, is making the clinicians life more challenging and feels like we value documentation more than the actual service being provided. It is my understanding that addiction counseling sessions are less of a charge than a behavioral health session. It did not make a lot of sense to me why the addiction counseling criteria and standards were so much higher and more frequent than that of behavioral health. I do think minimizing some of the added work outside of the session would allow for clinicians to have more time to provide quality treatment, take care of themselves, and complete genuine needed tasks with their spare time such as calling to check in on the patient (if needed) collaborating with their psychiatrist, probation officers, family members, etc. I do think more individuals like myself would primarily serve as an addition counselor if it was not for the intense mandates and standards related to documentation and treatment planning. Network and possibly retain more addiction counselors in the state of Kansas.

Only in reference to question 18, to help us maintain the specialty of addictions counseling within the overall field of MH disorders as just that, a specialization. I would hate for my licensure to be gobbled up by the MH umbrella after having spent 7yrs in college and a 4,000 hour supervised internship earning my place in the specialty field of addictions.

Other states have licensure such as LADCMH that combines addiction and mental health.

Reciprocity would be helpful to extend our practice in other States. Better funding for non-profits to level up our pay commiserate with our licensure and legitimize our work.

Required supervision plan for new counselors.

Review how we got to where we are...and fix the broken system. A licensed clinician..any..can DX and TX all DX's in DSM-5. Stop carving out Addiction as a special license. I think this license could be used for a narrow group of individuals who want a short-cut to help only in the substance field, thus they are not able to work with everyone and have less credentials. But not make already qualified clinicians jump through more hoops, to obtain another license they don't need. Should we create a license for more subsets? Like Severe mental illness/Psychotic disorders. For Adults only make a new license, For children only make a special license, on and on.

See above comments. Create a master addiction license for treating multiple addictions.
Temp license for students!
Thanks for doing things like this survey
thanks for your advocacy and time
That's a little bit of a loaded question, as we need/want as many individuals as possible to assist in the addiction field, which is stigmatized. We also want to ensure treatment efficacy. I think the BSRB frequently does a better job of promoting the importance of the various professions than the affiliate public & private entities/agencies that influence the <u>practitioners of the professions.</u>
The importance of training in therapies for people with dual diagnosis.
The temporary student license was a nice addition and has assisted in allowing more providers to work in field.
When addiction counselors get degrees from colleges that don't do internships it would be helpful if we could hire them and they could do on-the-job hours that could count as the needed hours. Supervisor should be required to spend more time supervising them. There have been a number of people from other states that I couldn't hire because of no internship because they couldn't get licensed check into licensing.
Would welcome chance to visit in person, by phone, etc. to further discuss observations and dealings with BSRB that impact service delivery.
Yes! Back in 2017, I wrote and sent an open letter to you. This information is still <u>pertinent 8 years later.</u>
Yes, it would be great if they could advocate for us to be on the same level as a LSCSW, as we have more hours post graduate, our exam is at the doctorate level, and yet we are not recognized by the VA as being "qualified". They accept LSCSW, with less training and a much less intense exam, but will not recognize the LCP which should be <u>vied at the same level as a PhD or PsyD</u>
Yes. See above. And remember, when I decided to get licensed in KS, I was doing KS a favor, and NOT the other way around. So, stop making it so difficult by removing barriers.
Your licensing exam should not be like the EPPP. The questions are not tailored just for those practicing in addictions. I notice some of those questions on the test are more for other professions such as the Psychologists and LPC's.