

Behavioral Sciences Regulatory Board

2025 Survey of Licensed Psychologists

Final Report

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Introduction and Methodology

This report is part of a series of reports studying survey results in the spring of 2025 from individuals holding a permanent license under the Kansas Behavioral Sciences Regulatory Board (BSRB). In Kansas, the BSRB is the state agency charged to license and regulate most of the state's mental health professionals, including the licensed psychologist profession. As of February 2025, Kansas offers one level of permanent licensure for the licensed psychology: an independent level of license called a Licensed Psychologist (LP) license. To assist the work of the Board, the BSRB utilizes seven subcommittees, called "Advisory Committees," which are comprised of the Board member for the profession (serving as Chair), a public Board member, and between three and ten other individuals, usually licensees for that profession.

In 2024, members of the Licensed Psychology Advisory Committee for the BSRB requested the creation of a survey of licensees in their profession. The purpose of the survey was to collect information relevant to the public protection mission of the Board, seek feedback on topics relevant to the work of the Advisory Committee, and to better understand the master's level psychology workforce in Kansas. The members of the Advisory Committee worked with the Executive Director of the BSRB to draft potential questions for a survey, while BSRB Advisory Committees for other professions developed similar questions for surveys for licensees in their professions. While the final survey included a few unique questions per profession, efforts were made to create uniformity for most topics between the professions, so both a profession-specific report and an overall summary report comparing professions could be created.

As of January 13, 2025, the total number of licensees in the licensed psychology profession in Kansas totaled 1,047. From January 24, 2025, to February 23, 2025, all LPs under the BSRB received an e-mail from the agency informing them about the optional survey and notifying them to expect an invitation sent directly from SurveyMonkey with a link to complete an optional survey from the BSRB. While the survey was optional, licensees were encouraged to complete the survey. Adjustments were made to the SurveyMonkey system to ensure responses remained anonymous, however a series of targeted reminders (about one per week) were sent to licensees who had not yet completed the survey.

Over the 31 days that the survey was open for responses, 297 individuals completed the survey, for an overall response rate of 28.4 percent.

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

Executive Summary

The 2025 Survey of Licensed Psychologists by the Kansas Behavioral Sciences Regulatory Board revealed helpful findings about workforce trends and other information related to practice and licensure. Over the 31 days the survey was open for responses, a total of 297 psychologists completed the survey.

Practice Location by County – Several counties were reported, but common responses showed that psychologists were most likely to practice in Johnson County, Sedgwick County, or Douglas County.

Practice Location by Urban, Rural, or Frontier Areas – The vast majority of psychologists reported practicing in urban areas (86 percent), while about 14 percent practice in rural areas.

Practice Area by Setting – Concerning practice area by setting, the majority of psychologists work in a private practice (55 percent), followed by 23 percent working in public practice, 12 percent in other areas, and 10 percent in education.

Length of Career Practicing Psychology – The vast majority of psychologists report practicing over 10 years (81 percent), while 11 percent have worked between five and 10 years.

Licensure in Multiple States – The majority of psychologists report being licensed in one state (54 percent), followed by 34 percent reporting being licensed in two states, and about 9 percent being licensed in three to five states.

Maintaining an Active License, but Not Currently Practicing – The vast majority of psychologists who maintain active licenses report continuing to provide services (81 percent). For individuals who maintain an active license but are not providing services, the most common reason is employment positions that required a license to be held but did not involve direct services being provided to clients.

Number of Hours Providing In-Person Services Per Week – The most common response was from psychologists providing between 20 and 40 hours of in-person services each week (39 percent), followed 23 percent providing 10 to 20 hours per week, 22 percent providing fewer than five hours per week, and 12 percent providing between five and 10 hours of in-person services per week.

Number of Hours Providing Telehealth/Remote Services Per Week – The most common response was from psychologists providing fewer than five hours of telehealth/remote services to clients each week (57 percent), followed by 19 percent providing between five to 10 hours of remote services per week, 17 percent providing between 10 to 20 hours of services per week, and 7 percent providing between 20 hours to 40 hours of remote services per week.

Number of Hours Overseeing or Managing Work of Others – The most common response was from psychologists spending less than five hours per week overseeing or managing others (66 percent), followed by 15 percent performing this task between five to 10 hours per week, while all other responses were less than 10 percent.

Anticipated Retirements in Next Five Years – The majority of psychologists do not anticipate retiring in the next five years (69 percent), though 18 percent anticipate retiring in the next five to 10 years, and 13 percent are unsure.

Familiarity with Licensed Psychology Advisory Committee – The majority of psychologists noted they were unfamiliar with the work of the BSRB’s Licensed Psychology Advisory Committee (64 percent), while 22 percent noted they were somewhat familiar with the work of the Committee. All other responses were less than seven percent.

Negative Practice-Related Issues Observed by Licensees – Over the past two years, about 18 percent of psychologists observed no practice-related negative issues nor areas where psychologists needed more continuing education or training. However, psychologists who reported observing negative issues highlighted the need for training in the areas of insurance, diagnostics, ethics, utilization of artificial intelligence, and several practice-related areas.

Negative Telehealth Issues Observed by Licensees – Sixty percent of psychologists had not experienced negative issues involving telehealth in the past two years. Several psychologists highlighted the benefits of remote practice, though other psychologists noted complications involving insurance, preservation of confidentiality, and technical issues.

Frequency of Providing Supervision – When asked the number of individuals each psychologist was providing supervision to at one time, 23 percent reported providing supervision to one person, while about 15 percent provided supervision to either two individuals or between three to five individuals (both 15 percent). (*Note: 35 percent of psychologists reported they preferred not to answer this question, though some psychologists noted stated in a different survey answer that there was a survey drafting error on this question, so respondents did not have the option to select an option to note providing supervision to “zero” individuals.*)

Negative Supervision Issues Experienced by Licensees – Psychologists noting having experienced negative issues involving supervision over the past two years highlighted concerns with supervisees not being at the same standard post-graduation as previous groups. Other concerns focused on generational differences, professional burnout, and issues involving psychologists to supervise other professions.

Utilization of Artificial Intelligence (AI) in Practice – At the time of the survey, about 76 percent of psychologists reported not using AI in practice, though some of these respondents stated they would be moving towards AI. Concerning psychologists who use AI in practice, the most

frequently reported uses include assistance with writing and grammar, other documentation, treatment planning, marketing, and research.

Additional Ways the BSRB Could Protect and Serve Consumers of Services – Thirty-one percent of psychologists did not have recommendations on additional ways the BSRB could protect and serve consumers of services. For the psychologists who offered recommendations, areas of focus included telehealth, regulation of master’s level psychologist, offering free continuing education hours, allowing psychologists to supervise individuals in other professions, improvements in the disciplinary process, and practice-areas.

Additional Comments and Feedback – Fifty-one percent of psychologists did not offer additional comments or feedback. However, for psychologists providing additional comments, the most frequently reported topics were telehealth, insurance, master’s level psychologists, and protection of the title of psychologists. Other notes focused on the use of AI, allowing psychologists to supervise individuals in other practices, and exploring prescription privileges for psychologists.

Survey Questions and Summary of Responses

Question 1 (LP). In what Kansas county/counties do you practice the profession of psychology?

LP Responses

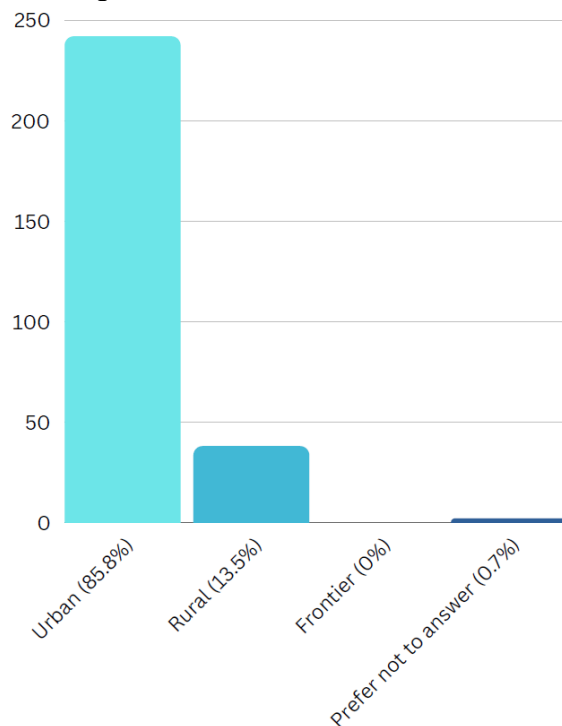
294 LPs answered question one. Full responses are included in Appendix 1 on page 18.

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

- Johnson (72 times);
- Sedgwick (44 times);
- Douglas (31 times);
- Shawnee (15 times);
- Riley (13 times); and
- None (11 times).

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

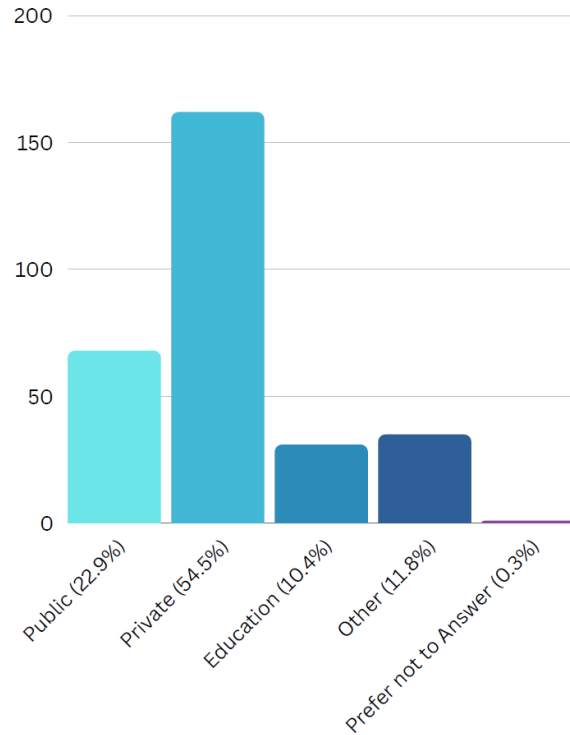
LP Responses



Of the 296 LPs that answered question 2, the vast majority (86%) reported living in an urban area, followed by licensees living in a rural area (14%). All other responses were less than 1%. According to the 2020 US Census, about 57% of Kansans live in urban counties, so the results from the survey are inconsistent with demographics from the most recent census and show that a higher percent of psychologists practice in an urban area than would correlate to the number of residents living in urban areas.

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

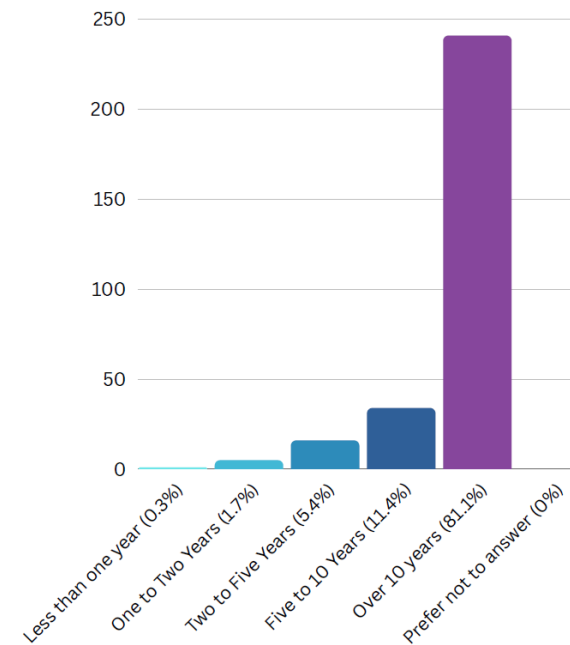
LP Responses



Of the 297 LPs that answered question 3, over half (55%) working in private practice, while about a quarter (23%) noted working in public practice, followed by individuals in other fields (12%) and education (10%). All other responses were less than 1%.

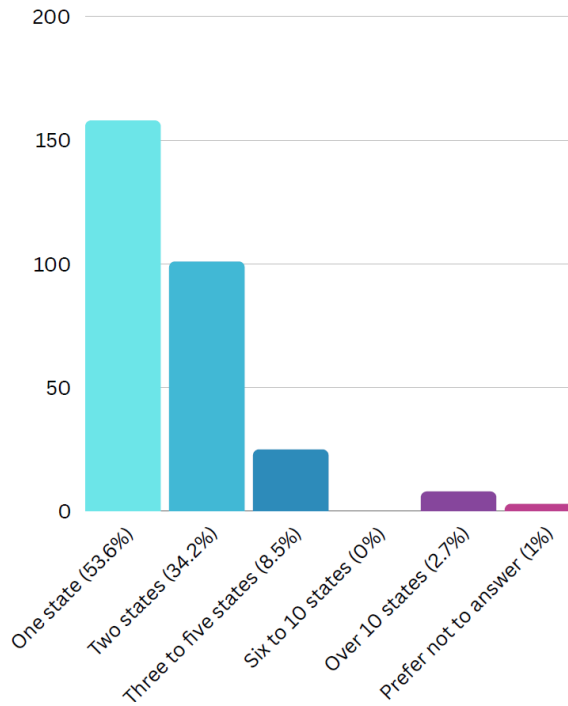
Question 4 (LP). How many years have you practiced the psychology profession (if applicable, you may include years practicing psychology in other states)?

LP Responses



Of the 297 LPs that answered question 4, when individuals were asked how many years they had been practicing master’s level psychology, the most popular response was over 10 years (81%), five to ten years (11%), then two to five years (5%). All other responses were under 2%.

**Question 5 (LP). Including Kansas, in how many states are you licensed as a psychologist?
LP Responses**



Of the 295 LPs who answered question 5, over half of licensees (54%) report being licensed to practice psychology in only one state, though about a third reported being licensed in two states (34%), followed by individuals licensed in three to five states (9%). All other responses were less than 3%.

Question 6 (LP). Do you maintain an active license, but no longer work as a psychologist? If so, please explain why you are not providing services currently.

LP Responses

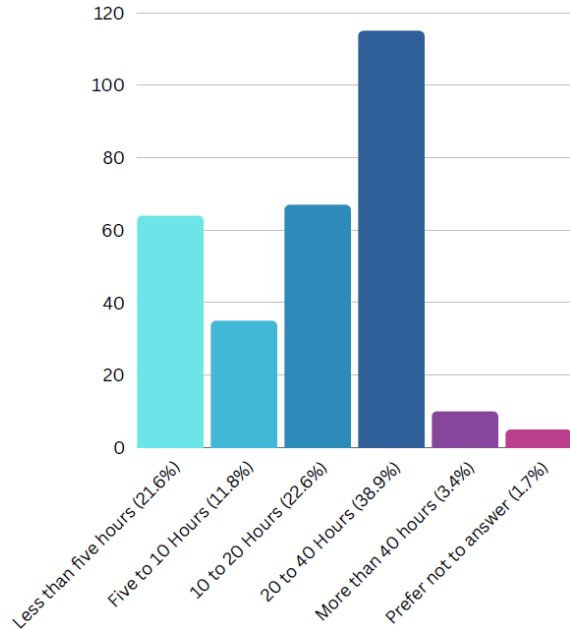
One hundred seventy-three LPs answered this question. (Responses for all licensees can be found in Appendix 2 on page 21)

The most frequent survey response (140 responses) was from respondents who noted they continued to work as a psychologist.

However, twenty respondents were not providing services despite maintaining an active license. The most common reason for this response (13 responses) included being employed in positions that did not require licensure for job responsibilities, and some respondents noted that maintaining an active license was required to hold the position, but unrelated to the tasks required for the job. Four respondents indicated that they were actively retired though their licenses had not expired.

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

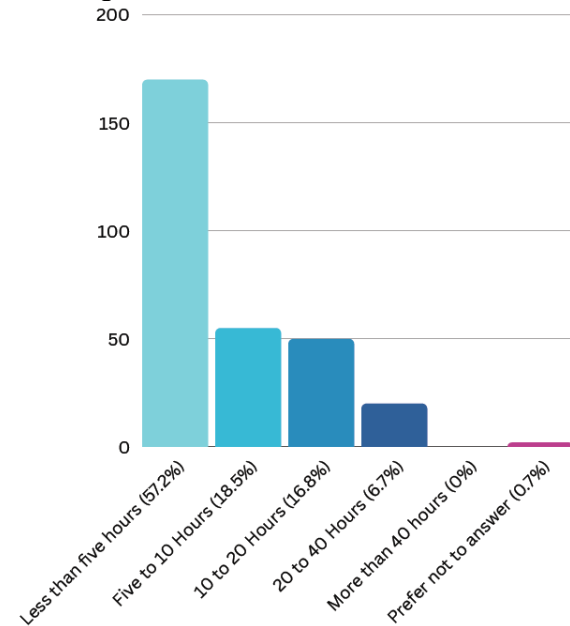
LP Responses



Of the 296 LPs who answered question 7, the most popular response was between 20 to 40 hours (39%), followed by 10 to 20 hours (23%), then less than five hours (22%), then between five and 10 hours (12%). All other answers were under 4%.

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

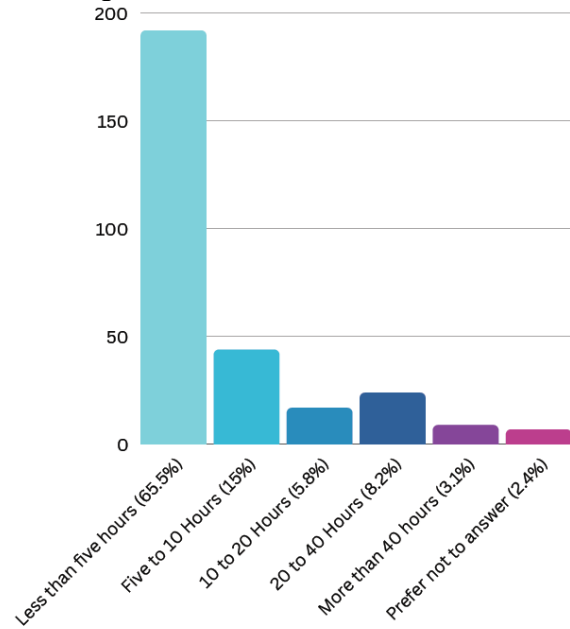
LP Responses



Of the 297 LPs who answered question 8, the most common response was less than five hours per week (57%), followed by five to 10 hours (19%), then 10 to 20 hours (17%). All other responses were less than 1%.

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

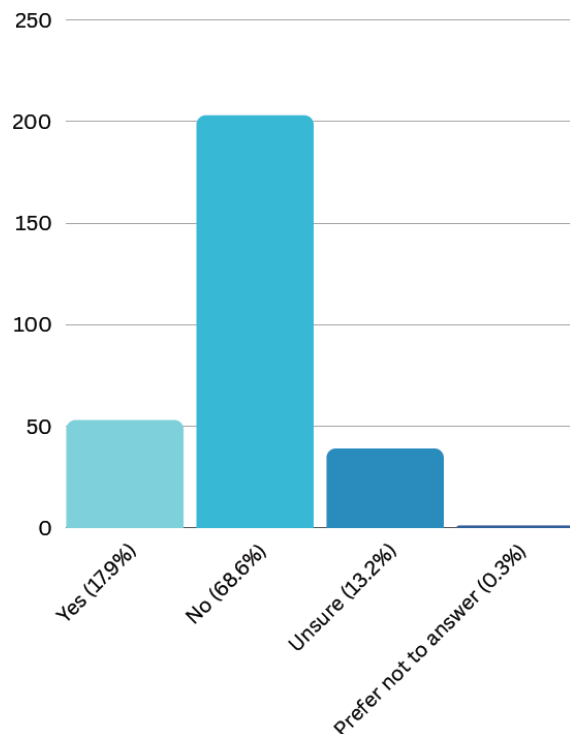
LP Responses



Of the 293 LPs who answered question 9, the vast majority of responses were less than five hours per week (66%), followed by between five hours and 10 hours (15%). All other responses were less than 9%.

Question 10 (LP). Do you anticipate retiring from the psychology profession in the next five years?

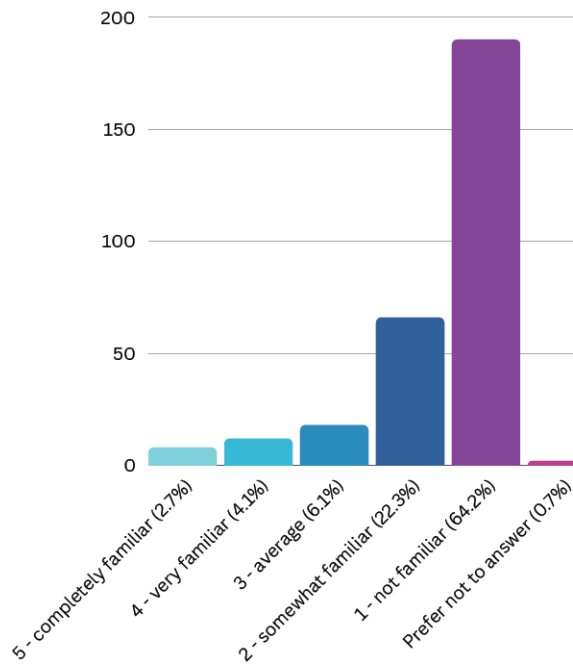
LP Responses



Of the 296 LPs who answered question 10, the most common response was “no” (69%), followed by “yes” (18%), then “unsure” (13%). Other responses were under 1%.

Question 11 (LP). 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 Licensed Psychology Advisory Committee?

LP Responses



Out of the respondents that answered question 12, the vast majority (64%) noted they were not familiar with the Advisory Committee, followed by respondents noting some familiarity (22%). All other answers were under 7%.

Question 12 (LP). Over the past two years, based on your observations and experience practicing in the psychology profession, could you share information on any practice-related negative issues you have seen, such as areas where practitioners appeared to need more continuing education or training in a certain area?

LP Responses

Two hundred and twenty-three LPs answered this question, identifying a wide variety of comments. (Responses for all licensees can be found in Appendix 3 on page 23).

Forty-one respondents indicated having experienced no practice-related negative issues in the past two years. 11 responses centered on diversity training and continuing education hours. Specifically, the most frequently reported training needs are in the following areas:

- Insurance;
- Diagnostics;

- ASD and Neurodivergence;
- Trauma;
- Evidence-based treatment;
- Ethics;
- AI; and
- Suicide.

While less frequently identified than the previously noted items, other licensees pointed out other practice-related negative issues concerning legal services. Other respondents indicated seeing concerns in the areas of trauma, LMLPs, boundaries, testing, mandatory reporting, and care for youth. Concerns were also raised regarding LPs supervising other professions.

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

LP Responses

Two hundred and thirty-six LPs answered this question, identifying a wide variety of comments on Telehealth. (Responses for all licensees can be found in Appendix 4 on page 34).

One hundred and forty-two responses indicated having experienced no issues concerning telehealth. Some respondents mentioned that telehealth has improved the accessibility of services.

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

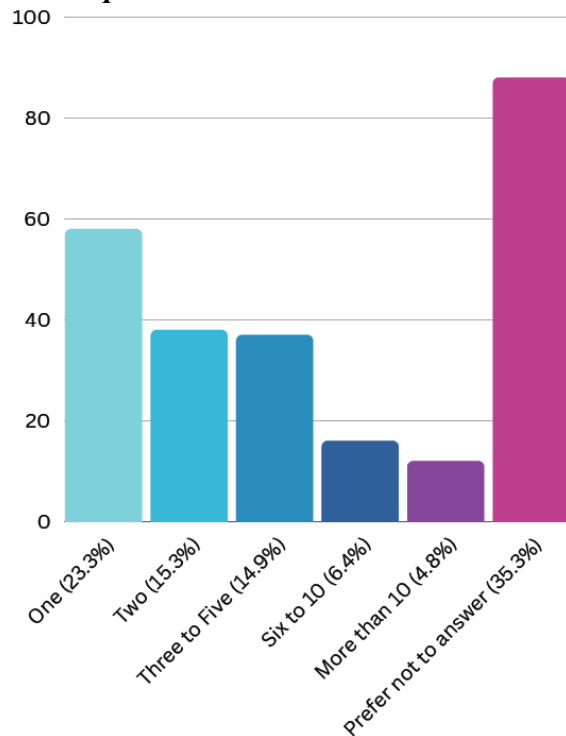
- Telehealth is easy;
- Telehealth requires less paperwork than in-person services;
- Telehealth benefits rural outreach;
- Telehealth is helpful when transportation issues arise; and
- Telehealth works well with adults.

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

- There are additional insurance barriers to face if providing telehealth;
- Clients and Providers are not in an appropriate or secure location during the session;
- Connectivity and Internet issues occur with telehealth;
- Ability to get to know client and patient safety after sessions; and
- Handling State Regulations across state lines.

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

LP Responses



Of the 249 LPs that answered question 14, the largest number of respondents (35%) noted they preferred not to answer, which is attributable to the lack of an option to answer zero. The second most popular answer was one (23%), followed by two (15%), then three to five (15%). Other answers were less than 7%.

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

LP Responses

Two hundred and thirty-five LPs answered this question and provided a variety of responses. (Responses can be found in Appendix 5 on page 41.)

Twenty-four respondents indicated experiencing no negative issues involving supervision over the past two years. Eighty-three respondents stated that they do not provide supervision.

However, some respondents reported experiencing negative issues related to supervision. The negative issue that was reported more than once was the recurrence of supervisees not being at the same standard post-graduation as previous groups. Other negative comments highlighted issues of generational differences, high levels of burnout, and allowing psychologists to supervise other professions.

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

LP Responses

Two hundred and fifty-seven LPs answered this question and provided a variety of responses. (Responses for all licensees can be found in Appendix 6 on page 46.)

One-hundred and ninety-six LPs who responded to the survey indicated that they do not use AI in their practice. Eleven expressed that they will be moving toward using AI. Three were unsure.

From the licensees indicated using AI in their practice. The most frequently reported use of AI in practice was for writing and grammar. Less frequently reported uses included documentation, treatment planning, marketing, and research.

Question 17 (LP). 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?

LP Responses

Two hundred ninety-seven LPs answered this question, identifying a variety of issues. (Responses for all licensees can be found in Appendix 7 on page 49.)

Ninety-two licensees reported having no recommendations or additional ways the BSRB could protect and serve consumers of services offered by BSRB licensees. 12 responses centered on Insurance and reimbursement. Specifically, the most frequently reported responses are in the following areas:

- Tele-health;
- Evidence-based practice;
- Complaints;
- LMLPs;
- Supervise other professions;
- Children and Families; and
- Free CEUs.

While less frequently identified than the previously noted items, other licensees pointed out other issues such as social media, PSYPACT, Ethics, and Burnout. Other respondents indicated EPPP and Post/pre-doc hours. Concerns were also raised regarding the term psychologist and vulnerable populations.

Question 18 (LP). 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 psychology profession?

LP Responses

One hundred and eighty LPs answered this question and identified a variety of issues. (Responses for all licensees can be found in Appendix 8 on Page 58.)

Ninety-one respondents stated that they had no recommendations. The most frequently reported topics in responses to this survey question included telehealth, insurance, master's level psychologists, and protecting the title of psychologist. Other respondents noted medications/prescriptions, AI, and allowing LPs to supervise other professions.

LP Q1. In what Kansas county/counties do you practice the profession of psychology? (294 responses)
All
All but mainly Sedgwick
All, I work virtually
Allen, Anderson, Bourbon, Linn, Neosho, Woodson
Atchison
Barton and Finney
Because I do a lot of telehealth in rural communities, I practice in multiple counties throughout Kansas.
Butler
Butler and Sedgwick
Butler, Sedgwick, and Sumner
Clay and Riley
Currently, I only practice virtually in KS, with 1 client in Sedgwick County, but I'll be moving back to KS this spring and will be practicing virtually from Johnson County with my KS client(s) and clients in many of the PSYPACT states..
Douglas (31 times)
Douglas and Johnson (2 times)
Douglas and Pawnee
Douglas and Shawnee
Douglas and Wyandotte (2 times)
Douglas, Johnson, and Wyandotte
Douglas, remote clients in Reno, Stafford
Ellis
Franklin, Johnson, and Miami
Geary
Harvey
Harvey and Sedgwick
I live out of state.
I practice from Johnson County and do telehealth in many counties. I work for Brightside Health
I serve people in any county as I provide telehealth services.
Jackson
Jackson and Johnson (2 times)
Jackson County, Missouri
Jackson, Johnson, Wyandotte
Jefferson
Johnson (Also in Jackson Co In MO)
Johnson (72 times)
Johnson and Leavenworth
Johnson and Wyandotte (9 times)
Johnson Co; also do TH to family's homes in a variety of locations
Johnson County (3 times)

Johnson physically and others through telehealth
Johnson, Shawnee, and Wyandotte
Kansa City
Kansas
Kiowa, Commanche, Barber, Pratt, Barton, Kingman, Sedgwick
Leavenworth (5 times)
Leavenworth and Wyandotte
Many-primarily in NE Kansas
McPherson
McPherson and Saline
Miami (3 times)
Military member
Missouri
My office is in Seward. But I have clients from Hugoton, Meade, Sublette, Satanta, and other counties coming to my office.
N/A (3 times)
N/A military
Neosho, Allen, Bourbon,
None (11 times)
None currently (2 times)
None yet. I practice in Nebraska.
None, federal (VA), out of state
None, practice primarily in Texas and via telehealth occasionally
None. I live and practice in Washington State
None. I practice in NE at the VA
None. I work in Texas.
Out of State Licensee (2 times)
Pittsburg (in person) and dozens of different counties (tele)
Pottawatomie, Riley
Practice in Texas. not currently in Kansas.
Reno, Sedgwick
Riley (13 times)
Riley, Geary, Pottowatamie
Saline (2 times)
Sedgwick (44 times)
Sedgwick + tele in various
Sedgwick and many rural counties
Sedgwick County (2 times)
Several, but my office is in MO
Shawnee (15 times)
Shawnee and Douglas
Shawnee, Douglas, Johnson, Franklin, Jefferson and some surrounding counties
Shawnee, Douglas, Johnson, Riley, Sedgwick

Statewide
Telehealth
Wyandotte (7 times)
Zero

LP Q6. Do you maintain an active license, but no longer work as psychologist? If so, please explain why you are not providing services currently. (173 responses)

34 years with the federal government. Currently working for Social Security as a Regional Psychology Medical Consultant. Age 68.

Active (2 times)

Active and working

Active but live in Oregon. Recently retired from federal job with VA.

Active license, currently practicing

Actively practice

Currently have active licenses

Currently winding private practice down to retirement, likely won't renew in 2026.

Federal government

I actively work.

I am a university professor and my license may be needed for grant project and/or possible part-time work as a 2nd income.

I am currently working as a psychologist

I am emeritus from the U of Iowa. I am involved as a trainer and supervisor of therapists, and I write. I do not currently see patients.

I am mostly retired, have an active license, work about 10-12 hours per month.

I am providing services

I continue to work as a psychologist (2 times)

I have a license but am in semi retirement.

I have an active license

I have an active license and am temporarily working as a psychologist in another country. I am planning to move back to Kansas so I maintain my license there.

I maintain an active license

I maintain an active license and currently practice full time.

I maintain an active license and provide clinical supervision to trainees, but my main role is as a University administrator not providing direct clinical services.

I practice and keep my active license.

I provide services very part-time. My primary role is as a professor.

I still practice

I still work

I still work as a psychologist (2 times)

I will retire soon and plan to keep my license active for at least a few years beyond that

I work as a consultant. I provide direct services only occasionally and not in Kansas in many years. I don't supervise anyone, but that was not a choice.

I work as a psychologist

I work full time at Western Regional Diagnostic and Correctional Center (WRDCC) in St. Joseph, Missouri. I am considering working part time in the near future in either MO or KS or both.

I work remotely for the Federal government serving Kansas and other States in the region.
I would do more but these big co want a cut and treat us & clients as "cash cows." Don't think it should be allowed - pay as an employee with benefits or out of profession.
I'm active.
I'm still active and licensed.
Licensed, semi retired
No (106 times)
No I still work
No I work in Texas.
No licensed and currently practicing.
No, I work as a psychologist.
No, in the process of starting a private practice, after working in hospitals for several years. Not yet seeing patients.
No, still working
No, working in FL
Not applicable
Retired from adm position still weighing options for part time private practice
Retired one month ago.
Retired: limited
Still practice
Still working
Still working as a psychologist
Yes, active license
Yes, I currently am not practicing. Due to being older., In my interest have changed to other concerns
Yes. Current role in the organization is administrative to help with clinical systems, processes, and procedures.

LP Q12. Over the past two years, based on your observations and experience practicing in the psychology profession, could you share information on any practice-related negative issues you have seen, such as areas where practitioners appeared to need more continuing education or training in a certain area?

* Ethics with telehealth and traveling

* Psychologists using master's level therapists under them to complete services and bill at psychologist rate.

?

A high need for more LPs in this state

Absolutely. I'm an eating disorders specialist with 40+ years of experience. I've trained and supervised hundreds (thousands if you count my national and international trainings) of providers. I have a group here in Wichita who I trained and supervised to be legitimate experts. That said, I'm aware of numerous providers across the state who hold themselves out as ED experts and are doing great harm! ED's have the second highest mortality rate of any psych dx. I deeply fear the quality of care and the lack of needed resources in our state as I move into more full retirement. The KC area has more resources but outside of that area, there's no higher level of care than outpatient in the state. There hasn't been since my own program with KU Med Wichita closed in 1997. It's a major problem!!

Addressing trauma issues

AI

All LPs I have worked with have appeared to be appropriately trained for the services they offer.

As many third party insurance companies have continued to make changes regarding who is legally liable for the technology we are required to use, additional training outlining the boundaries between where our liability begins and ends with regard to encryption technology would be increasingly helpful.

Assessment of various psychiatric disorders

Assisting children, teens and parents in dealing with the impact of electronics (e.g., social media, cyber bullying, sexting, time spent etc.) and navigating the issues this can cause in their lives, especially the youth! Perhaps new grads have had such training.

Attention-deficit hyperactivity disorder and the over-prescription of stimulant medications; Anxiety disorders and the inappropriate long-term use of benzodiazepines; Cannabis-induced psychotic and anxiety disorders

Autism, evaluation, disabilities, insurance compliance

Being sure to keep boundaries with clients and keeping information confidential; digital security;

Best practices in outpatient suicide specific care. Need more psychology evaluators for autism, LD/ADHD, forensic, and neuro.

Billing is an area that I do not have much information on, given that I work for a large hospital.

Billing, billing, billing

Boundaries
Burn out is increasing in every area for psychologists.
CEUs can be f=very expensive given the reimbursement rate of Insurance
Challenge to refer pts to therapist that is experienced in practicing evidence based treatment.
Clinicians don't generally engage in evidence-based practice, though they claim to.
Cognitive behavioral intervention for youth
Communication about when to refer a client elsewhere and/or when to terminate the relationship (because of completed goals or decreased value of continuing therapy).
Conceptualizations, assessment interpretation, working with other healthcare professionals
Confidentiality, professionalism - I attended therapy with a provider who started every session at least 15 minutes late, crisis intervention
Consider CEU pertaining to provision of expanded psychotherapy to older adults
Continued losses of funding. Wild expansion of inferior telephone and chat "therapy".
Countertransference issues, matters related to recognizing, understanding and managing their own biases, reactions and beliefs.
Court related services and consultation is a big issue with regard to the basics of court related requests and boundaries with parents/ caregivers/ agencies/ and attorneys with regard to requests and time demands(and charging for such)
Dealing with insurance
DEI, neurodiversity affirming care, recruiting into the field, supporting needs of trainees - recent cohorts have had higher level of burnout and mental health needs. Its a lot for supervisors to navigate.
Demands for service provision are high; opportunities for additional training, collaboration, and peer supervision have diminished.
Desperate need for professionals who can perform psychoeducational testing & evaluations (dyslexia, ADHD, Autism Spectrum Disorder)
Diagnosis
Diagnosis, treatment planning, assessing treatment progress, proving brief interventions, and suicide prevention risk factors.
Diagnostic skills seem to be a bit hit or miss
Differential diagnosis
Digital ethics, supervision
Diversity and cultural competency continues to be lacking, trauma informed as well
Diversity; ethics; supervision
Eating disorders, management of suicidal behavior as well as treatment.
Erosion of the standards and competence in the practice of psychology by the muti levels of poorly trained and supervised "practitioners"
Ethical issues in supervision of trainees, multicultural competence, update on ethical issues especially as related to current events
Ethics in practicing and supervising those who are not in the state where you are licensed (i.e. the client is not located in KS for the summer, but attends school in the state).

Ethics of texting and telehealth
Ethics
Testing
Ethics, telehealth
Evidence-based trauma therapies like CPT, PE, WET
Formalized testing and assessment
Gender issues
Geropsychology
Getting credentialed to take insurance with the various insurance companies and getting credentialed with Medicare. These are very complicated processes for individual private clinicians.
Health psychology (psychoeducation on sleep, nutrition, physical activity), too much emphasis on medication referrals
How disciplines can better advocate for their professions related to insurance coverage (reimbursement rates, # of sessions, types of services and what diagnoses are covered).
How Kansas treats transgender people. Basically I cannot talk about it legally.
How to connect patients with social services (including collaboration with social work)
I am a Child Psychologist who focuses on assessment/treatment of Neurodevelopmental Disorders. I have been increasingly concerned regarding the quality of Psychological Assessments and treatment of this population. Lack of standardized measures (e.g., I recently saw a non-autistic child that was diagnosed with Autism using a Rorschach Projective Test; another practitioner uses "checklists" out of magazine and continues to use outdated diagnostic criterion, (e.g., DSM-III- R). Many times, parents are not receiving results from Psychological Reports for 3-6 months. Also, in my community of Wichita, there are a lack of practitioners who have been trained on evidenced based treatments that results in no improvement or regression. Most of the time, parents are not involved in the treatment process resulting in no generalization. Anyone practicing at my clinics are required to use evidenced based assessments and treatments.
I am disturbed by master's level clinicians using therapeutic approaches that are not evidence-based (e.g., EMDR for any and ALL presenting concerns) and offering assessments at extremely low costs that do not follow best practices.
I am highly concerned about the proliferation of under-trained and unsupervised master's level providers who are conducting psychological testing. They are inflicting harm on clients with their lack of education and training.
I am seeing more and more master's level practitioners doing assessments for which they are not sufficiently trained or competent, sometimes leading to very negative outcomes for patients who are incorrectly diagnosed. I do believe MA level providers can do assessments but they ought to have specific training/supervision to be competent to do so. I understand there is a lot of need for this service but stepping in without the necessary training is not the way to solve the problem.
I am seeing too many people being improperly diagnosed with ADHD. I do not think enough clinicians consider personality factors when working with clients.

I believe psychologists, and the APA specifically, have been actively too involved in political discourse. Yes, politics occasionally comes up in the therapy room and can be addressed, but I do not think it is something that psychologists have to be involved with in a systematic way. Unrelatedly, I do think psychologists should be more informed about tech, AI, and how it will influence the profession in the coming years.

I believe that Ph.D. psychologists should be given the opportunity to supervise licensed professional counselors. The difference in the psychotherapy that "counselors" provide and "psychologists" provide their clients who seek mental/behavioral health services is almost if not imperceptible. Drawing legal or BSRB differences seems to me to be due to more professional territorial/turf protection than due to the two licensed professions delivering two different type of services. Both professions use the same diagnostic manual (DSM-5), use the same treatment codes that are filed with insurance companies and recorded in their respective electronic medical records and use the same therapeutic interventions, e.g., CBT, client-centered, psychodynamic. I recognize that in the area of "vocational/career" services such as a school counselor, there are differences. But in the "therapy room," these two professions deliver the same service.

I believe there is too much reliance on self-report surveys such as the PHQ-9 and GAD-7 to conclude the client should be diagnosed with depression/mood or anxiety disorder. I would recommend more comprehensive assessment of these disorders. For example, is the severe depression score on the PHQ-9 supported by clinical evidence of vegetative signs and does it meet duration criteria in the DSM?

I cannot think of anything global

I do think that many cases of trauma are still missed and misdiagnosed. I think it would be good to keep training in how trauma can negatively impact development and how broad the impact can be.

I find that when I receive testing reports from master's level psychologist, there are glaring issues related to the conceptualization.

I have believed for a long time that psychologists need more extensive training in the use of Psychiatric medications and how they can facilitate psychology and also greater training in performing psychotherapy with specific diagnostic groups.

I have not seen any

I have observed a few instances in which colleagues have over-estimated their range of expertise with certain disorders or treatment methods. For example, it is highly unlikely that one is an "expert" in both psychodynamic therapy and behavioral therapy. Yet some colleagues claim this on their online profiles or websites. It is likewise unlikely that one has expertise in treating young children, teens, middle age and seniors, yet some colleagues claim this. Continued education that focuses on the responsibility to accurately describe your strengths and your limitations might be helpful.

I have observed more nuance complaints that burden the Board and drive up malpractice costs.

I have seen LMLPs being referred to as a psychologist.

I have seen no such negative issues.

<p>I have seen people make inappropriate child custody recommendations/testimonies. I do not like that Kansas licenses Psychologists at the Master's level as I believe that term should be more protected. I think many people fail to understand the importance of cybersecurity guidelines and the ways that HIPAA impact their practices.</p>
<p>I see a fair amount of uncertainty about mandated reporting requirements, and also about HIPAA rules.</p>
<p>I think being charged \$500 for being late renewing my license due to illness was a bit harsh. No other complaints at this time.</p>
<p>I think it would be helpful for all new clinicians to have to have a BSRB clinical supervision training plan whether they intend on obtaining a clinical license or not.</p>
<p>I think our profession can always grow with regard to increasingly awareness of multicultural and systemic factors that certainly influence the clinical presentation of our patients. Some practitioners really value the importance of this, while others seem more hesitant to explore these issues, which I think necessitates more continuing education.</p>
<p>I think testing is one area as well as best practices for specific disorders. Boundaries are always good for reviewing.</p>
<p>I think that during covid standards were lowered in order for people to access more services. For example, supervised hours were lowered and I believe there was even BCBS reimbursement for practitioners at the non-clinical level.</p>
<p>I think that the federal government did a poor job of informing psychologists of the "No Surprises Act" legislation and its requirements. I also think that the use of more and more technology in the practice of psychology (messaging, teleconferencing, cloud records storage, data security software, AI, etc.) is creating increased risk of running afoul of privacy legislation (again, primarily federal) such that psychologists today, in addition to being psychologists, are having to almost be lawyers and software engineers to ascertain all of the associated requirements.</p>
<p>I think training in supervision of students.</p>
<p>I would encourage more training in areas of cultural competency. Most notably in the area of working with neurodivergent clients and supervisees.</p>
<p>I wouldn't say that I have noted negative issues relating to other psychologists. I have found that practitioners in other mental health disciplines appear to have gaps in knowledge regarding diagnosis, but still exercise the ability to diagnosis clients (even when the diagnosis is outside of their scope of training). I think this may in part be a consequence of a systemic issue relating to limited availability of psychologists who complete comprehensive psychological evaluations. As one of the limited number of psychologists in the area who complete these evaluations (especially evaluations that include neurodevelopmental diagnoses such as a Autism Spectrum Disorder), it is becoming increasingly prohibitive to provide these services due to exorbitant costs of testing materials and very low reimbursement rates from insurance companies.</p>
<p>I'm seeing more and more brand new therapists enter directly into private practice without spending some time gaining more experience in a public position. I think this is, in part, because it's so much easier to open a private practice than ever before. But, I don't think this serves clients well.</p>

In general there needs to be more emphasis on depth of training vs random CEUs that are not really beneficial to the professional or community.
Inclusion of parents in a portion of most sessions when working with youth. Providers are many times just meeting with the minor alone, without significant input and intervention including the parent.
Incompetence in diagnosis, particularly involving concussion/TBI and developmental disorders (e.g. ADHD and ASD).
Increased documentation reqs take away time from quality of care
Increasing number of patients who come to me after seeing a therapist with less training - and they are amazed at the different experience with a doctoral level psychologist. Increasing number of patients who say they contacted me because I was a psychologist, and not a clinician with less experience.
Instances where MHPs give custody recommendations in family law cases without having conducted an evaluation.
Insurance companies conducting audits and threatening fee recoupment has been the major negative.
Insurances getting harder to deal with = poor customer service, dwindling allowable amounts. I no longer accept any Medicare Advantage plans because of the \$\$ I've lost, having to wrestle with them to get consistent payments of the allowed amount.
I've had issues with clinicians responding in a timely manner and/or at all when I've requested records. I'm concerned about the advertising of some clinicians, skeptical that they're sufficiently competent in all the areas and with all the populations they list.
Knowing when and how to refer. Awareness of their own lack of cultural competence and blindspots. Consultation with other providers to ensure holistic treatment.
lack of in depth knowledge of trauma treatment
lacking training and expertise in adult Autism Spectrum Disorder testing and treatment. Also, I think there is broad inconsistencies in how clinicians are identifying and diagnosing both ADHD and Autism Spectrum Disorders in adults.
Licensed providers working outside their scope - for example providing assessment and diagnosis they are under qualified for.
Limited clinical knowledge of master's level psychologists and sw
LP's, no complaints. It is all the other masters level licenses that I encounter frequently practicing incompetently. Poor therapy services, writing letters to agencies/courts beyond their scope of training, providing "expert" opinions regarding people they never professionally met, providing custody opinions and recommendations, etc.
Maintaining healthy boundaries, navigating social media, professional continuing education rather than learning from social media about mental health topics, use of technology in practice
Mandated reporting
Master's level psychologists in Kansas conducting substandard psychoeducational/psychological evaluations.

Masters-level psychologists who identify themselves to the public as "psychologist" without clarifying the masters-level distinction. This is, at best, confusing to the public and, at worse, deceptive. I strongly believe that Kansas masters-level psychologists (LMLP) should be renamed. Maybe masters-level psychology practitioner? Just some title without the word "psychologist" in it, please. This change should apply retroactively to current LMLPs as well as those who achieve a masters-level license in the future.
Medications, medical conditions, substance use including illicit substances, device addiction,
More CEUs in Ethics, Suicide, DEI
More continuing education is needed for matters of diversity and how such matters are relevant to clinical practice and effectiveness.
More continuing education regarding suicide assessment and prevention.
More direct experience before graduating
More training in how to run their own practice
Most definitely. Few understand the limits of their expertise. Some don't understand maintaining appropriate case file documentation. Many whom provide Forensic services have little specialized knowledge in the area.
Multicultural
Multicultural and inclusionary considerations could be improved upon. I also think knowledge base on medications could also be expanded on for most providers.
multicultural issues in psychology, ethics of telehealth, the impact of AI on our field
N/A (10 times)
Navigating political changes, laws, rules/regulations which can change quickly
Navigating the current geopolitical landscape. I think we all need ongoing guidance as so much is changing so quickly. And ethical use of AI and how the landscape might be shifting.
Need more education about AI and mental health issues. Need more education about boundaries and HIPAA.
Need more specifically trauma-informed therapist in mental, not so much in psychology. We need more clinicians trained in bottom-up approaches to healing, not just top-down.
Need more training is diagnostic assessment. Lots of instances of not using the gold standard assessment instruments. Over reliance on checklists.
No (18 times)
No issues come to mind at this time.
No specific themes
None (6 times)
None in particular
None noted
None that I can think of.
None--Most practitioners seek out appropriate CE. For example, we have a peer support group to identify such issues.
Not in the past 2 years

Not sure (3 times)
Not that I am aware
Nothing prominent-perhaps expert testimony
Nothing that I am present aware.
Observations of providers utilizing approaches with little - no evidence-base, particularly for specific referral concerns, and/or practicing outside of scope of competency (e.g., attempting to treat disorders like OCD without previous training/supervision).
OCD and related disorders
One area of concern I have is the assessment for specific diagnoses versus looking at the whole-person and how a specific diagnosis helps them in their treatment plan or in accessing resources.
Only concern has been turnover and the shrinking practice roles specific to psychologists in clinical practice
Over diagnosis of PTSD due to trauma that does not meet the criteria for a criterion A event. Also, have seen an uptick in autism spectrum disorders being diagnosed without proper evaluation.
Overdiagnosed conditions (ADHD, Bipolar, DID, ASD)
Perhaps working with the trans population?
Perinatal/Postpartum MH; we need more clinicians specializing in this area. Also need more who specialize in Drug and Alcohol Treatment.
Practitioners are overloaded with CEU, fees etc. It is the companies who profit but do nothing themselves that have flaws. I was working with one that I think charged way more than going fee, but did not pay the promised percentage to me. Finally sought other options in doing own practice.
Practitioners need more continuing education in the areas of supervision and DEI.
Primarily - 2 issues. 1) untrained/inexperienced licensees practicing outside their expertise - primarily involving neuropsychology practice 2) licenses failing to adequately protect neuropsychological/psychological test material/content (e.g. test questions, manuals, test stimuli/contebt).
Programs graduating students in KS who have extremely strong beliefs about things like abortion or same sex marriages that they impose on their patients or are not clinically appropriate with clients who they disagree with. Personal beliefs should not impact patient work in this manner.
Psychoeducational evaluations: I frequently see assessments where individuals were diagnosed with an intellectual disability without evaluating adaptive functioning...and sometimes without an actual IQ test. Similarly, I regularly see individuals diagnosed with Autism based on a screening measures alone (i.e., parent questionnaire), no developmental history included, adaptive functioning, nor ADOS/ADI/MIGDAS. Therapy: It is difficult to find practitioners implementing evidence based treatment (e.g., CBT, parent training) with children. It is highly concerning.
Psychological testing and report writing

Psychologists (PhD and PsyD) are doing great. Masters level are disasters. Borderline worthless. Overconfident and unaware at the same time.
Psychologists needs more training on the Psychology Compact and how it can influence their practice. Especially, due to the need in rural areas of the country. They also need more training on the ethical issues related to telehealth.
Psychologists should learn how public schools work, special Ed laws, etc.
PSYPACT - more information on how it interacts with state licensure
Recognizing areas of competency, evaluation services, evidence based care (the latter is seen more as an issue at the masters level), and limited access to care
Responding to a surge in public interest for autism testing - is testing really needed, or is professional opinion enough for a diagnosis.
Running a practice and working with insurance. More people have high deductible plans, which puts a burden on providing care ethically.
Secure forms of communication with clients/patients
Severe mental illness, substance use, working with diverse populations (trans community, immigrant populations)
Shallow training, greater number of MA level practitioners, declining number of doctorate level practitioners.
Somatic psychology
some confusion on what is reportable, to whom to report in areas of abuse/neglect
Substance use disorders
Suicide assessment and treatment
Cultural competency/diversity
suicide prevention,
Telehealth ethics, multicultural/social justice/advocacy considerations at the root of many clinical issues.
Telehealth practice across state lines (i.e., PsycPact)
Telehealth, 9th
Telehealth, lgbt issues
Telework within state and across state lines
Terminating ethically

The entire practice of mental health delivery has been dumbed down over the last ten years, and particularly since 2020 when BCBS began reimbursing subclinical masters providers. While I have personally made a lot of money taking advantage of that change, we now have a flood of barely (and I mean BARELY) trained providers and because the Board has designated so many different credentials, the public has not even the slightest idea what is different between an LMLP, LCP, LPC, LMSW, LSCSW and so on. I have personally worked with and observed providers who have only the most rudimentary command of ethical practice and risk management, who are entirely more concerned with financial gain than clinical efficacy or ethical conduct, and most disturbingly, who enter practice ten minutes out of their masters program, with a minimal level of "supervision" contracted with someone who has no vestment at all in their professional development but just wants something "different" in their daily life and so meets with the new provider an hour or two a week and signs off. I am personally glad I'm close to retirement because the overall direction of mental health service delivery is declining on a weekly basis and as much as I love what I do, I won't be able to compete much longer with a growing provider base who buys a subscription to a cloud EMR and works a few hours a week, alone, in what amounts to a hobby practice. To say they need "more continuing education" is true perhaps, but a remarkable understatement of fact. They come out of masters programs with a shocking lack of face-to-face experience, often with an only online curriculum in poorly funded programs at small colleges who've found a business model in generating LPCs and LMFTs and in some cases even LMLPs. It is, in a word "discouraging" that we've come to this. And as much as we all want to see a strong provider base to serve a growing market of clients who no longer see mental health as stigmatized, bad education is not the way to do it. I could re-do my dissertation on this topic and it would be 250 pages long. Sad in every way, especially for the consumer.

The shifting demands of teletherapy/ online therapy.

There are many well qualified professionals in my area. No specific concerns come to mind; however, I am unsure regarding the availability for providers specializing in more serious psychiatric conditions.

There is an appalling lack of knowledge of evidence-based therapies (e.g., CBT-D, CBT-A, Ex/Rp for OCD, CPT, PE, etc.). I had a patient with health anxiety see a community provider for supportive care weekly for 3 years. After 5 months of EBP, she was symptom free. I also see over-reliance on non-evidence based and "fringe" approaches.

There is an imbalance related to practitioners with respect to working with trans/non binary individuals. There are extremes on both ends with disregard and disrespect on one end and over sympathizing on the other. There is a similar experience with respect to SUD between the extremes of disregarding SUD as an actual problem versus stigmatization.

There is an uptick in social media self-diagnosis and a potentially concerning number of professionals that relatedly entertain inaccurate diagnostics and invalidated treatments

There is no practical distinction between neuropsychologists and psychologists. As the former, I have come across iatrogenic reports by Master's level clinicians claiming to offer neuropsychological assessment including widely inaccurate diagnoses and potentially harmful treatment recommendations.
There seems to be a lack of providers able to conduct complete psychological testing in our area. As well as little resources for affordable therapy or support for parents with children needing mental health services.
There seems to be a lack of understanding at times regarding dissociation and trauma (i.e. Dissociative Identity Disorder).
To much pressure to conform to what majority of psychologists think is good.
Training in use of AI
Uncertainty about telehealth rules
Understanding evidence-based practice for common presenting concerns, e.g., pediatric anxiety, dyslexia in children.
Understanding PSYPACT and interjurisdictional practice parameters.
Use of AI tools for taking notes. Social media presence in a professional capacity - for example Therapist accounts on TikTok, Instagram, etc
Using evidence based methods rather than drawing conclusions not supported by the research (eg—basing adhd diagnosis solely on continuous performance testing)
We could use more in person continuing education in this area, or even in Kansas.
What is or isn't okay as far as being available for after hours calls
Working with insurance
Yes (2 times)
Yes, but it has been regarding several non-psychology mental health providers

LP Q13. Over the past two years, have you experienced any issues concerning telehealth, either through professional practice or observations of other practitioners? (236 responses)

a) Not knowing where a patient is physically located in case of emergency or how to access emergency services in other locations; b) Not knowing or observing fundamental information about people, e.g., ability to walk, startle response, ability to interact in an waiting room or with staff, etc. c) Not offering patients a choice of F2F or telehealth or being upfront about the service delivery platform.

As an early telehealth skeptic (one could say outright nay-sayer), I have seen the positive impact on access for patients and families, as well as a surprisingly positive impact on diagnostic assessment. The opportunity to see an individual (child or adult!) in their natural environment has reaped observational benefits I could never have anticipated.

Being aware of where the client is located. The client can travel to a different jurisdiction without telling the provider during the session.

Challenges especially providing treatment services to children and families via telehealth.

Clients trying to use their phone for a session, when not in a secure/HIPAA compliant location (others around)

Confusion over state by state regulations

Connectivity for some patients due to limited internet resources.

Connectivity issues with the internet, or the telehealth platforms. Having to remind clients of the importance of privacy and not being in spaces where others can hear the content of our conversations.

Continuing to learn what is and isn't appropriate to be treated via telehealth.

Differences and changes in reimbursement for telehealth services, which also varies based on which service is provided

Family resources such as poor internet connection or lack of adequate technology/devices to support visits

General access issues for families, particularly rural and frontier. Changing regs are certainly hard to keep up with!

Had to change internet providers

I am continually solicited to do zoom therapy

I am not sure what "issues" means in this context, but I have considered taking on a retirement practice someday as an expert witness for litigants who should not have been seen on telehealth and were underserved in doing so and experienced material harm. I realize this is not the popular zeitgeist, and online therapy is "oh so cool" but we only do it when there is little other alternative and most providers now are doing it not because it serves a need (most of our clients hate it) but because it is cheap and convenient for the provider and actually furthers the aforementioned "dumbing down" of the profession. Do I do it in certain situations? Yes. But is it my default? No. I recently took the Trust's training and am a PSYPACT subscriber and I actually came out of that training wondering if that's really what I wanted to be doing. I think we all should ask that question whether inside or between jurisdictions.

I believe that telehealth has been a real boon to psychologists who practice psychotherapy.
I do a good amount of telehealth and I would say our main issue is occasional tech/connection issues. Telehealth has been a hugely helpful resource for connecting patients with services who would not be able to attend in person services due to a variety of barriers.
I do not have any concerns regarding televideo, but I have significant concerns about therapy via telephone. Within my role overseeing clinicians, I get a lot of feedback that clients like doing therapy by telephone so that they can "do their grocery shopping," "drive their kid to dance," "go junking with their friend" while doing therapy. I'm not certain that newer clinicians often ensure that their client is in a physical and metaphorical location conducive to therapy.
I feel that actually seeing the patient in person is helpful in gaining a full sense of them and their issues so in that way see some limitations to telehealth but do see the value for those that live in areas where there are few resources
I find that because it is a "telehealth" appointment, clients think this means they can meet while they are driving, doing laundry, or in their office. I feel like most of my telehealth appointments are conducted while the person I am talking with is in their vehicle, which can be frustrating because someone cannot focus their full attention on two things at once.
I have been providing some telehealth for 15 years and only telehealth for 3 years. The only "issue" of concern I have noted is the occasional loss of privacy that some clients experience when they are home and family members walk in or interrupt. Something that never happened when I saw most people in my private office.
I have experienced no such issues.
I have found telehealth to be enormously beneficial. I practiced via telehealth for two years during the pandemic.
I have had a number of individuals tell me that they attempted to use national telehealth therapy businesses, and would find that they did not feel that the therapist or themselves set up confidential space. I have not heard this about local or private practice orgs. Generally, people have found increased access to telehealth extremely helpful.
I have not experienced any issues. I find it extremely helpful to be able to provide services to people who would otherwise not be able to attend sessions due to mobility disabilities, lack of transportation, agoraphobia, lack of childcare (but have children old enough that they can be in another area of the home, etc.), and other similar reasons.
I have not experienced any.
I have not had any negative experiences. Overall, it has made treatment much more accessible and most families appreciate it as an option.
I have observed confusion about telehealth rules/licensing rules concerning whether practitioner or client can be in states other than Kansas
I have talked with clients who are concerned about their insurance/coverage continuing to apply toward telehealth services in the future.

I haven't had any issues in my own practice. Nor have I heard of others having concerns.
I personally haven't had any problems with telehealth (my practice is 100% telehealth), but it is a bit frightening how PSYPACT is worded in that even the slightest discipline by a licensing board can result in the loss of one's APIT, so I hope that boards are considering that when deciding, for example, whether to discipline an APIT-holding psychologist for something like a late renewal fee payment or a nonconforming CEU (because if that psychologist sees numerous clients via PSYPACT like I do, discipline in that instance seems like it would be disproportionately harmful both to the psychologist and to his or her clients in other states).
I rarely use telehealth.
I sometimes hear of providers still providing audio-only therapy, which was briefly allowed during COVID but few insurances continue to cover it. I do not feel audio-only therapy is going to be as effective as even audio-visual telehealth. Some education/training for providers to be up to date on what is currently allowable is important. Telehealth has become the wild west. Some providers seem uncertain about the location rules i.e. whether it is the provider or the client who needs to be physically present in the state in which the provider is licensed.
I think telehealth is a wonderful option when necessary as it provides a platform for those who are unable to attend therapy in person. That being said, I personally believe there are some challenges with telehealth in that it is difficult to get a "feel" for a person via computer. In addition, you miss a lot of information from their overall body language.
I was initially highly resistant--thought being in the room was essential for effective intervention, but since starting to work remotely during the pandemic I have become completely comfortable providing service this way. I am pleased to be able to serve clients from places in the state where there are fewer options.
I work a lot with Geropsych who often need lessons in technology or do not have wi-fi
I work purely through telehealth for the department of veterans affairs and have for 4 years. I feel my therapy is just as effective and my clients greatly prefer the flexibility.
If a patient is not honest about their location it could result in a safety issue.
I'm grateful that telehealth is an option; however, I'm biased in favor of in-person therapy. I'm concerned that many private practitioners have not returned to providing in-person services.
I'm not a fan of telehealth in general but it's been a blessing for those with ED who can't easily travel 3-5 hours back and forth to see a specialist.
I'm not sure when I can do it across state lines.
insurance coverage for telehealth.
Insurance doesn't always cover telehealth
Internet interruptions
Issues with changing rules/regulations and staying up to date
It has been great! COVID really pushed it on everyone and while people are returning to the office and have f2f sessions are important, I think telehealth is here to stay.

It would be nice to have better interstate access. Psychology needs to pick up the pace with medicine and nursing (and even social work) as far as mobility across state lines (without having to pay for the PSYPACT). Can we figure out a national licensure that would allow PhDs especially to practice anywhere once licensed (just like in the VA?)
It's not conducive to crisis work, so recommend detailed information on how to access crisis services be given to client at intake.
It's a necessary evil, sometimes taken advantage of by patients and clinicians.
I've experienced some problems with clients being in public places or driving or having people off camera that are listening. Those are challenging for confidentiality and safety, but we have practices to ask and communicate clearly about expectations for use of telehealth.
Just getting internet connection on client's end to work or technical issues with my EMR.
Just insurance companies being very difficult to deal with.
Limitations to establishing/maintaining rapport during telehealth.
Making sure they are confidential
Many.. but a few to mention -providing services while driving or in public places - length of sessions seems work thru telehealth may be more efficient but have seen practitioners continue conversation to make sure billing works for them vs what was needed
Might need guidance on how to determine is someone is not a good candidate for telehealth and how to communicate this information effectively.
More difficult to establish personal connection, therapeutic alliance. Hard to assess facial expressions
My main concerns in telehealth are related to insurance reimbursements and maintaining the value this provides for rural communities to access high quality services.
No (102 times)
No answer
No concerns with telehealth services.
No issues (2 times)
No issues about how people practice on telehealth, but concerns about whether insurance will continue to cover it. I think it is important to have it be covered and to have it as an option for rural Kansans and people who could have transportation issues
No other than issues of location of client and practitioner being different (legal parity across state lines is needed)
No overt concerns...telehealth is a good option for geographically dispersed and transient communities
No working well but just a lot to keep up with to do it right.
No, I work inpatient hospital
No, it's gone well

No, my clients love the convenience and accessibility, though I know it doesn't work for everyone
No. Get over it. Telehealth and online education is the future. Psychology is going to die to master's level clinicians if we don't embrace innovation and change. We need more early career professionals on the board.
No. I do a very limited amount
No. Telehealth is a great addition.
No. I am a 100% remote psychologist and love it.
no. I do not really understand this question.
No. I exclusively practice telehealth, and it has increased access exponentially. There is more consistent attendance, increased reach, and has allowed me to serve those most in need of services.
No. I've had very positive experiences. I use doxy.me for video sessions.
None (9 times)
None in my experience.
None noted (2 times)
Not in the practice of telehealth. Patients have had some changes in insurance coverages or requirements that I haven't always been aware of.
Not really, but I also don't do much telehealth working predominantly with children and adolescents.
Not really. I think telehealth is really helpful for increasing access to behavioral health services for patients. I work with a chronically ill population - and telehealth can also help reduce appointment burden for patients.
Not really. It's been surprisingly useful.
Not sure
Not sure what you mean by issues. I dislike telehealth and find it inferior to in person therapy but am thankful for it in cases of illness, poor weather, infirmity.
Not too much, but while telehealth is a useful tool, it may be getting overused. Practitioners provide services in states where they are not licensed, and there is no real monitoring of their activities
Nothing serious.
Nothing specific, just feel it is evolving and so ongoing education is important
Only concerns have been connectivity and patients trying to drive while doing therapy.
Only technology issues
Patient crisis on telehealth, The VA has a very rigorous protocol regarding care management on telehealth as well as back up resources in the event of crisis. It would be worth a look at this as a model for practice.
Practicing across state lines
Practitioners are rarely informed and the nuanced ethical issues related to telehealth.
Same issue as stated in #12 above.
Seems to be a bit perplexing about what can and cannot be effectively offered. There always seems to be issues with confidentiality, what services are best, etc.
Some unique ethical issues (e.g., parents driving while on the call, seeing home environments that looked concerning)

Sometimes the connection is not optimal, leading to loss of sound or complete loss of connectivity.
Sure, some people are not a good match for telehealth. Also poor internet is often an issue.
technical limitations of the platforms, yes and connectivity disruption issues for families using a variety of devices/phones
Telehealth has been a godsend for my clients. I see a much better ability for people to attend sessions and engage in the long-term work needed in Eating Disorder recovery.
Telehealth is a great service allowing for people in underserved regions or unable to get to a clinician's office access to care they would not otherwise have. People with more severe and complicated disorders need more contact with treating sources.
Telehealth is over emphasized. It is a convenience for clients and providers, but it lack true interpersonal connection AND it leads to a devaluing of the therapeutic space. It is put out there that telehealth is "just as good, but it is not. It is a necessity in underserved particularly rural areas, but it is not the same as face-to-face. People are distracted and not fully present in the session.
Telehealth is over-used !
Telehealth remains a helpful tool. I find it draining and not engaging. I am concerned more people may move to telehealth and miss the personal connection offered by in-person tx
Tele-health seems to be appropriate for higher functioning cases. My observation is that in rural populations, it becomes borderline inappropriate for more severe (SPMI) cases.
Telehealth tech companies are providing some of the lowest quality services - it's shocking it's legal.
Telehealth was a godsend for practitioners and clients during covid-19. It is still so helpful to elderly and handicapped. This question seemed negatively oriented & I resent it.
The biggest issue for me has been the need to be licensed in the state where the client is located, or to have PSYPACT. I wish there was an easier way for me to see my patients when they are away from home.
The technology is helpful, but there are limitations to services that can be provided through that format, primarily neuropsychology
The threat of discontinuing reimbursement for telehealth services is particularly damaging for rural Kansas.

The transition into offering Telehealth services was certainly an adjustment and required additional education and research to identify best practices and how to navigate issues unique to Telehealth. I would say one of the concerns that I have worked to navigate and that I've seen others struggling with would be simply doing our best to ensure basic privacy and confidentiality. I have witnessed both clients and mental health professionals attempt a Telehealth session in a public or semi-private setting that would not be conducive to therapeutic work. For me this is an opportunity for education and boundary setting, but I'm not sure providers always practice appropriate boundaries with clients.

Transitioning from telehealth to in-person has been very difficult for some.

Unclear about best practices for telehealth since the pandemic.

We have only had positive telehealth experiences so far. Telehealth gives more people access to services.

Yes (6 times)

Yes, expansion of chat and telephone "therapy"

Yes, I think there are still inconsistencies re: how providers use telehealth. Having PSYPACT and taking additional CEs focused on the ethics/rules of telehealth has been very helpful in my practice.

Yes, many

Yes. People more lax in practicing outside of their state boundaries and outside the limits of their license/credentials.

Yes. Do some telehealth.

Difficulty primarily in disruptions to telehealth streaming due to tech limitations

2) increased time needed to tasks that is faster/more efficient in person. Loss of billing.

LP Q15. Over the past two years, have you experienced any negative issues involving supervision? If so, please explain. (235 responses)

A major struggle for assessment-focused internships/post-licensure hours is the focus on hours of face to face time. There is quite a bit of time spent in report writing which is an assessment part of the core clinical service being furnished, but supervisees feel like it doesn't "count" because those hours don't go into the face to face hours they are trying to build it. It creates a misplaced focus for them on the testing piece of assessment and de-emphasis on conceptualization, integration, and report writing. This is backwards given that some may go on to work in practices with psychometrists where they would do relatively little direct testing and spend the majority of their time on intakes, writing, and feedbacks. I respectfully ask that report writing time be considered direct service time from the point of view of accumulation of supervised hours.

Difficulty with intern-level supervisees who are not up to the level they should be - not up to the level where they used to be. Believe this may be due in part to having most of their education during the pandemic, but unsure as it seems to be getting worse, not better.

Do not supervise others.

Generational differences perhaps

I am involved in training psychologists and these graduate students report many negative experiences with supervisors including inconsistency of supervision meetings, boundary crossings, and other ethical issues.

I am not providing supervision to anyone and that was not an option in question # 14.

I do not do supervision.

I do not provide formal supervision. Zero should have been an available option above.

I do not supervise anyone. That was not an option in question 14.

I do not supervise by choice

I don't currently supervise others formally.

I don't provide supervision at this time

I don't provide supervision to anyone (I responded "prefer not to answer" to question #14 above because "0" wasn't a response option).

I don't provide supervision.

I don't supervise anyone

I don't supervise. Your question above was missing that as an option.

I had a supervisee that was not completing notes in a timely manner and I did not feel supported for holding her accountable by the office I was working in.

I have experienced no such negative issues.

I have found over my years in practice that the younger generation has more difficulty accepting feedback.

I have had an extern that had poor attention to detail and a chip on his shoulder who was unprofessional in many ways. I am also on our facilities training committee, and I have noticed a trend of entitlement and arrogance with recent trainees. Also, most alarmingly, is the complete lack of assessment experience coming out of graduate school, a trend that APA does not seem to care to acknowledge.
I have not
I only provide supervision in emergency cases if our clinic director is absent
I recently added a supervisee and found the training plan requirements to be overly costly for the supervisee.
I was ignorant to how little masters level counselors know. So it was a shock when I started supervising them.
individuals of different disciplines supervising (e.g., social worker supervising a counselor)
It is very difficult to incorporate new practitioners into our practice because they licenses are so restricted, preventing reimbursement from insurance companies. This is much easier in our Nebraska office
It seems that some of the early career professionals that I am supervising are not as capable or prepared for clinical work as compared to prior trainees.
I've struggled with issues related to lack of professionalism with younger trainees, difficulty maintaining professional supervision versus supervisee's desire/need for therapy, lack of training in psychological testing at universities, etc.
Just the variation in who is allowed to provide supervision to which licensees. I have considered providing supervision, but will pursue specific training before doing so.
Lack of standardization across companies.
Lack of true supervision
Managing personality issues between supervisees and co-supervision providers
N/A. I don't do any supervision of others.
NA - not currently directly supervising any other professionals or students.
No (160 times)
No also I don't supervise any individuals but there is no choice for that on the previous question.
No I do not currently supervise.
No issues personally. But others mention a lack of previously effective supervision
No negative issues
no opportunity for direct clinical supervision due to the regulations that supervisors must be same field; I would think a PhD could supervise an MA/MS regardless of the specific field
No standard of practice
No, I do not provide supervision.
No, I don't supervise. No option above for that
No, it has been a very rewarding experience.
No, thankfully. The only tricky part with supervision is that it does not count as a billable hour. It's an important part of our field but the need for me to prioritize RVUs inhibits me from wanting to be more involved in supervision at times.

No, the two I've supervised have been delightful
No. My supervisors are excellent and supervises rating me highly
None
Don't supervise anyone
None. I do not supervise anyone
Not applicable
Not currently supervising any clinicians.
Not enough clinical supervisors to support psychology in public sector work. It takes three years to get an entry level hire eligible to supervise. By that time, they leave for higher pay in private practice. Training programs are drying up and can't compete. I question psychology's future as a field as a high percentage are leaving higher education and agency work for private practice. It's a shame.
Not in the past 2 years. I quit supervising a few years ago. I was always training and supervising psychology interns, medical students, residents, and other mental health practitioners throughout my career. In all of that I had one REALLY concerning experience with a PhD student at a local university.
Not personally. However, I have had trainees disclose issues with other supervisors without much awareness of the best options for reporting this if the internal protocols are insufficient in responding to their complaint.
Not too much. Sometimes the expectations of the BSRB are not entirely clear. But, they've been very helpful.
Not with me. Part of my job is navigating supervisory issues for our students.
Nothing very out of the ordinary.
One is very very well trained and experienced. The other just didn't get the education and mentorship they needed and I am concerned whether they will ever become clinically licensed. The LMLP programs have largely become stepping stones to doctoral programs, which is certainly welcome as a hedge against the "dumbing down" problem, but it somewhat leaves Kansas only with LMLPs who can't get into doctoral programs. There are also just concerns about, what lack of a better word, could be described as "maturity" and "vocational identity." It is in many ways too easy to get these degrees and there is almost no culling process that I can discern. Some programs are better than others and some candidates are better than others, but there is a fair number who just aren't great providers and think they are. I've been at this over 30 years and I never let myself think I'm any good. And thus I do about 150 hours of continuing education a year. And when supervisees come to me with CE requests they are always the easy, cheap, online class, not something mindfully selected to address an area of need. We now do our own training in house and that's improved, but the yearning for improvement and growth is often not present and God forbid they take a risk or feel uncomfortable.
Recent students and graduates of doctoral programs I have supervised have tended to be less skilled in critical thinking, formulation, and conceptualizing their patients and plans for interventions. Instead, these supervisees have had difficulty thinking outside of the DSM and manualized treatments.

recruiting into the field, supporting needs of trainees - recent cohorts have had higher level of burnout and mental health needs. Its a lot for supervisors to navigate. I am a training director and this has also been challenging in mentorship of supervisors and navigating a political landscape that produces significant barriers in addressing training gaps and that impact educational and service excellence.
See above, I'm not supervising anyone.
Some supervisees seem less experienced and mature
struggling to find supervisors for trainees in a multi discipline office
Students require more structure, support and teaching than ever before in my time being a supervisor. It is twice as much work if not triple.
Supervisees, as I noted above, are seeing increased service demands, with lees time for supervision and peer-to-peer contact.
The above example was a practicum student that I removed from their placement due to unethical harmful behaviors towards LGBTQIA+ children but their program maintained their ability to graduate.
This may need to clarify giving or receiving supervision.
I had a negative experience providing supervision to a psychology intern who was telling other supervisors and peers in the program that she was unhappy with the supervision while telling me she felt it was going well. She asked other supervisors not to tell me and they agreed while encouraging her to talk with me. We were not able to build a trusting relationship although worked together adequately.
Trainees who had their clinical training experiences interrupted by the COVID-19 pandemic.
Underprepared and under-skilled practicum student
When a practitioner has more than one supervisor there is a greater need to clarify relationships and communication
Yes- having a trainee that was not receptive to feedback or responsive to remediation efforts, leading to termination of their training with me.
Yes, I was supervising several master level counselors, both pre and post graduation. Having the board approve supervision proved very difficult. This was frustrating since the master level counselors had been taught largely by instructors who were PhD level psychologists. There is also a lack of supervisors in the area. Yes, some supervision can be conducted online. However, I am not sure if a provider in a different part of the state has an understanding of the unique cultural issues that arise in southeast Kansas (SES, ethnicity, religion, etc...). Similarly, I worked at a rather large agency, some of the supervision included how to navigate agency related issues. I am not sure how a supervisor who has never worked at the agency, and maybe have not even heard of the agency, can provide supervision on these issues. Tele supervision is not a panacea to these issues.
Yes, supervisees not following guidelines established and discussed with them, seem to not take their job seriously/being somewhat flippant.
Yes. I work in a government agency.
Your forced choice options did not give me the option to answer "0." Oops.

Your question is too vague

LP Q16. Do you currently use artificial intelligence (AI) in your practice? If you do, in what areas do you use AI? (297 responses)
Absolutely not
AI is sometimes useful to begin a search of information and then Google includes the sources of the information parallel to the "article" that seems like a useful next step--not much different from a traditional information search online.
Basic use--making public statements; creating exam questions; helping with lectures.
Do not use AI.
Do not use.
Finding current research for medical opinions.
Guiding the writing of intakes
I am still trying to discern where AI has a place in my work. It is somewhat helpful to search records, but I find it misses clinical information needed by psychologists. It may be more useful to psychiatrists/ medical doctors who need data from imaging, labs, etc. The statistical probabilities stemming from hard data, which I assume AI can provide, would be useful. Psychologists also have to rely on interactions, mood, thought content, reality testing, etc. Not sure AI can be helpful there.
I am trying to avoid it -- other than for proofing writing. Our EMR offers this and staff and I reviewed it and I'll believe it when I see it. I'm a pretty savvy IT guy and have been since the 1980s and the idea that the AI is going to listen to our session and write the note is about as plausible as flying cars. It might do it, but the ethical and risk management issues present in that scenario haven't been touched. And I don't know where APA is at on this. Last CE conference I attended in 2023 in DC, all the classes were very young psychologists talking about how to use TikTok and while entertaining I think in retrospect it was not very foreword thinking or helpful. Don't know if I'll make it to Denver in August, but that will be on my agenda if a class is offered.
I do not use AI in my practice.
I have used AI to generate form letters
I primarily use AI to improve emails or letters of recommendation. I have also benefitted from using AI to help identify relevant research in areas of clinical interest.
I try to keep my use of this minimal. Security and quality concerns. There may be some embedded elements in my emr for autocomplete.
I use AI (deidentified) to assist in cleaning up some parts of my writing. I do have some ethical concerns regarding how AI is possibly being used, hypothetically speaking, as this appears to be a brand new area with no clear guidelines as of yet (at least to my knowledge).
I use AI in my private practice where I see 5 people a week. I do not use AI in my supervisory role.
I use AI to help generate ideas for exposure
I use ChatGPT occasionally to help me create a handout or to summarize information on a given topic.
I will occasionally use it to research a question.

If I want to check myself on information, I ask AI. I have found that it can provide quick general findings, but often lacks specific statistical information. The agency I work for plans to rollout AI assisted notes within the next year.
Minimal use to help with report writing or letter writing. Just to help clarify thoughts I've written or to give a jumping off point. I never rely solely on AI for anything.
No (185 times)
No and I am opposed to AI psychology
No and I pray I never do.
NO but we are moving towards using it
No- I don't believe the state of the art is yet sufficiently ready for clinical practice. Aldi, many ethical issues/ potential pitfalls.
NO! (2 times)
no, I am starting to use AI in writing a new book on attitudes
No, but exploring potential applications
No, but I would definitely be interested in a secure AI for notetaking. Adjunct resources between sessions have potential for increased learning and change as well. Could see it being helpful for psychological reports as well. If we don't embrace AI, we are obsolete. I use AI all the time in my administrative roles, notetaking, editing, communications, etc... I hope you use it to analyze these qualitative responses. :)
No, but I'm considering using AI to capture documentation during psychotherapy sessions.
No, but there is potential for this.
No, however my hospital is beta testing AI-supported clinical note dictation and it would be great to hear some feedback on this for our field.
No, I do not and I have concerns about the protection of confidentiality.
No, I do not think this is a good idea, but I hear others are using this technology to write reports. I do not allow my supervisees to use AI for anything.
No, not a fan
No. I prefer not to use an AI notes writer.
No. I have some serious ethical concerns about the role of AI in our field and in our society as a whole.
No... interested in learning more though
not currently. Brightside will be using AI for session notes in the future.
Not in my "practice but, I have used AI to generate an image for a book cover.
Not right now
Not that I am aware
Not yet, but I am hoping to. I'm hoping to use this to assist with documentation (possibly with transcribing sessions for progress notes).
Not yet, but I anticipate using it to transcribe sessions.
Occasionally to clarify test interpretation and language.

Occasionally use AI to generate treatment plans for generic presenting concerns. Example prompt: "please create a psychotherapy treatment plan for an individual struggling with a depressive disorder and problematic communication patterns with a spouse/partner."
Only in reviewing emails
Primarily to look over presentations and make sure that my objectives and the presentations match
Progress note creation via UpHeal
Progress notes, treatment plans (with HIPAA compliant service that clients consent to)
Report Writing
Researching, however I ask for, and double check original references provided.
Sometimes I use it as a jump start to write treatment plans
That is a very old term.
To help answer questions, to provide resources, like using Google.
Treatment planning basics
Use for generating client reports and progress notes.
we are exploring AI and the potential it may offer
We are just starting to explore how to ethically and appropriately utilize AI to assist with clinical documentation, supervision, and quality assurance.
We use it to turn brief notes taken during a session into a narrative.
We use upheal.io for documentation. It has been an amazing time saver and the notes are far more accurate. Patients have felt comfortable.
Yes - but for non-clinical questions
Yes - critical review of my writing; generating new ideas; answers to technology questions
Yes! use AI in too many ways to mention
Yes, editing reports, searching for resources, diagnostic issues
Yes, for note taking purposes.
Yes, we use a tool called Eleos with our clinical documentation. Our providers were very skeptical and resistant to adding it, but it has been AMAZING and very well received. It has improved quality of documentation and timeliness.
Yes. I use it to answer questions about substantive issues and to identify articles on these issues.
Yes. I use it for assistance with research.
Yes. chat gpt for professional emails, and presentations. Looking into AI software that is HIPAA compliant for documentation and reports.
Yes. Report writing
Yes; I sometimes use AI to help write brief reports and to organize records to review.

LP 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? (297 responses)

Additional trainings on risk mgmt and social/networking events for psychologists.

Adjusting licensing standards to focus on evidence-based practice and require demonstration of that skill through a practical exam prior to licensure.

Advocate for appropriate reimbursement, continued coverage of telehealth, and support PSYPACT

Advocate for enhanced multicultural competence and telehealth services.

Advocate for vulnerable populations (e.g., LGBTQ+, racial/ethnic minorities)

Advocating for mental health parity to be followed by insurance companies; advocating for clinician reimbursement and treatment with insurers which interferes with consumers being able to get affordable care

Allow Psychology to supervise other professions for clinical license.

An avenue where they can report their needs as a client and what they want from their therapist

As above, more clarity around AI and it's use would be helpful.

As described in #12

At the very least, we need to throw the hell out the idea that anyone gets licensed by opening their own private practice on top of a coffee shop and pays someone to have lunch with them once a week and kind of talk about clients. All supervision needs to be in an organized program of study or at the very least an organization -- CMHC, hospital, group practice, something, anything that is not the lunch supervision model. I don't believe you'll do this, but it is the only way things could be improved. It doesn't matter if it is two years or ten years, if you are not engaged with an organization and getting a diverse experience set and serious supervision, you're not going to come out as a professional provider. I could go through case after case on this. I see therapists as clients. I have had to talk them out having sex with clients, violating confidentiality, engaging in dual business relationships, cyberstalking clients, defrauding insurance by fudging diagnoses, and on and on. I am glad you are asking on this survey because it signals to me that you might actually be aware of these concerns, but it is going to be incredibly difficult to put the genie back in the bottle. Once BCBS usurped the Board and decided to reimburse everyone and their dog in 2020, the training game was never going to be the same.

Being mindful of social media and AI impact, as well as questionable business practices of larger platforms - ie Betterhelp - who may blur some of our professional ethical lines.

Also continuing to work with APA to encourage increased and fair services rates from CMS and other commercial insurance companies.

Best help is the efficiency of licensing new psychology interns, who will only have a year of clinical supervised time with us, and need insurance paneling as rapidly as possible. We cannot get the process started until a match is made, and the arrive within 3 to 4 months.
Better clarification (and enforcement) of who is allowed to use the term psychologist. For example, I see master's-level counselors on Psychology Today calling themselves psychologists. And address the master's level testing issue raised above.
Better over site of mid-level clinicians. Many practice outside their scope.
Better protect consumers from practitioners practicing Subspecialty areas of practice with out sufficient training/expertise (neuropsychology, health psychology).
Burnout is a real issue, especially for people working in underserved communities. Finding ways to alleviate their stressors, such as having overnight crisis services available can make a huge impact.
Cannot think of any at this time.
Can't think of any off-hand. Maybe more opportunities for psychologists to meet and network. Encourage more continuing education around providing supervision
CEs specific to treatment with children/adolescents would always be welcome!
Change state law preventing insurance audits of anything beyond identification information and diagnosis.
Clarification on providing mental health services through telehealth
Clarify the practice boundaries of master's level psychologists to the public.
Complaints to the board need to be handled quickly and efficiently. I am aware of two examples of issues taking over a year and still not reaching a satisfactory resolution. These were simple issues that could have been resolved quickly.
Concern for masters level clinicians and other licenses doing testing when not qualified or incompetent
Consider removing ethics/censure violations and after a certain amount of years.
Continuing information to the public about the difference between professionals who can prescribe, and who do not
continuing to provide education on how to handle litigious clients
Crack down on providers who practice outside the limits of their expertise. Clinicians at community mental health centers who provide court ordered competency evals ate a group that comes to mind.
Disallowing passing the EPPP, even if all the ethics questions are answered wrong.
Do not allow masters levels to conduct evaluations and especially not testing. It's negligent and depreciating the entire profession. Frankly some of the PsyD's out of low quality programs are also concerning. But can't have it all.
Doing what we can to influence the funding for acute/crisis mental health care.
Draw up a policy about what we can talk about with transexual kids.

Education about what therapy is as well as boundaries that therapists should have.
Encourage more long-term training post licensure. Topic or area does not matter but more depth is needed.
Ethical matters should be handled by practitioners, not attorneys.
Fight for higher reimbursement's from insurance companies so more providers accept it. Patients need ways to get affordable services.
Fight for prescription authority
Follow APA recommendations for KS. We don't need extra regulations. Eliminate the post-doc year. We are in a workforce crisis, and we need to act now. Do not adopt the extra EPPP test. Examine if we have a racial bias in passing the EPPP in our state. It's a ridiculous test and does not protect the public, but too often, keeps those with the academic training and experience from practicing. We need more interdisciplinary supervision. APA accredited internships allow for a percentage of supervision from other disciplines. Post-doc hours should as well, but like I said earlier - get rid of it.
Free ethics trainings
Have meaningful or not mid-level continuing ed
Help protect us from insurance companies.
Historically BSRB in Kansas has made it difficult for psychologists to transfer their license to Kansas resulting in a dearth of PHD's and Psy.D's in the state. This is harmful to communities. Making licensing less cumbersome would protect the citizens by attracting more psychologists.
I am a newer KS LP. I am also getting licensed in MO. I am not suggesting a process like in Missouri; however, I did appreciate the focus on CEs related to suicide screening and risk assessment. If there were gaps areas identified through this survey, requiring training or CE in those areas would be appropriate.
I am surprised that other professions licensed by BSRB require less structured supervision (not on premises, as psychology PhD candidates are required to obtain), with dramatically fewer hours of coursework and clinical work in training. Perhaps on-premises supervision is no longer required for PhD psychology licensees, either. I thought it was beneficial at the time I was seeking licensure.
I appreciate the efforts of the BSRB- I recognize that it can be challenging. I know the Board is aware that some of us do challenging work such as custody evaluations and other evaluations where the client may not get the answer or results that they are seeking. Ongoing consideration of how to balance these difficult situations in my mind requires ongoing consideration on the part of all parties
I do not. I do think sending surveys like these are beneficial. It gives those of us in the field a chance to voice what is and is not working.

I don't know if it's the role of the board, but I sense that strides could be made if coordination existed among providers and the community: from a referral system that aims for a good fit; to an understanding on the part of the public about what therapy is for; to practitioners being willing to have a reasonable "end goal" in mind. I sense this kind of coordination could ease some of the access issues that are currently a problem for the public.

I don't think so. Appreciate you allowing telehealth!

I have found the board accessible and easy to communicate with.

I have none.

I hope you continue to support telehealth

I think another big barrier for patients is the clunky insurance system- which can make it hard to find a provider in-network who accepts their insurance. And while big public systems negotiate contracts on behalf of providers, private practice therapists often have to battle insurance companies for reimbursement. The system is a mess but maybe this is an area (in time) where our licensing board can better support providers and patients to ensure fair access to services and fair reimbursement for care.

I think it would be good to be able to go through the complaint process faster than it appears to currently go. I understand the need for thorough investigation and that people are innocent until proven guilty, but I am aware of one particular complaint where - in my opinion - the social worker is predatory and I am concerned about the continued harm that has been at risk during the now year that he has been under investigation.

I think psychologists would like to see more emphasis on addressing the competency of other licensees in the provision of assessment and evaluation. Most master's level folks are not qualified to give standardized assessments AND interpret on their own.

I think some no-cost continuing Ed offerings around Telehealth and perhaps AI could be helpful. Some additional support around diversity issues (eg racism)and what's happening politically could also be helpful to at least some of us.

I think the BSRB should provide more guidance on telehealth and more guidance of the use of AI, specifically with regards to note taking.

I think the standards have decreased as insurance has reimbursed clinicians with less training. My husband is a supervisor at a large agency(also a psychologist) and they have LMFT's that come for a practicum after schooling - and they have not been taught how to diagnose. So he has to teach them.

I think there should be increased restrictions on the types of services that master's level psychologists can provide. Broadly though, I think this dynamic of doctoral level and master's level psychologists is very confusing for consumers.

I think this survey shows you are trying to do everything you can to improve services. Well done.

I wish I knew how to better protect those in need. The field of eating disorders has one organization devoted to providing informed training and certification for ED providers. That organization has undergone significant changes in the past year and the requirements to be a certified eating disorders specialist have been significantly reduced. Very worrisome. Certain specialties need some kind of certification process so the public knows the provider has truly received advanced training and supervision (OCD, EDs, Complex Trauma...). But I don't see how that could be managed at the state level.

I would like LPs to be able to supervise professional counselors in training in KS. It's borderline insulting that they cannot given our training.

I would look close at the quality of training for LPs and master's level people. How many face to face hours of supervision did they receive? was it 100 percent on-line? Does the training involve empirically based procedures. Also, the BSRB needs to look at the amount of Ethics training for MA level practitioners (e.g., Marriage and Family Therapy).

I would suggest speaking with more practitioners about how activities are classified for pre and post doc hours. There are some current definitions that do not make sense in actual practice for what does/does not count as direct hours.

I'm concerned about the quality of clinical training in training programs. I've noticed some trends in particularly social work programs focusing training on social advocacy and less on clinical or practical skills of direct service work. I'm worried about their skills in direct service work post-graduation. Also, there is not a lot of training or guidance for those that provide clinical supervision for licensure for most licenses. I think more guidance there could ensure that high quality supervision is occurring during that time period.

I'm hoping there is clarification on which license types are appropriate to be advertising and completing psychological assessments. This appears to be becoming questionable in that numerous non clinical psychologists are eliciting only patients for ADHD assessments, which are billed at a high level and not usually submitted to insurance. This seems to present several ethical considerations

I'm not sure what avenue would work best for advocating for adequate compensation for specific services, but I would think this is something that would be impactful coming from the BSRB. I want clients to be able to access appropriate resources for diagnosis and treatment recommendations, but I fear this is lacking at the moment and likely to continue to decrease over time. We need more psychologists willing to do testing and they should be compensated for their time, expertise, and the expenses incurred from testing. I also think that many providers would benefit greatly from education and training around appropriate boundary setting with clients.

I'm worried about some of the practitioners that are being graduated from a number of institutions being unprepared as clinicians. Even more troubling is that many of them seem to not know what they don't know.

Improve outreach so members of marginalized groups understand they can receive confidential, unrestricted services
Increase required diagnostic CEU, particularly in areas of ADHD and ASD.
Increase the number of required CE hours and monitor the quality of CE offerings
Increased insurance reimbursement and more consistent reimbursement to allow all consumers to receive quality care from well-trained providers.
It is a laborious process to make a report to the Board.
It would be good to provide guidelines for the use of touch.
It would be great if there was some way to ensure that clinicians are providing treatments that are evidence-based and proven to be helpful for the diagnoses they are treating.
Keep track of what APA is doing with credentialing masters programs and what support they will be giving for master's level psychologists so other states will have this licensure like in Kansas and there can be some consistency across states
Legal guidance/consultation if needed.
Make a license transferable across state lines. It would be helpful for the psychologist to only be made to be licensed where the client is, not both the client and the psychologist
Many states have rules and regulations about the involvement of mental health professionals in custody cases, specifically regarding prohibitions against giving custody and parenting time recommendations while functioning as a therapist rather than as an evaluator. Would the BSRB consider this kind of legislation or rules?
Masters and bachelor's level clinicians should have supervision/oversight by doctoral level providers, much like physician assistants work with MDs.
Mid-level providers not trained in reliable and valid evaluation methods making premature diagnoses that result in the overreliance on addictive psychiatric medications; behavioral health providers being directly involved in the provision of Ketamine and MDMA treatments outside scientific protocols, often resulting in boundary transgressions and violations
More available psychological services. Avoid long wait lists
More oversight with social workers. I have struggled supervising in an employee capacity, with difficulties with diagnosis and therapy strategies. I feel more regulation/structure would be helpful. I also have concern with advanced standing degrees, as it seems like folks who got those degrees are struggling the most with understanding therapy, techniques, strategies, and ethics. All other licenses appear to have more structure and regulation.
More support against insurance denials due to poor documentation. I have found that very few interns are coming to us with a clear understanding of how to show medical necessity.
N/A (5 times)
No (60 times)

No, I have not practiced in KS since 2013.
No, seems like the current in-place system is effective.
No. I am licensed In 4 states. Kansas has been the smoothest by faaar
No. I feel that the BSRB does a very good job.
No...I would recommend the BSRB be allowed to suspend the CEU requirement for psychologists licensed for 30 years
None (8 times)
None at this time (2 times)
None come to mind immediately
None come to mind.
None I can think if
None that I can think of
Not at this time (3 times)
Not currently - though I would wish to be able to use my psypact credential to serve KS patients with myself being in another state rather than only allowing the patient to be in another state. Wouldn't mind the state advocating that for a change to PSYPACT in the future.
Not really
Not sure (4 times)
Not sure, honestly. I would like to say more, but I don't know enough to comment intelligently.
Not that I am aware
Not that I can think of. Free CE opportunities would be wonderful!
Nothing that comes to mind.
Nothing that I am present aware. I appreciate being asked though.
Offer free or low-cost education opportunities either live or recorded. It's always hard to get the right mix of hours and differences in what counts in Kansas vs Missouri (for those of us needing to maintain both)
Offer training opportunities and more ways for providers to connect.
One major issue is finding qualified providers who accept insurance. This is not an issue restricted to KS. We need help lobbying for better reimbursement rates from insurance so private practice providers are motivated to apply to be paneled with more insurance providers, including Medicare and Medicaid.
Our board needs to be vigilant about potential state regulations aimed at interfering with client confidentiality. See the bill that passed in Ohio and the one that's been proposed for school counselors in S Dakota requiring counselors to notify parents about any gender-related issues that arise during sessions.
Patients in state hospitals esp. sex predator unit at Larned State Hospital are being mistreated by Licensees
Please do not cut CE requirements any more than they are.

Please pay closer attention to the therapy training and experience before issuing licenses. I appreciate the CE requirement for 6 hours in the diagnosis and treatment of mental disorders and 3 hours in ethics. I would like to see more CE offerings in the area of ethics in social media. Please note that Kansas has one of the highest number of required CE credits in the nation.

Possibly consider having a prospective licensee submit letters of recommendation from clinical supervisors to vouch for their competency in several different areas.

Protect DEI and the requirement for cultural competence

Protect services provided by psychologist by not allowing master's / bachelor level individuals do things that are reserved for psychologists.

provide current list of supervisors for trainees to reach out to; allow PhD to supervise LCPC candidates

Provide information on available resources for collaboration and continuing education

PSYPACT

Push back on anti-trans and anti-lgbtqia+ legislation

Refer to my comments about masters level practitioners. Without being on one of your committees, I don't know that I can provide any specific, relevant recommendations in this survey.

Some sort of newsletter to update providers on current regulations/standards would be helpful.

Sorry, no

Status quo is acceptable

Streamlined Complaint investigations. Some providers have had complaints and the process for review has been over a year. This is demanding on the provider and the consumer who did not have any resolution.

The biggest barrier to practice that I encounter is insurance companies and their varied and ever changing requirements for practitioners, including ridiculous audits, denial of certain diagnoses, and seemingly concerted efforts to avoid reimbursement for services. They are constantly screwing up on provider directories and continuing coverage. So advocating for psychologists with all insurance companies, private as well as Medicare, Medicaid, and Tricare. I have lost money over record requests, requirements to re apply for insurances I have been empaneled on for years. This is why so many providers are moving toward private pay only.

The BSRB does a terrific job. I am thankful to be licensed in the State of Kansas. Other than creating, what I perceive as an unnecessary major difference between what LPC, LCPC, Social Workers, and Psychologist do in providing psychotherapy to clients/patients, I have no concerns.

The Missouri Board offers the ethical sequence which has been wonderful, but I guess you don't need to duplicate that service here in KC. I'm happy with the BSRB.

This board deserves a lot of credit for how it balances protecting the public while assisting licensees
To allow LPs to supervise master levels counselors without undo burden.
To work with juvenile courts to better assess access to LPs who are willing to work with this population.
Treat us with courtesy & respect. Reciprocity was very hard to get from KS. APA wants to do away with state control & differences, as it interferes with free trade for Psychologists.
We need to allow types of midlevels to be supervised under Psychologists and bill commercial and government insurance under them. Huge hinderance to client care at our practice.

LP 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 psychology profession? (180 responses)

A minor one. When a member of the public files an ethical complaint against a psychologist, it would be helpful if BSRB reviewed the complaint with the complainer and boiled the complaint down to the specific complaint or question rather than just forwarding a rambling letter to the psychologist to try and figure out what the actual complaint is so a coherent response can be provided.

Again, I would request the BSRB advocate for psychologists with insurance companies to receive appropriate compensation and find incentives for more psychologists to perform psychological evaluations.

All in all, I have been involved with BSRB for years and have seen it grow and mature. It does a good job. Many rapidly evolving challenges ahead (e.g, telehealth, AI, etc) that will require careful consideration and monitoring.

All my interactions with BSRB have been timely and professional. They are knowledgeable and helpful! Great experiences getting licensed!

allow supervision across disciplines

As master level psychology professionals want to get licensure in other states, it has been an ongoing discussion about them using a term other than psychologist to keep the integrity of the doctorate degree. I believe this is very important.

At this chaotic time in our country's politics and the divisive consequences in our communities, I implore the BSRB to keep the focus on serving all the people of Kansas whether rich or poor, citizen or noncitizen, child or adult, employed or not employed. Thank you.

Change the requirement that every single complaint does not warrant an investigation. If a complaint is obviously irrational and based on the delusional beliefs of a consumer, perhaps it can quickly be recognized for the frivolous, ludicrous complaint it is without an investigation. Something to consider. Our perhaps a complaint requires a response from the provider before determining whether the complaint has merit for further investigation.

Continue to allow PSYPACT; I am a PSYPACT provider and it helps serve rural populations throughout the US.

Do anything you can to strengthen the ongoing use of telehealth services as it has been such a positive game-changer for clients.

get us prescription authority

Good to see the additional service of the online banking of CE. Hoping to see it improving the renewal process.

Guidance and alternatives are needed for trainees whose supervisor dies as they are accumulating hours.

Guidance around the use of AI in practice could be helpful.

I am a strong advocate of providing psychologists with the opportunity of prescribing psychotropic medications.

I am of the opinion that people who are to become licensees in behavioral health professions in Kansas should be required to undergo at least 50 hours of personal psychotherapy within their first five years of practice focused on developing a full understanding of their own personality factors. Licensees should have the capacity to understand their own characterological vulnerabilities. If a mental health professional cannot take stock of their own strengths, weaknesses, and vulnerabilities, they have no business practicing a profession that purports to treat other people's emotional lives and personality traits from a position of emotional maturity and health.

I am satisfied with my experience navigating the statutes and regulations, the continuing education is appropriate in my opinion and I have appreciated the support/feedback I have received any time I have reached out for advice from BSRB. Thank you for your service to our important profession.

I appreciate all the BSRB does! Again, free CE opportunities would be wonderful!

I appreciate the work that you all do.

I appreciate those that serve on the committee

I believe the rules around remote work need to be based on where the psychologist is located not the state the patient resides in. I realize this is a complicated matter but for those of us who are not eligible for the compact, it's impossible to see patients out of state. Further, I should be automatically eligible to join the compact based on my licensure in KS and MO not based on graduate program.

I currently am not seeing anyone in my office, nor am I seeing any supervisees.

I have appreciated the support for anti-trans medical bills by the KPA.

I have found telehealth to be incredibly useful for the elderly and those who do not have transportation

I have some questions about ethical duties and responsibilities to clients if licensed MH providers go on strike related to unions. I've read some things related to cases in California, but I think this might be an issue in Kansas soon.

I need to look into difference between Licensed Doctoral and Master level psychologists because I am not clear about the difference. It seems to be a bit of a grey area for me. Thanks.

I question the high cut off mark for passing the national exam. Ph.D.s go through extensive number of years of education, passing 100s of tests, going through comprehensive exams, etc. Then after a year or more of finishing supervision requirements, the candidates have re-study stuff that may or may not be on test and hope their anxiety doesn't diminish their accuracy of correctly answering a high level of test questions, some of which may not reflect what kinds of professional actions (other than ethics) that they will do in their upcoming jobs as a psychologist.

I think I covered the main one above. I might also add that there is an abject lack of -- for lack of a better word -- respect for senior clinicians (meaning experienced not elderly) by younger ones. There is a sort of "okay boomer" philosophy and the idea that anyone would be held accountable for suboptimal behavior or practice is subverted by insinuations that the supervisor is acting in a discriminatory manner rather than trying to help the supervisee meet even basic standards of practice. We are in a constant process of conflict resolution -- and getting pretty good at it -- because younger staff have come to associate correction with harassment. I could go on endlessly about this and the negative results its had on other providers and consumers, but it would require too much disclosure. Bottom line: the juniors are running the show now and arranging the experience to be as comfortable and "safe" as possible for them which equates to bad supervision and training.

I think the process works.

I very much appreciate that Kansas joined PSYPACT.

I was not aware that the Advisory Committee broadcasts its meetings every other month. This is useful information. Thank you.

I will say that when working with the board for licensure and renewal, the administrative support and the board have been fantastic. (frankly, a lot better that Texas)

I would encourage strong advocacy with state legislature to provide student loan repayment for working in non-profit/state orgs for five years rather than the 10 at the national level. This would attract more individuals to come to and stay practicing in Kansas.

I would like to see mental health providers get reimbursed at a higher rate, but that is not necessarily a BSRB issue.

I would say that older psychologists with decades of experience should have reduced CE requirements than younger colleagues with much less experience. Most of the CE courses I am required to attend add very little to my ability to provide high level care. Senior psychologists and those who have achieved ABPP certification should not be required to spend so many hours comparing CE credits in my opinion.

I wrote to the board about a year ago regarding the trans issue. The response I got was totally unacceptable.

If there is not a database for providers to log their CEUs, that would be very helpful.

I'm a lawyer in addition to being a psychologist, and even though it helps me as a lawyer when fellow psychologists retain me to represent them in licensing-board complaint cases stemming from mandated child-abuse reports, I always hate to see those clients having to defend mandated actions that they took, so I just always tell boards anytime I can that I think they shouldn't even entertain complaints based on, for example, alleged incompetence in making a mandated child-abuse report (i.e., shouldn't even make licensees submit responses to those kinds of complaints)--I think that boards should only investigate complaints stemming from mandated reports if there's an allegation of bad faith (i.e., if the complainant argues that the licensee made an unfounded report knowingly/maliciously).

I'm aware there are movements toward requiring precise hours around diversity training that has been embattled w/ the politicians. I don't think the board requiring hours with special populations is necessary as other states have done, but also would encourage the board to have clear language regarding if/when taking a on case where culture/demographics is a key concern and how an LP should be prepared to document that training/continuing ed (including doing couples work, family work, working with kids, etc. areas beyond race/ethnicity, sexuality). If an LP has not done recent training and then has a complaint or concern w/ a patient, it may be useful to have a "recommended" training areas beyond those required. Ideally, there would be some research to support the number of hours required. Personally, I dislike "this is the standard now" decisions/changes without strong empirical support. For e.g. it's reasonable to require suicide prevention with a minimum of 3 hours. It's also reasonable to recommend six hours for clinicians working with populations who pose elevated risks (e.g. veterans, adolescents, LGBTQ) when considering that the key charge of these regs is to protect the public. If number of training hours has a positive relationship with outcome, it is the board's job (I think) to help review/ produce/ evaluate/ communicate data to compel LPs toward the criteria changes. I am supportive of the current requirements for the board on CE requirements and believe it's sufficient to place the burden on the individual psychologist to include self-selected training with special populations with whom they are most likely to interact (and/or chose educational programs for their areas of weakness or desired expertise regardless of setting). My most significant beef is for LPs to be able to supervise master's level providers (even APA has moved this direction with their task force on credentialing master's programs, time for the state of KS to catch up). We have the training, arguably more than those w/ master's level. Please let us use it in KS. I'm not supervising anyone at this time and would like to be able to offer my expertise to trainees near my office. Also, I'd like to say thank you for being quick to get the tele-health PSYPACT adjustments made. I hope you will continue to support this.

In my opinion, after 35 years of practice, continuing ed. requirement is excessive.

It could be helpful to get a little more guidance on what is considered acceptable for CEs for licensure. There is a list but I always have questions. Some examples of each category could be helpful and especially examples of items that haven't been accepted. Also there are so many types of conferences affiliated with medical organizations, nursing organizations, professional organizations and difficult to tell if relevant CEs from those would be accepted.

It would be very helpful for the BSRB to provide resources related to jurisprudence issues related to mental healthcare practice in KS (eg, state laws that may regularly come up in clinical practice but vary state to state - such as duty to warn, etc).

I've felt the website could be updated, but generally, pleased.

Just wanted to note that while I am licensed in 2 states, due to PSYPACT I see folks in many states via telehealth.

Look at what Missouri and other states have done concerning restructuring supervised hours for licensure. Those hours should not need to be at the postdoctoral level. Focus on the number of hours, not whether they were obtained pre or post doc.

Make AI note programs illegal

Make it easier to do telehealth across state lines. PSYPACT is an option, but it is expensive and cumbersome. I had a telehealth license in Florida - it was simple, easy and the only restriction was that I could not practice in person. I would highly recommend their model-administered by their health dept. Cost me \$35 a year as they required I obtain a registered agent in Florida.

Master's level clinicians do not have the appropriate clinical training to conduct psychological assessments. This should be restricted to doctoral level psychologists.

Monitoring the practice of masters level providers to ensure they are not working outside of their scope of practice, especially regarding psychological testing

No (90 times)

No, but thank you for the work you do!

No, for the most part I've had a very positive experience with the board itself and appreciate you guys. Just continue to protect our doctoral specialty. The entire profession depends on it as "coaches" make the entire profession weaker already.

No. I'm sorry that I really am not that helpful in this way. Honestly I feel like I probably should get more involved with the profession as service or engaging in some form of profession related activism but I don't know where to start and my self- concept has always been sort of apolitical

Not at this time. Thanks for all you do!

Not necessarily but this survey did not allow for answering that I do not provide any supervision at this time.

Nothing else to share.

Nothing that comes to mind.

Of course, DEI is a major concern right now, given the climate of the nation.

Oklahoma allows the use of Board approved technicians to conduct specific duties surrounding psychological assessment. The net effect is freeing the clinician to perform the clinical components of the evaluation process and allowing technicians to perform the manualized data collection and mundane input tasks. This has significantly reduced waitlists for the community, while yielding high-quality clinical services at a cost savings to the insurance payor.

It's my understanding that technicians in KS are ABA-related (which is great "OK has those, too), but the specific provisos that surround use in psychological assessment has been a game changer.

Online education is increasing. How will license requirements change for these applicants?

Please extend my thanks to all of the BSRB Board Members, Advisory Board Members and Staff who provide a great service to the citizens and inhabitants of Kansas.

Please protect us from predatory insurance practices by managed care and Medicare Advantage.

Please remember that not all levels of psychology training are equal and remote training is not the same as in person

Please support any legislature or other initiatives for increasing access to telehealth psychological services

Protect DEI and the requirement for cultural competence

Providing flexibility will help keep providers working. For example it was very helpful to me as a mom with young kids to accrue my postdoc supervised hours over a longer period.

Psychologists/BSRB need to be ahead of the AI movement and its implications for treatment, chart review, etc. I trust the local Board is working with the APA and other national organizations on this issue.

PSYPACT and license portability

Reciprocal license availability with adjoining states

Reducing the number of required CEUs

See above. I'd also recommend more safe guards at the masters level to ensure the highest quality of care being provided to patients

See comment on question 17. I have had this happen three or four times in the past.

seriously consider the need for a totally separate mid-level psychology licensure

Similar -- updating statutes, rules, regs regarding telehealth services.

Sorry no. thank you for your work

Statutes and regulations seem relevant, comprehensive, and relatively straightforward. No feedback for now.

STOP GIVING/SELLING LICENSEES' MAILING ADDRESSES AND EMAIL ADDRESSES TO THIRD PARTIES!

Support for a University in Ks to offer a PsyD

Telehealth needs to be protected.

Thank you for the work you do!

Thanks for soliciting feedback!

Thanks for surveying the field and supporting us.

The quality of psychology training is excellent, but if we don't loosen up, our state won't have a pipeline for psychology much longer. Quantity is winning over quality, and I commend our master's programs for focusing on meeting the exploding demand for services in our state and opening their admissions. I hope psychology can respond and invest in keeping our training programs viable.

There appear to be an over abundance of masters level clinicians. Many of these professionals have fine training, but it appears that a fair number lack professional ethics or sensitivity. That is, some masters clinicians are happy to charge way under market value, which can cheapen the value of our work, in the public's eye.

They seem to be doing a good job now.

We have a great program in masters level psychology, makes us relatively unique as a state and helps the underserved populations.

We need so much help with these insurance companies who try to interfere with treatment, are slow to pay. Clients pay for this insurance and yet they operate in bad faith. I have not been paid \$1000.00 + owed for a year and excuse was they sent it to the wrong address. I have only received payments directly into an account or to the same PO Address for safety/confidentiality, so that was a bald faced lie. Client quit treatment as she is afraid they will never pay, so they get out of giving her what her workplace paid for.

We need to amplify our focus on nutrition education for clients. The research is clear that what we eat affects our brain, body, and mood.

Work with other states to develop reciprocity. The PSYPACT has been great for psychologists. I don't know if other licenses have similar programs. Thanks for your service to our profession.

Working with other states on reciprocal licenses. I have had several people who have moved out of state since the time of offering telehealth that would have liked to have continued therapy remotely with me. We could have done that, but it would have required me getting licensed in multiple states which was not feasible.

Yes, thank you for committing the time and resources for this survey.

You don't have an option of zero hours of supervision or zero supervisees on this questionnaire. You might want to have a few psychologists review your questionnaire drafts next time to be sure that it doesn't have any errors of this kind.